



WHITE COATS
BLACK⁴ LIVES

Racial Justice Report Card

2019

FULL REPORT WITH SUPPLEMENTAL MATERIALS

Table of Contents

Acknowledgements

Introduction

Background to the Racial Justice Report Card (RJRC)

Methods

Scoring

2019 Metrics

URM Student Representation

URM Faculty Representation

URM Recognition

URM Recruitment

Anti-Racist Training & Curriculum

Discrimination Reporting

URM Grade Disparity

URM Support/Resources

Campus Policing

Marginalized Patient Protection

Equal Access for All Patients

Immigrant Patient Protection

Staff Compensation & Insurance

Anti-Racist IRB Policies

Report Card Summaries

Conclusions & Recommendations

URM Student Representation

URM Faculty Representation

URM Recognition

URM Recruitment

Anti-Racist Training & Curriculum

Discrimination Reporting

URM Grade Disparity

URM Support/Resources

Campus Policing

Marginalized Patient Protection

Equal Access for All Patients

Immigrant Patient Protection
Staff Compensation & Insurance
Anti-Racist IRB Policies

Summary

References

Appendix A: 2019 Metrics and Scoring

Appendix B: Full Report Cards by School

Frank H. Netter School of Medicine at Quinnipiac University

George Washington University

Harvard Medical School

Icahn School of Medicine at Mount Sinai

Johns Hopkins University School of Medicine

Sidney Kimmel Medical College at Thomas Jefferson University

Tulane University School of Medicine

University of California Berkeley - University of California San Francisco Joint
Medical Program

University of California, San Francisco School of Medicine

University of Colorado School of Medicine

University of Miami Miller School of Medicine

University of Michigan School of Medicine

Perelman School of Medicine at the University of Pennsylvania

University of Pittsburgh School of Medicine

University of Rochester School of Medicine & Dentistry

Washington University in St. Louis School of Medicine

Yale School of Medicine

Appendix C: 2019 Responses by Institution

Appendix D: Glossary

Appendix E: Medicaid Representation at Affiliate Hospitals

Appendix F: 2018 Metrics

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Introduction

Background to the Racial Justice Report Card (RJRC)

Racism has played a significant role in the history of American medicine and continues to plague our healthcare system. Black Americans die 4 years earlier than their white counterparts (Arias 2019), have poorer access to health insurance and healthcare, and are underrepresented in the physician workforce. Medical schools and their affiliated hospitals are tremendously powerful in American healthcare and have a responsibility to promote racial justice in medicine; however, they have largely failed to do so:

- In 2018, only 11.2% of medical school graduates were Black, Latinx, or Native American (Association of American Medical Colleges 2019).
- Patients of color are often unable to access care at academic medical centers in their communities. For example, Black patients in New York City are less than half as likely as white patients to receive care at academic medical centers (Tikannen 2017).
- Low-wage healthcare workers, including many who work at academic medical centers, are often paid less than a living wage. Indeed, over 1 million women healthcare workers and their children, disproportionately women of color, live in poverty (McKluskey 2016, Himmelstein 2019).

White Coats for Black Lives (WC4BL) believes that in addition to promoting diversity and inclusion, academic medical centers must also commit to policies and practices that intentionally promote racial justice. The Racial Justice Report Card is a WC4BL initiative with three principal goals:

1. Articulate specific ways in which academic medical centers can promote racial justice
2. Allow medical students to express their views on the policies and practices of their institutions and facilitate students' efforts to advocate for change
3. Ensure public accountability for academic medical centers to promote racial justice

The Report Card consists of fourteen metrics that evaluate institutions' curriculum and climate, student and faculty diversity, policing, racial integration of clinical care sites, treatment of workers, and research protocols. WC4BL relies heavily on the input of local students for the completion of this report. We believe that local chapters and groups are best equipped to evaluate their schools and interpret the nuances of these metrics as they relate to their institution's specific environment.

Ultimately, WC4BL hopes that the Racial Justice Report Card will highlight best practices and encourage academic medical centers to direct their considerable power and resources toward addressing the needs of our patients and colleagues of color.

Methods

The Racial Justice Report Card was initially developed in the fall of 2016, inspired in part by the American Medical Student Association's PharmFree Scorecard (AMSA, 2012). Students at Icahn School of Medicine at Mount Sinai created a comprehensive set of metrics that was then edited by the National Working Group of White Coats for Black Lives, alongside feedback from students across the nation.

The inaugural Racial Justice Report Card was published in the spring of 2018, and evaluated ten medical schools and their affiliated academic medical centers, which were chosen based on their national prominence as measured by NIH funding:

- Harvard Medical School (Boston, MA)
- Icahn School of Medicine at Mount Sinai (New York, NY)
- Johns Hopkins School of Medicine (Baltimore, MD)
- Perelman School of Medicine at the University of Pennsylvania (Philadelphia, PA)
- Sidney Kimmel Medical College at Thomas Jefferson University (Philadelphia, PA)
- University of California, San Francisco School of Medicine (San Francisco, CA)
- University of Michigan Medical School (Ann Arbor, MI)
- University of Pittsburgh School of Medicine (Pittsburgh, PA)
- Washington University School of Medicine in St. Louis (St. Louis, MO)
- Yale School of Medicine (New Haven, CT)

These schools were reevaluated for this year's Racial Justice Report Card. The following additional schools were evaluated for the first time in 2019:

- Frank H. Netter MD School of Medicine at Quinnipiac University (North Haven, CT)
- George Washington University School of Medicine and Health Sciences (Washington DC)
- Tulane University School of Medicine (New Orleans, LA)
- University of California Berkeley - University of California San Francisco Joint Medical Program (Berkeley, CA and San Francisco, CA)
- University of Colorado School of Medicine (Aurora, CO)
- University of Miami Miller School of Medicine (Miami, FL)
- University of Rochester School of Medicine and Dentistry (Rochester, NY)

Because the Racial Justice Report Card aims to promote the perspectives and leadership of students, grading and research was conducted by medical students at the schools being graded whenever possible, and included focus groups with current students. Students also penned the bulk of each metric's extended responses that delineate explanations for a given grade. The remainder of the research was conducted by members of the National Working Group using information available on public websites. Report cards for Johns Hopkins, University of Michigan, and Washington University in St. Louis were completed solely on publicly available information by the National Racial Justice Report Card Committee after unsuccessful outreach to relevant student groups. For all schools, the percentages of URM students were calculated based on data from the American Association of Medical Colleges (AAMC 2017). The shares of patients covered by Medicaid insurance at each teaching hospital were calculated using Medicare Cost Reports HCRIS files for 2017.

The office of the dean of each medical school was supplied with a draft copy of the school's report card from the Racial Justice Report Card National Working Group, who keep local students' contributions confidential. Administrators were instructed to provide feedback and additional data directly to the National Working Group, and not to contact students at their own institutions. These stipulations were detailed in email communications with administrators, after students provided feedback in 2018 that they were targeted and intimidated as contributors.

Where public data sources contradicted information supplied by the school, public information was considered the basis of the school's grade, and the school's claim was noted in a footnote.

After students at institutions provided final grades, this cumulative report was compiled by the Racial Justice Report Card committee.

Scoring

Each of the metrics within the Racial Justice Report Card is graded separately with a grade of A, B, or C, with the exception of Metric 13 (Staff Compensation and Insurance), which is graded with an A or C. The institution's overall grade is an average of the grades on the fourteen individual metrics. Of note, because the lowest possible grade on each metric was a C, grades of C often represent what in most academic settings would be a grade of F -- that is, a failure on the part of the institution to meet the criteria laid out in the metric. In light of this fact, overall grades should be interpreted conservatively; an overall grade of B, for example, likely reflects significant shortcomings on many specific metrics.

Although school administrators may contribute additional evidence, students are the final arbiters of the grades assigned to their institutions. This policy is intended to upend the typical medical hierarchy by empowering students to evaluate the performance of their institutions.

Scores:

A = The above metric is fully met (2)

B = The metric is partially met (1)

C = The metric is not met or there is no publicly available information (0)

Final School Grade (Average):

A = 1.72-2

A- = 1.44-1.71

B+ = 1.00-1.43

B = 0.87-1

B- = 0.58-0.86

C+ = 0.30-0.57

C = 0 - 0.29

2019 Metrics

After the release of the inaugural pilot report cards, WC4BL solicited feedback from students across the country. As a result of this feedback, the original fifteen metrics were revised to the current fourteen below. These changes are intended to make the metrics more comprehensive, applicable across a variety of institutions, and useful as a springboard for future demands for change.

The previous metric “URM Representation” was subdivided into the two metrics, “URM Student Representation” and “URM Faculty Representation”, evaluating diversity among students and faculty. Additionally, student dialogue following the 2018 report card better delineated expectations of what an explicitly anti-racist medical education should incorporate. As a result, the three metrics “Anti-Racism Training”, “URM Leadership”, and “Anti-Racist Curriculum” were modified and incorporated into the new metric “Anti-Racist Training and Curriculum”. The primary goal of this new metric is to set higher and more comprehensive standards for academic training in order to meet the metric fully.

Appendix D briefly lists the fifteen 2018 metrics. Please refer to the [2018 Racial Justice Report Card](#) to view the original metrics in full.

URM Student Representation

Medical school students are at least 13% Black, 1% Native American, and 17% Latinx (corresponding to the share of these groups in the U.S. population).

Given the significant underrepresentation of Black, Latinx, and Native American people among physicians, it is imperative that medical schools proactively seek to rectify these disparities by training a physician workforce that is *at least* representative of the U.S. population. Although medical schools frequently argue that their failure to enroll URM students reflects shortcomings of the K-12 and undergraduate education systems, medical schools themselves have significant power to address disparities in the educational pipeline to medical school. For one thing, many medical schools are affiliated (formally or otherwise) with undergraduate institutions and can collaborate with those institutions to support URM students interested in pursuing careers in medicine. Moreover, medical schools and academic medical centers are often the

largest and wealthiest institutions in their local communities and thus have significant potential to financially support local public schools and their students, both directly through taxes and voluntary contributions to local governments, and indirectly through improved wages for school childrens' parents. Finally, medical schools must think of themselves as educational institutions, not merely credentialing organizations. It is therefore their role to support and train students who may have received inadequate education prior to enrolling in medical school.

URM Faculty Representation

Medical school faculty are at least 13% Black, 1% Native American, and 17% Latinx (corresponding to the share of these groups in the U.S. population).

In the same way that medical schools have significant resources with which to address disparities in the educational pipeline, they can also have a positive impact in the medical profession by committing to the development and promotion of URM clinicians. The vast majority of medical schools have insufficient URM representation among faculty and medical school leadership. This is not accidental. The leadership of a medical school or hospital reflects the principles and priorities of the institution. An anti-racist institution does not simply tolerate the presence of Black and brown people, but ensures their promotion to the highest levels of leadership. In other words, diversity and inclusion are not just about having people of different identities and experiences present within an institution or organization, but transforming the environment through the integration and promotion of marginalized individuals.

Many racist practices and policies restrict the inclusion of URM faculty, and it is the medical institution's responsibility to remove these barriers. This may include greater transparency in the qualifications for faculty positions, active recruitment of URM faculty, greater financial and mentorship support for URM faculty, and formal acknowledgment of the racial justice-related labor (mentorship, recruitment, committees, etc) in which most URM faculty participate. As with student representation, it is imperative that medical schools proactively seek to rectify disparities in faculty representation so it is *at least* representative of the U.S. population.

URM Recognition

The physical space of the medical school acknowledges the contributions of alumni and other physicians of color (through plaques, statues, portraits, and building names) and does not celebrate racist or white supremacist individuals.

In recent years, many municipalities and universities have removed the names and likenesses of Confederate generals and white supremacists from public spaces. Because many medical school founders and donors are less well-known, there has been less attention paid to the individuals celebrated on medical school campuses. As part of a broader project of reckoning with medicine's troubling history of racism, medical schools ought to undertake research into the ideologies and activities of individuals featured on their campuses, and remove the names and images of those found to have supported eugenics or other white supremacist causes. This research must extend not only to historical figures, but also to contemporary donors who have engaged in practices such as weapons manufacturing, exploitation of low-wage workers, funding of racist political causes, or employment discrimination. Furthermore, medical schools must ensure that alumni of color, as well as patients and other people of color who have contributed to the advancement of medical science, are celebrated publicly.

URM Recruitment

The medical school's recruitment policies promote racial justice. The medical school application does not inquire about the applicant's criminal history. The medical school recruits and admits undocumented students and students of color who attended public high schools in the county or state where the medical school is located. Students of color who participate in recruitment are compensated for their time.

As a part of their commitment to the communities they serve, medical schools ought to enroll students of color from their local communities. This requires the development of meaningful pipeline programs with longitudinal investment in students of color, and a commitment to admitting students to medical school after they have completed the pipeline programming. This also requires ensuring that students of color, including undocumented students who cannot receive federal educational loans, are financially able to complete medical school.

With regard to recruitment, most medical schools rely on URM medical students to volunteer large amounts of time to recruit prospective URM students. These commitments reduce the time that URM medical students have available for other activities, such as studying, research, or leisure. While many URM medical students feel motivated to participate in recruitment activities even without pay, medical schools ought to compensate these students fairly for their time and/or pay other professional staff to carry out recruitment activities.

Of note, WC4BL would like to acknowledge that many medical school staff members, especially staff members of color, have engaged in serious, committed efforts in recent years to recruit and support URM students. WC4BL has heard from students at many institutions how much they value and appreciate these staff members; WC4BL hopes, through this report card, to highlight the additional resources, cultural changes, policies, and protections that are necessary in order to more effectively support URM students.

Anti-Racist Training & Curriculum

The curriculum incorporates information about the history of racism in medicine, intersectional oppression, and racial justice strategies, and explicitly addresses the fact that race is a sociopolitical construct, not a biological one. Lecturers avoid describing race per se (rather than racism) as a risk factor for disease, cause of health disparities, or basis for diagnostic reasoning. Community advocates and students who are underrepresented in medicine are incorporated in the planning and leadership of the preclinical curriculum.

Many medical school lecturers state or suggest that race is biological or genetic. This is sometimes done explicitly, but is more often implied by describing persons of a particular race as being at elevated risk for a given disease. The problem with the implication that race is genetic or biological—beyond the fact that it is false—is that it obscures the fact that observed differences between people of different races are political in nature and are artifacts of social disparities. When, for example, “being Black” is described as a risk factor for hypertension, it curtails discussion of how the manifestations of racism, such as chronic stress, food deserts, and poor access to healthcare, might contribute to hypertension. It is essential that future physicians be aware that race is a sociopolitical construct designed to create a political hierarchy, and that it is the dominant groups’ pursuit of power that contributes to illness. To this end, any discussion of “racial disparities” in medical school courses should include a thorough examination of the ways in which oppression contributes to disease.

Medicine also has a long and well-documented history of exclusion, eugenics, and unethical experimentation on people of color. Knowledge of this history is essential for understanding the complex and fraught relationship that exists between medical institutions and communities of color today. However, many medical professionals lack even a basic awareness of this history. To rectify this, medical school curricula must include information about these events, and extensive discussions about their lasting impact on communities of color. It is also important that students and faculty understand the ways in which racism intersects with other forms of oppression, including misogyny, transphobia, homophobia, Islamophobia, xenophobia, classism, and ableism.

Finally, physicians-in-training must be equipped with concrete tools to address both interpersonal and structural racism within and outside of the healthcare system. These tools might include techniques for addressing racist comments by colleagues, data analysis skills for identifying inequities in care, and training in activism and organizing. In order to properly train faculty and students in these topics, medical schools may need to seek assistance from outside organizations or individuals with relevant expertise and personal experience. Medical schools have increasingly incorporated information on health inequities and public health into their curricula. While people of color and local community members are sometimes asked to speak on panels addressing these issues, they are rarely involved in the design and leadership of mandatory curricular activities. Medical schools should develop formal, compensated roles for community advocates and people of color, including students of color, to design and lead curricular activities on topics about which they have expertise.

Discrimination Reporting

The medical school has a system for collecting student and faculty reports of racism and other forms of oppression, and a clear plan for follow-up when problems are reported.

Many students of color, LGBTQ students, women, and members of other marginalized groups, experience incidents of bigotry, harassment, or discrimination in the course of their medical school careers. In order to ensure a safe learning environment for all students, medical schools must have well-described procedures for reporting such incidents to trusted members of the administration, ideally individuals who share the student's relevant identity (e.g. a URM faculty member should be available to receive reports of racism). Reporting systems should allow students the option of reporting the

incident anonymously and there should be clear procedures for following up student reports in a timely manner. A general description of each reported incident and the follow-up actions taken should be available to all students.

URM Grade Disparity

There are no racial disparities in medical students' grades or honors, including AOA election.

It is widely acknowledged among medical students that there are significant racial disparities in the grades students receive. Medical schools must take responsibility for these disparities, whether they reflect bias on the part of graders or disparities in “performance,” such as on standardized tests. It is the job of medical schools to ensure that they create an environment in which all students can thrive and receive equally high-quality training. Medical schools must therefore conduct internal investigations of grading disparities, and develop clear, publicly-available action plans for how they plan to address disparities.

Moreover, it is well-documented that, among students with the same grades, Black and Asian students are less likely than white students to be elected to the Alpha Omega Alpha (AOA) Honor Medical Society (Boatright 2017). It is the position of WC4BL that the ranking of medical students in general, and AOA election in particular, is contrary to the purpose of medical education, which is to create uniformly well-trained physicians who are skilled at working as members of a collaborative team. At a minimum, medical schools must evaluate the existence of racial disparities in AOA membership, and if disparities exist, suspend AOA elections until new criteria have been created that result in the election of a representative group of students.

URM Support/Resources

Black, Native American, and Latinx (URM) students have access to designated physical spaces, as well as support staff, including administrators, physician mentors, mental health providers, and peer counselors.

Given the underrepresentation of Black, Native American, and Latinx students in medical school, and pervasive racism both within medicine and in the broader society, URM students require designated support systems to ensure their success in medical school. These include private physical spaces where URM students can spend time together and seek out resources, designated staff prepared to address common

concerns, URM physician mentors, URM mental health providers who can accommodate medical students' schedules, and peer counseling programs.

Campus Policing

There is no hospital/campus police force, or police are used as a last resort after the failure of alternative safety structures such as peer walking escorts, restorative justice councils, and mediation. If police or security officers exist, publicly-available data should demonstrate that they have not disproportionately stopped, arrested, or otherwise interacted with people of color.

WC4BL advocates for the abolition of police forces and the development of alternative structures to ensure community safety. These alternatives include, but are not limited to, restorative/transformational justice and mediation structures, unarmed intervention teams, walking escorts, geographically-dispersed "safe spaces," and adequate healthcare for people with mental illness and substance use disorders. Some of these alternatives are already in place within hospitals—for example, mental health professionals are available at all times to provide care for individuals who are agitated.

Medical schools and hospitals are encouraged to pilot safety structures that do not rely on the police, and ultimately eliminate the need for police or security officers within the hospital or medical school campus. Medical schools that have security officers or police must document the activity of those officers and assess whether there are racial disparities in the community members they stop, arrest, or otherwise interact with. This data, and clear plans for addressing any disparities identified, must be publicly available.

Marginalized Patient Protection

Expectations for students' level of independence and supervision are clearly documented and are consistent across training sites (for example, students are not disproportionately given the opportunity to "practice" while rotating in VA or public hospitals or while volunteering in free clinics).

Most medical schools coordinate student-run free clinics, in which uninsured and otherwise marginalized patients are able to access free care provided by first and second year medical students. These first or second year students, who have no clinical training, are not permitted to care for patients within hospitals or clinics, but are allowed to do so in the setting of free clinics. The fact that these students are permitted

to provide care is often justified on the basis that these patients do not have access to more comprehensive care provided by fully-trained providers. Academic medical centers must ensure that all patients in their local area have access to high-quality healthcare, and are not reliant on untrained medical students for care.

Moreover, in many medical schools, students are allowed to practice with greater independence in settings (such as public hospitals) that serve marginalized patients, than in those that serve more privileged patients. Given that all patients' health and safety is equally important, students should practice under the same guidelines and with the same level of supervision in all clinical settings.

Equal Access for All Patients

At the primary teaching hospital, patients of color are represented in all services (including specialist services) and practices at their rate in the local population. Patients of color are not segregated in resident or student clinics.

Many practices at academic medical centers have a policy of not seeing patients who have public Medicaid insurance or lack health insurance altogether. Given that uninsured patients and those with Medicaid are disproportionately people of color, this policy effectively limits the access of people of color to care at academic medical centers (Tikkanen 2017). Moreover, in cases where uninsured or publicly insured patients can be seen at academic medical centers, they are often segregated in clinics staffed by physicians-in-training (residents and fellows), while privately insured patients have access to fully-trained (attending) physicians. Academic medical centers must create policies that ensure that patients of color have equal access to care, and ensure that all patients are seen by the same providers and within the same clinics. To assess the effectiveness of these policies, academic medical centers should document the racial demographics and insurance status of patients seen in each clinic, and make this information publicly available.

Immigrant Patient Protection

The primary teaching hospital has demonstrated a commitment to immigrant patients including multilingual signs stating that patients are welcome regardless of immigration status, and a policy of referring immigration authorities to hospital attorneys prior to any cooperation by hospital staff.

Given the violent anti-immigrant policies of the federal executive branch, it is essential that hospitals affirm their commitment to immigrant patients and conduct

outreach to immigrant communities to assure patients that they will be safe if they seek care. Ensuring the safety of immigrant patients requires limiting cooperation between hospital staff and immigration authorities, as well as training hospital staff to refuse to speak with immigration authorities until it has been ascertained that they are legally required to do so.

Of note, contributors to this report also emphasize that, given the current political climate, medical schools and their affiliated institutions may also have private policies that protect their immigrant patients. These policies may remain undisclosed to students completing this report in order to avoid immigration authorities learning ways to circumvent these policies and systems.

Staff Compensation & Insurance

All medical school staff and staff at the primary teaching hospital are paid a living wage as defined by local advocacy organizations. All full-time staff have comprehensive health insurance that is accepted at the health system where they work.

Medical schools and their affiliated hospitals are large employers, frequently among the largest in their city or state. However, many healthcare workers, disproportionately workers of color, earn below a living wage, or are themselves without health insurance (Chou 2009, Himmelstein 2019). Medical schools and academic medical centers must ensure that all of their employees have access to high-quality medical care and have sufficient earnings to live above poverty.

Anti-Racist IRB Policies

IRB approval process requires researchers involved in any research that uses race to precisely define race and how it is being used in the research project. IRB approval process requires any research that uses race to include precise definitions of race and how it is being used in the research project. People of color are clearly identified as being a "vulnerable population" for research purposes, and IRB policies outline strategies to protect people of color from abusive practices.

There is a long history of race being defined as biological or genetic in scientific literature, in spite of abundant evidence to the contrary. For instance, there is more genetic heterogeneity between individuals of the same race than between races (Yudell 2016).

That is not to say that race cannot or should not be studied. Although it is socially constructed, race and racism have real and devastating effects on health. Any study that includes race should define it as a sociopolitical construct and examine observed differences as a product of racism, whether through differential health access, economic inequality, etc. If scientists are looking to study the effects of geography, ancestry, or other demographic variables on health or disease, they must clearly state these intentions and carefully gather their data in a scientific manner.

To promote appropriate research on racism that does not rely on inaccurate understandings of race, Institutional Review Boards (IRBs), the bodies responsible for approving research projects involving human subjects, should require researchers to precisely define the purpose and function of race in their research, and reject projects that define race as biological. Student projects should be specifically reviewed by qualified faculty to ensure that they do not utilize biological conceptions of race.

Lastly, given the history of abuse of people of color in scientific research, IRBs must specifically delineate protections for research subjects of color.

Report Card Summaries

Below are graphic summaries of the seventeen evaluated academic medical centers.

	OVERALL GRADE	1. URM STUDENT REPRESENTATION	2. URM FACULTY REPRESENTATION	3. URM RECOGNITION	4. URM RECRUITMENT	5. ANTI-RACIST TRAINING & CURRICULUM	6. DISCRIMINATION REPORTING	7. URM GRADE DISPARITY	8. URM SUPPORT/RESOURCES	9. CAMPUS POLICING	10. MARGINALIZED PATIENT PROTECTION	11. IMMIGRANT ACCESS FOR ALL PATIENTS	12. STAFF COMPENSATION & INSURANCE	13. ANTI-RACIST IRB POLICIES
QUINNIPIAC UNIVERSITY (FRANK H. NETTER)	C+	C	C	B	B	B	B	C	C	B	A	C	C	C
GEORGE WASHINGTON UNIVERSITY	B-	C	C	C	B	B	B	C	A	B	A	A	B	C
HARVARD UNIVERSITY	C+	C	C	C	B	C	B	C	B	C	C	C	B	C
MT. SINAI (ICAHN)	C+	C	C	C	B	B	B	B	B	B	C	C	B	C
JOHNS HOPKINS UNIVERSITY	C+	C	C	C	B	B	A	C	A	C	C	B	C	C
UNIVERSITY OF PENNSYLVANIA (PERELMAN)	C	C	C	C	B	B	B	C	B	C	C	C	C	C
THOMAS JEFFERSON UNIVERSITY (SIDNEY KIMMEL)	C	C	C	C	B	B	B	C	B	C	C	C	C	C
TULANE UNIVERSITY	B-	C	C	C	B	B	B	C	A	N/A	B	B	C	C
UC BERKELEY - UC SAN FRANCISCO	B-	C	B	B	B	B	B	C	B	C	B	C	B	A
UNIVERSITY OF CALIFORNIA, SAN FRANCISCO	B-	A	B	B	B	B	B	B	B	B	B	C	B	C
UNIVERSITY OF COLORADO	B-	B	C	B	B	B	B	C	B	C	B	B	B	C
UNIVERSITY OF MICHIGAN	B-	C	C	A	B	B	A	C	B	B	C	B	B	C
UNIVERSITY OF MIAMI (MILLER)	C+	C	B	B	B	B	A	C	B	C	C	B	C	C
UNIVERSITY OF PITTSBURGH	B-	C	C	C	B	B	B	C	B	C	B	B	C	A
UNIVERSITY OF ROCHESTER	C+	C	C	B	B	C	B	C	B	C	B	B	B	C
WASHINGTON UNIVERSITY IN ST. LOUIS	C+	C	C	C	B	B	A	C	A	C	C	B	C	C
YALE UNIVERSITY	C+	C	C	B	B	C	A	C	B	C	B	C	C	C

Grading System:
A= Institution meets metric's anti-racism standards
B= Partial elements of the metric are met
C= Institution does not meet standards or no publicly available data

The full 2019 Racial Justice Report Card document and more information on the RJRC initiative can be found on whitecoats4blacklives.org

The Frank H. Netter MD School of Medicine at Quinnipiac University

RACIAL JUSTICE REPORT CARD

The Racial Justice Report Card (RJRC) is an initiative by White Coats 4 Black Lives (WC4BL). The report card serves not only as an organizing tool for justice-oriented medical students, but also as a set of standards for medical schools aspiring towards transparency and progress in cultivating an anti-racist environment.

METRIC	GRADE & NOTES
1. URM STUDENT REPRESENTATION	C Black people represent only 8% of students. Latinx people represent %9 of students. Native American people represent 0.2% of students.
2. URM FACULTY REPRESENTATION	C There is no data to use as evidence to support the URM proportions among faculty.
3. URM RECOGNITION	B During different cultural and heritage months (We have rotating exhibits of physicians, scientists, and other societal influencers)
4. URM RECRUITMENT	B The percentage of racially URM students is increasing on this campus, but URM feel that more efforts need to be made in retaining students of color.
5. ANTI-RACIST TRAINING & CURRICULUM	B The curriculum punctuates with discussion, but there is no dedicated discussion on the role of racism.
6. DISCRIMINATION REPORTING	B The SOM has a "Report of Concern" function that allows for students and faculty reports of unprofessionalism, racism, sexism, or other forms of oppression
7. URM GRADE DISPARITY	C Quinnipiac School of Medicine does not have an AOA chapter. The SOM is not currently assessing grades and grade disparity data based on how students self-identify.
8. URM SUPPORT/RESOURCES	C Netter has no dedicated Office of Multicultural Affairs with staff whose sole responsibility it is to provide support and resources to URM medical students.
9. CAMPUS POLICING	B Quinnipiac has a campus security force 24 hours a day. The process of reporting a concern can be used to report complaints about the conduct of security officers.
10. MARGINALIZED PATIENT PROTECTION	A There are clear policies on the supervision of medical students during required clinical rotations.
11. EQUAL ACCESS FOR ALL PATIENTS	C There is no publicly available information on racial segregation of care at Quinnipiac SOM clinical affiliate sites.
12. IMMIGRANT PATIENT PROTECTION	C Not aware of public policies or statements affirming their support for immigrant patients at any of the major clinical sites.
13. STAFF COMPENSATION & INSURANCE	C Quinnipiac ensures that all employees have access to high-quality medical care and have sufficient earnings to live above poverty, but offers no public information to confirm this.
14. ANTI-RACISM IRB POLICIES	C The Quinnipiac IRB does have any specific language regarding anti-racist policy
OVERALL GRADE:	C+ Quinnipiac must call attention to the need for an Office of Diversity and Inclusion and resources for URM students.

Grading System:

A= Institution meets metric's anti-racism standards

B= Partial elements of the metric are met

C= Institution does not meet standards or no publicly available data

The full 2019 RJRC report can be read on whitecoats4blacklives.org/rjrc



George Washington University School of Medicine & Health Sciences

RACIAL JUSTICE REPORT CARD

The Racial Justice Report Card (RJRC) is an initiative by White Coats 4 Black Lives (WC4BL). The report card serves not only as an organizing tool for justice-oriented medical students, but also as a set of standards for medical schools aspiring towards transparency and progress in cultivating an anti-racist environment.

METRIC	GRADE & NOTES	
1. URM STUDENT REPRESENTATION	C	Current GW medical student makeup is not representative of the U.S. or the Washington, D.C. Population.
2. URM FACULTY REPRESENTATION	C	Among full-time faculty, 8.4% identify as African American, 3.7% identify as Latinx; there was no data for Native American faculty
3. URM RECOGNITION	C	Although the med school has new imagery of URM students & faculty, the portraits honoring former faculty & alumni still consist primarily of white men. The CW school mascot is also rooted in racism.
4. URM RECRUITMENT	B*	GWU admits undocumented students. However, the application does inquire about applicants' criminal records. URM students who participate in recruitment efforts are compensated for their time.
5. ANTI-RACIST TRAINING & CURRICULUM	B	Race is identified as a social construct, however the history of racism, intersectional oppression, and racial justice strategies are not addressed. Race is also often used as a risk factor for disease without due evidence.
6. DISCRIMINATION REPORTING	B	Student concerns are followed up but there is lack of transparency involved and some indications that this process is not enough to force change.
7. URM GRADE DISPARITY	C	This information is not publicly available.
8. URM SUPPORT/RESOURCES	A	Through the Office of Diversity & Inclusion, URM students have access to a structured support system and an "open-door" culture.
9. CAMPUS POLICING	B	While there is a new policy to conduct bias training among campus police officers, training has not been implemented in a visibly consistent manner.
10. MARGINALIZED PATIENT PROTECTION	A	End of rotation surveys and 4th year exit surveys indicate that supervision is consistent across all rotation sites. A high level of supervision is maintained in the student-staffed Healing Clinic.
11. EQUAL ACCESS FOR ALL PATIENTS	A	The George Washington University Hospital accepts both Medicaid and Medicare insurances. The hospital serves patients across D.C., Maryland and Virginia areas based on zip code.
12. IMMIGRANT PATIENT PROTECTION	B	There is no policy in place to refer immigration authorities to hospital attorneys prior to cooperation by hospital staff.
13. STAFF COMPENSATION & INSURANCE	C	Although GW adheres to minimum wage guidelines for contractors of the D.C. Government, some full-time staff members are not paid a living wage as defined by MIT's Living Wage Calculator.
14. ANTI-RACISM IRB POLICIES	C	GW's IRB application does not specifically require researchers applying for approval (using race) to precisely define race and how it is being used in the research project.
OVERALL GRADE:	B-	George Washington University must take additional measures to improve URM representation, anti-racist curriculum, URM recognition and provide fair compensation

Grading System:

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B= Partial elements of the metric are met

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Harvard Medical School

RACIAL JUSTICE REPORT CARD

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METRIC	GRADE & NOTES	
1. URM STUDENT REPRESENTATION	C	71% of current HMS students are Black, 0% are Native American, and 6.5% are Latinx. An additional 7.5% identify as multiracial.
2. URM FACULTY REPRESENTATION	C	6.1 % of full-time HMS faculty are Black, Native American, or Latinx.
3. URM RECOGNITION	C	The majority of individuals who are represented in public spaces are white men.
4. URM RECRUITMENT	B	Mentoring programs and sessions with applicants exist. There's a policy of enrolling DACA students. All students must undergo background checks.
5. ANTI-RACIST TRAINING & CURRICULUM	C	Required coursework does not specifically address anti-racism strategies. Race rather than racism is discussed. Electives and student led initiatives also exist.
6. DISCRIMINATION REPORTING	B	There is an anonymous reporting platform, but the follow-up procedure is unclear. Students can also talk to the Dean or Ombudsperson.
7. URM GRADE DISPARITY	C	The information was not publicly available.
8. URM SUPPORT/RESOURCES	B	The Office of Recruitment and Multicultural Affairs has staff, resources and mentors for URM students.
9. CAMPUS POLICING	C	The police force includes diversity and community liaisons and has diversity and inclusion training. There is no publicly available data on racism in policing.
10. MARGINALIZED PATIENT PROTECTION	C	There are policies regarding supervision of medical students, but students are given more autonomy when seeing patients in the free clinic.
11. EQUAL ACCESS FOR ALL PATIENTS	C	Patients of color appear to be overrepresented at the public hospital system and underrepresented at other Harvard teaching hospitals.
12. IMMIGRANT PATIENT PROTECTION	B	Some hospitals have policies and public commitment to immigrants patients while others do not.
13. STAFF COMPENSATION & INSURANCE	C	Employees at several Harvard teaching hospitals earn at or above the minimum wage of \$14.70/hr. Eligibility for health insurance varies.
14. ANTI-RACISM IRB POLICIES	B	While there is no policy in the Investigator Manual Harvard Medical School endorses that the IRB has required researchers define the use of race in their research.
OVERALL GRADE:		C+

Grading System:

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Icahn School of Medicine at Mount Sinai

RACIAL JUSTICE REPORT CARD

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METRIC	GRADE & NOTES
1. URM STUDENT REPRESENTATION	C In 2018-2019, approximately 8% of Mount Sinai students were Black, 4% were Latinx, and 0.2% were Native American.
2. URM FACULTY REPRESENTATION	C The percentage of faculty that is URM is not publicly available.
3. URM RECOGNITION	C The school bears the name of Carl Icahn, a corporate raider who has made his billions at the expense of low-income and unionized workers and was a former special advisor for President Trump.
4. URM RECRUITMENT	B Pipeline programs exist, but there is poor representation from the local community of East Harlem. Undocumented students are able to matriculate. Applicants are asked about criminal history.
5. ANTI-RACIST TRAINING & CURRICULUM	B Some lectures exist regarding race and racism in medicine, but there is no discussion about intersectionality or anti-racism strategies in the formal curriculum.
6. DISCRIMINATION REPORTING	B There are reporting platforms and anonymized data is released, but follow-up remains unclear.
7. URM GRADE DISPARITY	B Mt. Sinai has made changes to address racial disparities in AOA, but information on grading disparities is not publicly available.
8. URM SUPPORT/RESOURCES	B The Center for Multicultural & Community Affairs (CMCA) offers support for promoting diversity, but resources and physical spaces for URM are insufficient.
9. CAMPUS POLICING	B URM students report being profiled on campus by security. Mt. Sinai is working on unconscious bias training for security.
10. MARGINALIZED PATIENT PROTECTION	C Students are given more autonomy when seeing patients of color, poor, and/or undocumented in clinical sites and student-run free clinics.
11. EQUAL ACCESS FOR ALL PATIENTS	C There is no formal data available on patient racial demographics in different hospitals. Academic Medical Centers like Mt. Sinai see fewer patients with Medicaid compared to other hospitals in NYC. Mount Sinai has publicly affirmed their commitment to immigrant patients, students and staff. Multilingual signage is largely missing from the hospital campus.
13. STAFF COMPENSATION & INSURANCE	C Mount Sinai complies with all NYC wages laws, but has no public policy of paying all employees the NYC living wage. Health insurance access is unclear.
14. ANTI-RACISM IRB POLICIES	C There are no specific IRB policies protecting research subjects of color. There is no required review of how researchers are using "race" in their research. There is no routine review of student projects for use of race.

OVERALL GRADE: C+

Grading System:

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B= Partial elements of the metric are met

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Johns Hopkins University School of Medicine

RACIAL JUSTICE REPORT CARD

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METRIC	GRADE & NOTES
1. URM STUDENT REPRESENTATION	C According to the Johns Hopkins School of Medicine, only 25 of 1118 entering MD students in 2018 were URM.
2. URM FACULTY REPRESENTATION	C Among faculty members, 8% (226) were URM (defined by JHU as black or African-American, Hispanic, American Indian, Hawaiian, other Pacific Islander) in 2019, with no change (8%) from 2015.
3. URM RECOGNITION	B There are exhibits and projects to highlight people of color and their contributions, but is unclear whether JHU has assessed whether other individuals they commemorate have promoted racist ideology.
4. URM RECRUITMENT	B There are pipeline programs targeted recruitment efforts for URM. It is unclear whether undocumented students may enroll in the School of Medicine.
5. ANTI-RACIST TRAINING & CURRICULUM	B While a Health Care Disparities course teaches that race is a social construct, no public course materials refer or revolve specifically around racism, intersectionality, or anti-racism strategies
6. DISCRIMINATION REPORTING	B Per the Johns Hopkins administration, there is a plan to launch an ombudsperson office for medical students, but this office is not yet in place.
7. URM GRADE DISPARITY	C There is no publicly available information about racial disparities in grades or AOA election.
8. URM SUPPORT/RESOURCES	B URM students do not have access to dedicated physical spaces, mental health providers, or peer counselors.
9. CAMPUS POLICING	C There are discussions of a proposal in the Maryland legislature to create a Johns Hopkins Police force.
10. MARGINALIZED PATIENT PROTECTION	A Hopkins maintains guidelines on medical students' scope of practice and supervision, including in extracurricular clinical activities such as free clinics or international rotations.
11. EQUAL ACCESS FOR ALL PATIENTS	C While 43% of Baltimore residents have Medicaid insurance, less than 30% of patients discharged from Johns Hopkins Hospital in 2016 had Medicaid insurance.
12. IMMIGRANT PATIENT PROTECTION	C Hopkins Hospital employees must immediately refer immigration enforcement to the Legal or Compliance Department. No signage addresses patients' due process rights or protections.
13. STAFF COMPENSATION & INSURANCE	C The living wage in Baltimore for a single adult is \$13.28/hour. JHU has committed to paying its full-time, part-time, and limited staff no less than \$12.51/hour, effective July 1, 2017.
14. ANTI-RACISM IRB POLICIES	C There are no specific IRB policies related to race or racism, including no requirements related to how race is defined in research protocols.

OVERALL GRADE: C+

Grading System:

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Perelman School of Medicine at the University of Pennsylvania

RACIAL JUSTICE REPORT CARD

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METRIC	GRADE & NOTES	
1. URM STUDENT REPRESENTATION	C	Among current Perelman School of Medicine students, 8.4% are Black, 7.6% are Latinx, and none are Native American.
2. URM FACULTY REPRESENTATION	C	Overall, Black, Latinx, and Native American people comprise less than 10% of full-time PSOM faculty.
3. URM RECOGNITION	C	There are some images that celebrate Black alumni and faculty, but there is also continued celebration of historically known racist individuals (John Morgan).
4. URM RECRUITMENT	B	Despite several pipeline programs, there is poor representation of URM from Pennsylvania. Undocumented students are not able to matriculate at Penn Med.
5. ANTI-RACIST TRAINING & CURRICULUM	B	There is not discussion of anti-racism strategies or intersectionality. Some courses briefly touch on racism in medicine. Elective conferences and workshops exist.
6. DISCRIMINATION REPORTING	B	There is a mistreatment policy and reporting platform, but the follow-up is unclear.
7. URM GRADE DISPARITY	C	URM students express concern about discrimination in grading. URM students are significantly underrepresented in AOA.
8. URM SUPPORT/RESOURCES	B	The Program for Diversity and Inclusion offers mentorship to all medical students. There are no designated physical spaces for URM students and no dedicated mental health providers.
9. CAMPUS POLICING	C	There are public safety officers, but it is unclear how in depth their training on diversity is and how they are held accountable.
10. MARGINALIZED PATIENT PROTECTION	C	Preclinical students at student-run free clinics are allowed to see patients with resident supervision, whereas, at UPHS facilities, they are only able to shadow or observe.
11. EQUAL ACCESS FOR ALL PATIENTS	C	There is no formal data available on patient demographics in different hospital practices. Anecdotal evidence suggests segregation in patient care by insurance status.
12. IMMIGRANT PATIENT PROTECTION	C	Signage is monolingual. UPHS has not made public statements affirming a commitment to immigrant patients. No formal strategies exist to ensure that undocumented patients are well-served at UPHS facilities.
13. STAFF COMPENSATION & INSURANCE	C	The living wage in Philadelphia for a single adult is \$12.64/hour. Information on the wages and benefits of UPHS staff is not publicly available.
14. ANTI-RACISM IRB POLICIES	C	There are no specific guidelines around treatment of race in research. People of color are not included under "vulnerable populations".

OVERALL GRADE: C

Grading System:

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Sidney Kimmel Medical College at Thomas Jefferson University

RACIAL JUSTICE REPORT CARD

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METRIC	GRADE & NOTES
1. URM STUDENT REPRESENTATION	C 2% of SKMC medical students are Black, 2.2% are Latinx, and none are Native American.
2. URM FACULTY REPRESENTATION	C The Office of Diversity and Inclusion Initiatives (ODII) participates in faculty recruitment and hiring, but there is no public information to indicate their success in promoting a racially representative faculty.
3. URM RECOGNITION	C There is celebration of historically known racism individuals such as Thomas Jefferson and J. Marlon Sims. There is one poster in the alumni building that commemorates Black graduates of the school.
4. URM RECRUITMENT	B Recruitment efforts and financial aid for URM students exist. There's no formal policy of admitting undocumented students. Applicants with a felony conviction will not be offered admission under most circumstances.
5. ANTI-RACIST TRAINING & CURRICULUM	B Efforts to promote education about the history of racism in medicine, intersectional oppression, and racial justice strategies have been largely extracurricular and student-led.
6. DISCRIMINATION REPORTING	B Anonymous reporting platforms exist. However, follow-up on reports is unclear.
7. URM GRADE DISPARITY	C Unfortunately this information is not publicly available and largely anecdotal in nature
8. URM SUPPORT/RESOURCES	B There is one official physical space for URM (ODII). Campus diversity initiatives are largely student-led, not mandatory, and not well-integrated into the curriculum.
9. CAMPUS POLICING	C There is a police force, but there is no information about race or police training.
10. MARGINALIZED PATIENT PROTECTION	C There is a policy regarding supervision in clinical settings, but students have more autonomy in providing care in student-run free clinics that largely serve poor patients and patients of color.
11. EQUAL ACCESS FOR ALL PATIENTS	C Medicaid patients, who are disproportionately people of color, are underrepresented at Jefferson Hospital.
12. IMMIGRANT PATIENT PROTECTION	C Jefferson has made no public statements affirming a commitment immigrant patients. Jefferson Hospital has no policy directing the behavior of hospital staff when they interact with immigration authorities.
13. STAFF COMPENSATION & INSURANCE	C The living wage for a single adult living in Philadelphia is \$12.64/hour. Information about staff wages and benefits at SKMC and its affiliated hospitals is not publicly available.
14. ANTI-RACISM IRB POLICIES	C There are no specific guidelines around treatment of race in research at Jefferson.

OVERALL GRADE: C

Grading System:

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Tulane University School of Medicine

RACIAL JUSTICE REPORT CARD

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METRIC	GRADE & NOTES
1. URM STUDENT REPRESENTATION	C Diversity statistics show that minority groups are not proportionally represented among the student body.
2. URM FACULTY REPRESENTATION	C This information is not publicly available.
3. URM RECOGNITION	C The school is named after Paul Tulane, the largest donor to confederate states. Gibson Hall and online portal "Gibson" are named after Randall Lee Gibson, who was a confederate general.
4. URM RECRUITMENT	B URMs participating in formal recruitment efforts are not yet compensated for their time. Emphasis should continue to be placed on recruiting URM students from New Orleans and Louisiana.
5. ANTI-RACIST TRAINING & CURRICULUM	B There are only a handful of opportunities for interested students to pursue electives which discuss racism/social determinants of health.
6. DISCRIMINATION REPORTING	B The follow-up plan after submitting a report is not widely known to medical students
7. URM GRADE DISPARITY	C This information is not publicly available.
8. URM SUPPORT/RESOURCES	A The Office of Multicultural Affairs has a physical support space. Tulane Counseling & Psychological Services has a support group for women of color. There is an undergraduate workshop series aimed to build a safe space for LatinX students.
9. CAMPUS POLICING	N/A Tulane students interpreted this metric differently than RJRC National Group (see full report card). Students scored their institution out of 13 metrics.
10. MARGINALIZED PATIENT PROTECTION	B There is no definitive document outlining students' limits of responsibility at student run clinics but should be clarified going forward.
11. EQUAL ACCESS FOR ALL PATIENTS	B Medicaid and Medicare patients are seen in the faculty run clinics
12. IMMIGRANT PATIENT PROTECTION	C TMC has no public statement welcoming immigrants or policies governing interactions between hospital staff and immigration authorities.
13. STAFF COMPENSATION & INSURANCE	C Not all medical school staff and staff at the primary teaching hospital are paid a living wage. No information is available for subcontracted employees.
14. ANTI-RACISM IRB POLICIES	B The only time "race" was mentioned in Tulane University's Standard Operating Procedures for its Human Research Protection Plan was in regard to selecting members of the IRB.

OVERALL GRADE: B-

Grading System:

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University of California Berkeley - University of California San Francisco Joint Medical Program

RACIAL JUSTICE REPORT CARD

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METRIC	GRADE & NOTES
1. URM STUDENT REPRESENTATION	C For the 2018-2019 school year, the JMP has 48 enrolled students. The student population is 2% Black, 10% Latinx, and 0% Native American.
2. URM FACULTY REPRESENTATION	B Of 26 total teaching faculty, 15% (n=4) are Black/African-American, 4% are Latinx (n=1), and 0% are Native American.
3. URM RECOGNITION	B The physical spaces of the JMP are not named after racist or white supremacist individuals, but there are no spaces or plaques celebrating physicians of color led by the institution.
4. URM RECRUITMENT	B School application does not inquire about applicants' criminal history. The medical school does recruit and admit undocumented students, students of color, and from the local community.
5. ANTI-RACIST TRAINING & CURRICULUM	B The JMP curriculum incorporates anti-racism. However, the PBL-based environment may place a burden on students of marginalized identities to teach peers' about anti-racist medicine.
6. DISCRIMINATION REPORTING	B Most JMP students are unaware of how to make reports regarding racism and other forms of oppression through existing UCSF or UCB reporting systems.
7. URM GRADE DISPARITY	C Administrators know of disparities in grades for URM students. The JMP has no honors. The school has not evaluated these racial disparities, and has not articulated a plan to address them.
8. URM SUPPORT/RESOURCES	B Despite support through UCB and UCSF, the JMP itself does not have any specific space, support staff, administrators, physician mentors, mental health providers, or peer counselors.
9. CAMPUS POLICING	C UCB and UCSF security is enforced by armed police officers. There is no information about any UC-specific training police officers receive in regards to racial bias or de-escalation strategies.
10. MARGINALIZED PATIENT PROTECTION	B Students' level of independence can vary significantly across UCB and UCSF training sites, typically depending on faculty discretion.
11. EQUAL ACCESS FOR ALL PATIENTS	C This information is not currently publicly available. However, UCSF Health is beginning to capture data on patient care demographics to inform health system improvements.
12. IMMIGRANT PATIENT PROTECTION	B UCSF facilities have public multilingual signage supporting immigrant patients. Despite policies protecting undocumented patients, there are no trainings or efforts to make these policies clear to patients or staff.
13. STAFF COMPENSATION & INSURANCE	A This metric is met primarily due to the JMP's small staff size. Of note, not all UCB or UCSF staff relevant to the JMP program are paid living wages or have access to medical insurance.
14. ANTI-RACISM IRB POLICIES	C This information is not publicly available. The JMP utilizes UC Berkeley IRB for research. It should be noted that the JMP conducts a very small subset of the research done at UC Berkeley.

OVERALL GRADE: B-

Grading System:

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**WHITE COATS
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University of California, San Francisco (UCSF)

RACIAL JUSTICE REPORT CARD

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METRIC	GRADE & NOTES
1. URM STUDENT REPRESENTATION	A The 2018 incoming class included 34.6% of students overall being underrepresented in medicine
2. URM FACULTY REPRESENTATION	C Although UCSF has initiatives that aim to increase diversity among faculty members, none of the URM groups are proportionately represented among faculty
3. URM RECOGNITION	B Some buildings bear the names of oppressive individuals (Zuckerberg), financial institutions (WellsFargo), and corporations (Genetec).
4. URM RECRUITMENT	B Outreach programs exist. Undocumented students are encouraged to enroll. Many students of color are still lost due to a lack of financial aid.
5. ANTI-RACIST TRAINING & CURRICULUM	B Anti-racism efforts vary. Race is sometimes defined as sociopolitical, but other times is implied to be genetic. Lecturers tasked to deliver content related to racism often lack expertise.
6. DISCRIMINATION REPORTING	B There is a system for reporting mistreatment. There are anecdotal reports of students delaying complaints -- in some cases, fearing compromised anonymity or retaliation in grading.
7. URM GRADE DISPARITY	B UCSF conducted a study of disparities in honors grading and AOA election. For the classes of 2013-2016, URM students were half as likely to receive honors, 3x less likely to receive AOA.
8. URM SUPPORT/RESOURCES	B Despite comprehensive resource centers and expert staff, there are concerns that programs are underfunded, understaffed, and therefore limited in their scope.
9. CAMPUS POLICING	B While UCPD and UC security officers receive training in unconscious bias, there is no information about any UC-specific training in regards to de-escalation strategies.
10. MARGINALIZED PATIENT PROTECTION	B Pre-clinical students at student-run free clinics are allowed to see patients with a lower level of supervision than typically occurs at other facilities.
11. EQUAL ACCESS FOR ALL PATIENTS	C This information is not currently publicly available. However, UCSF Health is beginning to capture data on patient care demographics to inform health system improvements.
12. IMMIGRANT PATIENT PROTECTION	B UCSF facilities have public multilingual signage supporting immigrant patients. Despite policies protecting undocumented patients, there are no trainings or efforts to make these policies clear to patients or staff.
13. STAFF COMPENSATION & INSURANCE	C UC Health has proposed to reduce the yearly income increase for staff as well as increase healthcare co-pays and premiums. They are systemically transitioning to a contract workforce.
14. ANTI-RACISM IRB POLICIES	C UCSF's Differences Matter initiative has a focus group dedicated to increasing underrepresented groups in clinical trials. There is no public evidence of how initiatives combat racism.
OVERALL GRADE: B-	

Grading System:

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**WHITE COATS
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University of Colorado School of Medicine

RACIAL JUSTICE REPORT CARD

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METRIC	GRADE & NOTES	
1. URM STUDENT REPRESENTATION	B	Only students that identify as Native American are proportionately represented.
2. URM FACULTY REPRESENTATION	C	No URM faculty group is proportionately represented.
3. URM RECOGNITION	B	One building celebrates an Native American politician, otherwise white figures are overwhelmingly represented on campus.
4. URM RECRUITMENT	B	Background check is required, but there are efforts and initiatives to recruit URM students.
5. ANTI-RACIST TRAINING & CURRICULUM	B	Curriculum discuss social determinants of health and race. But anti-racist training is inadequate, or not mandatory.
6. DISCRIMINATION REPORTING	B	Student have options for reporting discrimination, but there are currently no clear plan for follow-up addressing consequences for individual who engage in racist behaviors.
7. URM GRADE DISPARITY	C	This information is not publicly available.
8. URM SUPPORT/RESOURCES	B	URM have some resources through the Office of Diversity and Inclusion, but they are limited.
9. CAMPUS POLICING	C	Though the campus police has received training to address bias and racism, racial profiling has been reported, and no plans to actively reduce reliance on police has been identified.
10. MARGINALIZED PATIENT PROTECTION	B	The actions of students at the DAWN clinic are in line with their level of training, but they are inconsistently supervised and the clinic often lacks essential resources.
11. EQUAL ACCESS FOR ALL PATIENTS	B	UHealth takes more Medicaid patients than their proportion in the population in the area serviced.
12. IMMIGRANT PATIENT PROTECTION	B	The hospital has symbolic commitment to immigrants, but no policies explicitly protecting undocumented patients
13. STAFF COMPENSATION & INSURANCE	C	This information is not publicly available.
14. ANTI-RACISM IRB POLICIES	C	IRB process has no requirements regarding the treatment of race
OVERALL GRADE:		B-
		UHealth and the school of medicine has shown interest and initiatives to protect marginalized groups. Yet, transparent, bold and systematic policies are urgently needed.

Grading System:

A= Institution meets metric's anti-racism standards

B= Partial elements of the metric are met

C= Institution does not meet standards or no publicly available data

The full 2019 RJRC report can be read on whitecoats4blacklives.org/rjrc



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University of Miami Leonard M. Miller School of Medicine

RACIAL JUSTICE REPORT CARD

The Racial Justice Report Card (RJRC) is an initiative by White Coats 4 Black Lives (WC4BL). The report card serves not only as an organizing tool for justice-oriented medical students, but also as a set of standards for medical schools aspiring towards transparency and progress in cultivating an anti-racist environment.

METRIC	GRADE & NOTES	
1. URM STUDENT REPRESENTATION	C	Miller student enrollment is not reflective of either Miami or U.S. populations of LatinX, Black, or Native Americans.
2. URM FACULTY REPRESENTATION	B	The proportions of American Indian and Black medical school faculty do not correspond with proportions of these groups in the U.S., Miami-Dade county, and the Miller student population. Medical school faculty are 29% LatinX.
3. URM RECOGNITION	B	The medical education building is named after Lewis Rosenstiel who financially supported the disruption of the Civil Rights movement. On the other hand, a display on the first floor of Jackson Hospital recognizes local Black healthcare leaders.
4. URM RECRUITMENT	B	Miller requires more structural & financial support for URM recruitment efforts by Admissions, the ODI, and students. There is no public position against the denial of education based on legal status.
5. ANTI-RACIST TRAINING & CURRICULUM	B	There is no baseline training for faculty and guest lecturers to understand the construction and implications of race, and there is no policy requiring race be defined as a social construction.
6. DISCRIMINATION REPORTING	A	The medical school uses two reporting systems for learner's mistreatment, as well as non-learner's mistreatment. Their policy includes a clear plan for follow-up when problems are reported.
7. URM GRADE DISPARITY	C	This information is not publicly available.
8. URM SUPPORT/RESOURCES	B	The Office of Diversity & Inclusion is spearheading a new physical space for URM students. Mental health support is limited on campus, with no specific explicit function to support URM students.
9. CAMPUS POLICING	C	The medical campus involves multiple security corporations and policing agencies. No policies outline responsibilities or universal training. There is no restorative justice council to minimize police reliance.
10. MARGINALIZED PATIENT PROTECTION	C	Racial disparities between student health fair participants and patients, along with less rigorous training and supervision, lead to exploitative racialized relationships between Miller and communities.
11. EQUAL ACCESS FOR ALL PATIENTS	B	Jackson, one of the teaching hospitals, has a comprehensive financial system to improve care access for uninsured, undocumented, and low-income patients. Barriers in this system persist.
12. IMMIGRANT PATIENT PROTECTION	C	While facilities have multilingual signage, they do not specifically support immigrant patients. Despite policies protecting undocumented patients, there are no trainings or efforts to make these policies clear to patients or staff.
13. STAFF COMPENSATION & INSURANCE	C	This information is not publicly available.
14. ANTI-RACISM IRB POLICIES	C	The UMiami IRB process does not explicitly require research to include precise definitions of race and how it is being used in a research project.
OVERALL GRADE:		C+
<p>Despite substantive efforts by organizations across the institution, UMMSM lacks significant structural commitments to marginalized patients, students, and faculty. Potential grading disparities and exploitative health fairs need urgent interrogation.</p>		

Grading System:

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University of Michigan School of Medicine

RACIAL JUSTICE REPORT CARD

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METRIC	GRADE & NOTES
1. URM STUDENT REPRESENTATION	C In the 2018-2019 academic year, 6.1% of students were African-American/Black, 4.2% Latinx, and .25% Native American.
2. URM FACULTY REPRESENTATION	C In 2017, 4% of faculty were African-American/Black, 4% Latinx and .5% Native American.
3. URM RECOGNITION	A Several buildings honor racial justice advocates and African-American alumni. However, a science building is named after C.C. Little, a eugenics proponent and anti-immigrant spokesperson.
4. URM RECRUITMENT	B Several recruitment and pipeline efforts exist. DACA recipients are encouraged to apply and the medical school is willing to offer institutional loans to assist them..
5. ANTI-RACIST TRAINING & CURRICULUM	B Mandatory coursework that addresses unconscious bias, race in medicine and the history of racism in medicine exists. There is little exposure to intersectional oppression and anti-racism strategy.
6. DISCRIMINATION REPORTING	A There is a reporting platform and clear follow-up procedures for received reports through the Office for Institutional Equity.
7. URM GRADE DISPARITY	C There is no publicly available information on whether disparities exist in AOA membership or grades at University of Michigan Medical School.
8. URM SUPPORT/RESOURCES	B Office of Health Equity and Inclusion (OHEI) coordinates workshops, academic coaching, wellness initiatives, and lecture series to support URM students and provides a physical space for them. There is a bias response team that responds to incidents without law enforcement. There is no evidence that there have been explicit attempts to address racism in policing.
9. CAMPUS POLICING	B Pre-clinical students are given more autonomy in providing patient care in student-run free clinics compared to other settings.
10. MARGINALIZED PATIENT PROTECTION	C There is no publicly available information on racial segregation of care at University of Michigan facilities. Patients with Medicaid are underrepresented at UM Hospitals.
11. EQUAL ACCESS FOR ALL PATIENTS	B There are multilingual signs. Attorneys are affiliated with Michigan Medicine to address immigration concerns. There are no public policies or statements affirming support for immigrant patients.
12. IMMIGRANT PATIENT PROTECTION	B Regular staff are paid at or above minimum wage of \$12.02/hr. Temporary staff are ensured a wage of \$9.25/hr. Living wage is \$13.24/hr. Access to health insurance for staff is unclear.
13. STAFF COMPENSATION & INSURANCE	C People of color aren't included under "vulnerable research subjects". There are no specific policies protecting research subjects of color. There is no required review of the use of race in research.
14. ANTI-RACISM IRB POLICIES	C

OVERALL GRADE: B-

Grading System:

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Perelman School of Medicine at the University of Pennsylvania

RACIAL JUSTICE REPORT CARD

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METRIC	GRADE & NOTES	
1. URM STUDENT REPRESENTATION	C	Among current Perelman School of Medicine students, 8.4% are Black, 7.6% are Latinx, and none are Native American.
2. URM FACULTY REPRESENTATION	C	Overall, Black, Latinx, and Native American people comprise less than 10% of full-time PSOM faculty.
3. URM RECOGNITION	C	There are some images that celebrate Black alumni and faculty, but there is also continued celebration of historically known racist individuals (John Morgan).
4. URM RECRUITMENT	B	Despite several pipeline programs, there is poor representation of URM from Pennsylvania. Undocumented students are not able to matriculate at Penn Med.
5. ANTI-RACIST TRAINING & CURRICULUM	B	There is not discussion of anti-racism strategies or intersectionality. Some courses briefly touch on racism in medicine. Elective conferences and workshops exist.
6. DISCRIMINATION REPORTING	B	There is a mistreatment policy and reporting platform, but the follow-up is unclear.
7. URM GRADE DISPARITY	C	URM students express concern about discrimination in grading. URM students are significantly underrepresented in AOA.
8. URM SUPPORT/RESOURCES	B	The Program for Diversity and Inclusion offers mentorship to all medical students. There are no designated physical spaces for URM students and no dedicated mental health providers.
9. CAMPUS POLICING	C	There are public safety officers, but it is unclear how in depth their training on diversity is and how they are held accountable.
10. MARGINALIZED PATIENT PROTECTION	C	Preclinical students at student-run free clinics are allowed to see patients with resident supervision, whereas, at UPHS facilities, they are only able to shadow or observe.
11. EQUAL ACCESS FOR ALL PATIENTS	C	There is no formal data available on patient demographics in different hospital practices. Anecdotal evidence suggests segregation in patient care by insurance status.
12. IMMIGRANT PATIENT PROTECTION	C	Signage is monolingual. UPHS has not made public statements affirming a commitment to immigrant patients. No formal strategies exist to ensure that undocumented patients are well-served at UPHS facilities.
13. STAFF COMPENSATION & INSURANCE	C	The living wage in Philadelphia for a single adult is \$12.64/hour. Information on the wages and benefits of UPHS staff is not publicly available.
14. ANTI-RACISM IRB POLICIES	C	There are no specific guidelines around treatment of race in research. People of color are not included under "vulnerable populations".
OVERALL GRADE:		C

Grading System:

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University of Pittsburgh School of Medicine

RACIAL JUSTICE REPORT CARD

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METRIC	GRADE & NOTES
1. URM STUDENT REPRESENTATION	C Of current students, 12% are Black, 4.6% are Latinx, and none are Native American. Using a different method, University of Pittsburgh SOM's website states only that 17% of MSIs are URM.
2. URM FACULTY REPRESENTATION	C UPSOM's "Framework for Diversity" mentions a "Provost Diversity Fellows Program", with no public information about this program.
3. URM RECOGNITION	C The primary medical school building is named for Alan M. Scaife. The Scaife family funds white supremacist and anti-immigrant organizations.
4. URM RECRUITMENT	B Many initiatives recruit URM students, but there is no public information on how these programs translate into matriculation to the medical school.
5. ANTI-RACIST TRAINING & CURRICULUM	B There is a significant lack of oversight control in regards to portrayals of race and racism in course materials and lectures. Community members are reimbursed for planning and teaching time.
6. DISCRIMINATION REPORTING	B Some students report that Honor Council has been used in the past to silence students who speak out against racism and sexism among their peers and UPSOM faculty.
7. URM GRADE DISPARITY	C Racial disparities in AOA exist. No formal plan exists to further address these disparities, though faculty members have expressed willingness to work with students on this matter.
8. URM SUPPORT/RESOURCES	B URM students do not have designated physical spaces, mental health providers, or peer counselors. URM mentorship often falls to uncompensated work by student organizations.
9. CAMPUS POLICING	C University of Pittsburgh has a campus police force. There are no publicly published reports on racism in policing, and there is no public information on efforts to reduce racism.
10. MARGINALIZED PATIENT PROTECTION	B Pre-clinical students are permitted to provide direct patient care in student-run free clinics; in other clinical settings they are generally not permitted to participate beyond observation.
11. EQUAL ACCESS FOR ALL PATIENTS	B While 16% of Pennsylvania adults have Medicaid insurance, only 2% of patients discharged from UPMC Presbyterian in 2016 had Medicaid insurance.
12. IMMIGRANT PATIENT PROTECTION	C Immigration status is not listed as a protected identity in UPMC's nondiscrimination policy. UPMC has no public statements or policies on staff interaction with immigration authorities.
13. STAFF COMPENSATION & INSURANCE	A UPMC has committed to raising its institutional minimum wage to \$15/hour by 2021.
14. ANTI-RACISM IRB POLICIES	B IRB policy requires researchers to explain potential use of race. International (but not domestic) research studies require a memo of cultural appropriateness.

OVERALL GRADE: B-

Grading System:

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University of Rochester School of Medicine & Dentistry

RACIAL JUSTICE REPORT CARD

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METRIC	GRADE & NOTES	
1. URM STUDENT REPRESENTATION	C	No URM groups are proportionately represented (compared to US population) among students. Less than 20% of students in 2018-2019 are URM.
2. URM FACULTY REPRESENTATION	C	No URM groups are proportionately represented (compared to the US population) among faculty. Less than 6% of faculty in 2018-2019 are URM.
3. URM RECOGNITION	B	There is some recognition of URM alumni, but there is also continued celebration of historically known racist individuals in the school's history.
4. URM RECRUITMENT	B	There are pipeline programs to recruit URM students. URSMD does not recruit or accept undocumented applicants.
5. ANTI-RACIST TRAINING & CURRICULUM	C	Current training on social determinants of health fails to adequately consider history of racism. Race is sometimes implied or stated to be biological and is often taught as a risk factor for disease.
6. DISCRIMINATION REPORTING	B	There are some systems for collecting reports, but the follow-up process is case-dependent and unclear to students.
7. URM GRADE DISPARITY	C	There are known disparities in grades and AOA selection. This info. is not made publicly available, nor are there plans to address the AOA disparities.
8. URM SUPPORT/RESOURCES	B	The Center for Advocacy, Community Health, Education and Diversity has staff, administrators, and resources available to support URM students.
9. CAMPUS POLICING	C	UofR Public Safety includes armed officers. There is no publicly-available data demonstrating that officers have not disproportionately interacted with people of color.
10. MARGINALIZED PATIENT PROTECTION	B	Policies exist to ensure that all patients receive equally well-supervised care, but students are often informally given more autonomy when caring for marginalized patients in free clinics.
11. EQUAL ACCESS FOR ALL PATIENTS	B	Medicaid patients, who are disproportionately people of color, are underrepresented at Highland Hospital, but are proportionately represented at Strong Memorial Hospital.
12. IMMIGRANT PATIENT PROTECTION	B	Strong Memorial Hospital has no public statement affirming support for immigrant patients, but policies require patient and physician consent for law enforcement access to patients.
13. STAFF COMPENSATION & INSURANCE	C	Non-represented staff must accrue 2 years of benefit eligible service in order to be paid City of Rochester living wage of \$12.09/hr with health insurance.
14. ANTI-RACISM IRB POLICIES	C	IRB policies do not explicitly protect people of color and do not require researchers to explicitly define how they plan to use race in their research.
OVERALL GRADE:		C+
		The University of Rochester must take additional measures to promote racial justice in student and faculty recruitment, curriculum and grading, as well as in policing and anti-racism IRB policies.

Grading System:

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Washington University in St. Louis School of Medicine

RACIAL JUSTICE REPORT CARD

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METRIC	GRADE & NOTES
1. URM STUDENT REPRESENTATION	C Among WUSTL students, 5.6% are Black, 3.2% are Latinx, and less than 1% are Native American.
2. URM FACULTY REPRESENTATION	C 11% of residents and fellows and 5.5% of faculty are people of color at WUSTL.
3. URM RECOGNITION	C A building is named after James McDonnell, whose company admitted to firing a black employee due to his participation in Civil Rights protests.
4. URM RECRUITMENT	B Several pipeline and recruitment initiatives exist. To matriculate, DACA recipients must demonstrate the ability to cover the tuition and living expenses. Background checks and a drug screen are required.
5. ANTI-RACIST TRAINING & CURRICULUM	B Several mandatory and elective courses exist that address bias, diversity, and health disparities. There are no courses that address intersectional oppression or anti-racism strategies.
6. DISCRIMINATION REPORTING	A There is a reporting system and summaries of reports are publically available. The Assistant Provost assists students in navigating concerns and connects them to programs.
7. URM GRADE DISPARITY	C There is no evidence that WUSTL has assessed whether racial disparities in AOA or grading exist, and there is no clear plan to address disparities.
8. URM SUPPORT/RESOURCES	A The Office of Diversity Programs provides support, mentorship, networking, and physical space for URM students. Student Health Services and diversity trainers are available for support and counseling.
9. CAMPUS POLICING	C The WUPD has an Impartial policing policy that prohibits racial profiling, but accountability and oversight is unclear and not publically available.
10. MARGINALIZED PATIENT PROTECTION	C Students are offered more autonomy in delivering patient care at student-run free clinics.
11. EQUAL ACCESS FOR ALL PATIENTS	B WUSTL states that 22% of patients served at their institutions are URM. Medicaid patients, who are disproportionately people of color, are likely underrepresented at Barnes-Jewish Hospital.
12. IMMIGRANT PATIENT PROTECTION	C WUSTL is associated with a clinic that serves Latinx patients, WUSTL-affiliated hospitals have taken no public actions to support immigrant patients. There is no policy regarding non-cooperation with ICE. The living wage is \$11.57/hour. The minimum wage at WU for all regular full time medical school staff is \$12.25/hr. But, temporary and part-time staff do not have access to the same wages.
13. STAFF COMPENSATION & INSURANCE	C
14. ANTI-RACISM IRB POLICIES	C People of color are not specifically included in the policy's definition of "vulnerable populations. The IRB encourages diversity of race, gender, and cultural background.

OVERALL GRADE: C+

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Yale School of Medicine

RACIAL JUSTICE REPORT CARD

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METRIC	GRADE & NOTES
1. URM STUDENT REPRESENTATION	C Approximately 5% of Yale medical students were Black, 4% were Latinx, and 0.4% were Native American
2. URM FACULTY REPRESENTATION	C Yale faculty is approximately 4% Black, 3% Latinx, and 0.1% Native American.
3. URM RECOGNITION	B While there are efforts to remove the names of white supremacist individuals, it is unclear whether alumni of color are publicly celebrated in the physical space of the medical school.
4. URM RECRUITMENT	B Several pipeline program exist. Applicants are asked about their criminal history. Yale School of Medicine states that they welcome applicants regardless immigration status.
5. ANTI-RACIST TRAINING & CURRICULUM	C Electives related to racial justice exist. Publicly available course materials make no mention of the history of race or racism in medicine, nor do they discuss race as a sociopolitical factor.
6. DISCRIMINATION REPORTING	A The Yale mistreatment policy explicitly protects against mistreatment on the basis of race, and describes clear follow-up steps that will be taken.
7. URM GRADE DISPARITY	C There is no publicly available information on whether disparities exist in grades or other forms of student evaluation.
8. URM SUPPORT/RESOURCES	B The Office for Diversity, Inclusion, and Community Engagement (DICE) offers support to URM. There are no designated physical spaces or mental health providers for URM students Yale has a campus police force, but there is no evidence that there have been efforts to address racist policing or pursue alternative safety structures.
9. CAMPUS POLICING	C Clear policies exist regarding supervision on clinical rotations as well as for the free clinic. However, pre-clinical students are often informally given more autonomy in patient care the free clinic.
10. MARGINALIZED PATIENT PROTECTION	B There is no publicly available information on racial segregation of care at Yale facilities.
11. EQUAL ACCESS FOR ALL PATIENTS	C Yale New Haven Hospital has no public policies or statements affirming their support for immigrant patients.
12. IMMIGRANT PATIENT PROTECTION	C There is not publicly-available information on whether all Yale School of Medicine and Yale New Haven Hospital employees are paid at least the New Haven living wage (\$13.05/hour for a single adult).
13. STAFF COMPENSATION & INSURANCE	C There are no specific policies protecting research subjects of color. There is no required review of how researchers use "race" in research. There is no routine review of student projects for their use of race.
14. ANTI-RACISM IRB POLICIES	C

OVERALL GRADE: C+

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Conclusions & Recommendations

The Racial Justice Report Card consists of fourteen metrics that evaluate each institution's curriculum and climate, student and faculty diversity, policing, racial integration of clinical care sites, treatment of workers, and research protocols.

This report is not a comprehensive list of all that is required to ensure racial justice in American medical education and healthcare; however, we believe it is a starting point to describe the state of racial equity at academic medical centers. Based on the 2019 Report Card grades, we share the following conclusions and recommendations.

URM Student Representation

The representation of Black, Latinx, and Native American (URM) medical students in all of the evaluated schools, except for one, is well below the share of these groups in the U.S. population.

Clearly, these disparities must be corrected, and medical schools must graduate diverse classes that are representative of the U.S. population. However, diversity cannot consist merely of having people of color present. Instead, medical schools need to develop justice-oriented cultures that actively value and celebrate people of all social identities, backgrounds, and experiences. This requires dedicated resources, the will to engage with diversity of people and thought, and the justice-oriented leadership of people of color.

We recommend that all medical schools and academic medical centers:

- Publish data on student demographics, including explanations for inequities and plans to increase URM representation
- Avoid the use of standardized exams such as the MCAT in admissions decisions
- Create comprehensive pipeline programs that support URM students from the medical school's local community, including financial support to local public schools and their students (in the form of taxes, voluntary payments, and living wages for all employees), and guaranteed undergraduate and medical school admission and financial aid

URM Faculty Representation

The underrepresentation of Black, Latinx, and Native American (URM) individuals is even more stark among faculty and individuals in leadership positions than it is among students. Further, racial disparities often increase at higher levels of leadership within the medical school and affiliated hospital(s). None of the evaluated medical centers have faculty or leadership teams that represent the U.S. population.

We recommend that all medical schools and academic medical centers:

- Publish data on faculty and leadership demographics, including explanations for inequities and plans to increase URM representation
- Create programs geared toward the recruitment and retainment of URM faculty
- Increase the value placed on URM faculty members' participation in mentorship, recruitment, and community outreach in hiring and promotion decisions

URM Recognition

Among the schools graded, there is significant variation in the recognition given to URM students, faculty, and leadership. Some schools celebrate URM individuals in medicine with portraits, collections, and building names. Other institutions lack this URM recognition, and some promote racist alumni, donors, and researchers.

It is important that the value and contributions of URM individuals be consistently woven into the fabric of the institution, and not merely highlighted in the context of “diversity” celebrations, special lectures or exhibits, or holidays. Highlighting URM individuals only in the context of “diversity” demonstrates a shallow understanding of inclusion and places value on URM individuals only as proof that an institution is not homogenous.

Moreover, schools must proactively seek to remove public recognition of donors, alumni, and other individuals who have endorsed white supremacy in their ideologies or actions. In its response to the first draft of the racial justice report card, one school aptly recognized that “the lack of diversity seen in art at [our school] *reflects the School's past, not its present*” (emphasis added). This recognition makes the continuing presence of racist and white supremacist individuals and ideals in public spaces all the

more egregious. It is each school's responsibility to recognize and de-center the racist history of medicine in the United States.

We recommend that all medical schools and academic medical centers:

- Evaluate the racial makeup of individuals who are publicly celebrated in names, portraits, sculptures, etc.
- Remove any representations of individuals who have espoused racist/white supremacist ideologies or have participated in racist oppression
- Increase representations of people of color, particularly individuals with intersecting marginalized identities (e.g. Black women), in order to ensure that public representations are *at least* representative of the U.S. population

URM Recruitment

Several of the graded schools reported having pipeline programs for URM students interested in medicine. While many of these programs have been in place for decades, the number of students from pipeline programs that eventually matriculated in the medical school is small or unknown, and URM students remain significantly underrepresented at almost all of the schools graded.

The majority of schools reported doing targeted recruitment of URM students through recruitment fairs or school visits, however, few schools spoke about specifically about recruiting local students of color. A common theme was that current URM students devote significant time to participate in recruitment, but were not compensated for their time or efforts.

Several schools consider applications from undocumented students on the same basis as international students. Because undocumented and international students are ineligible for federal student financial aid, international applicants are generally required demonstrate that they have on hand sufficient funds for 2-4 years of medical school tuition. Such policies effectively bar undocumented students from enrolling in the medical school. Other schools that were evaluated offer institutional loans to DACA recipients and other undocumented students, and consequently have successfully enrolled undocumented students.

The majority of evaluated schools require students to disclose any criminal history in the application process.

We recommend that all medical schools and academic medical centers:

- Annually evaluate and publicly share data on the effectiveness of pipeline programs, e.g. the number of pipeline participants who ultimately enroll in medical school
- Provide longitudinal support for URM students through pipeline program beginning in elementary and middle school (see recommendations under “URM Representation”)
- Create a mechanism for guaranteed admission for local URM students
- Increase recruitment efforts at historically black colleges and universities (HBCUs), Hispanic-serving institutions (HSIs), and local public colleges (including community colleges)
- Publicly state that undocumented students are invited to apply to the medical school, and provide institutional financial aid that allows undocumented students to matriculate
- Compensate URM students at a rate at or above the local living wage for the time they spend performing recruitment on behalf of the medical school
- Remove inquiries about criminal background from the application process and, if necessary, advocate that prior criminal justice system involvement be removed as a disqualification for physician licensing in the state where the school is located

Anti-Racist Training & Curriculum

While the majority of schools evaluated had some form of education on social determinants of health, schools did not uniformly provide instruction on the sociopolitical (non-biological) nature of race. Moreover, even at schools where students received instruction on the sociopolitical nature of race, lecturers continue to describe race itself (rather than racism) as a risk factor for disease, tool for diagnostic reasoning, or predictor of treatment response.

Many of the evaluated schools have unconscious bias training and/or at least one lecture addressing the history of racism in medicine. However, among schools that offer training on the history of racism in medicine or unconscious bias, most have no mechanism to ensure *all students and faculty* receive the training.

Moreover, very few schools offer training specifically in anti-racism organizing or advocacy strategies. Racism has been built into American medical practice, and must therefore be purposefully deconstructed through directly naming racism and training students in anti-racist practice. This extends far beyond unconscious bias training; the mechanisms that generate racial inequity in medicine are structural, and students and faculty must be taught how to intentionally dismantle these structures. Anti-racism training can cover many topics, but should include discussion of the intentional creation of race as a hierarchical system (first through religious justifications and then “scientific” ones), the link between racism and capitalism in the United States, and white supremacy. With this foundation, participants can then learn about anti-racism as a practice that intentionally dismantles racism and white domination, elevates the voices of marginalized individuals, and fights for the well-being of all individuals.

The manner in which this information is imparted to faculty and trainees is important. Even well-conceived trainings are unlikely to be effective if they are optional, non-longitudinal, purely lecture-based and/or limited to online modules. Trainings must involve active participation to fully engage trainees in discussions about complex topics and situations. All trainings should be fully incorporated into the entire curriculum, and not restricted to stand-alone sessions.

Many schools reported incorporating the voices of students of color in the planning of education sessions. However, most schools fail to proactively include and compensate local community members, activists, policymakers, and organizations in the curriculum and co-curricular activities. Comprehensive medical education that includes medical history, racism in medicine, public/community health, and health policy and access, requires the involvement of URM leadership from both within and outside of medical schools.

We recommend that all medical schools and academic medical centers:

- Provide education to students and faculty on racialization as a sociopolitical process
- Issue guidelines to all instructors specifying that race should not be described in lectures or other forms of instruction as a risk factor, tool for diagnostic reasoning, or predictor of treatment response

- Create a formal system for students to provide feedback on lectures in which race is inappropriately described or implied to be biological
- Provide students with a comprehensive education on the history of racism in medicine and medical research that extends beyond singular examples (for example, the Tuskegee syphilis experiment)
- Explicitly discuss and challenge racialized medical guidelines (for example, guidelines for the treatment of hypertension)
- Advocate for the removal of racialized medicine from all shelf and board exams
- Create mandatory, in-person, interactive comprehensive trainings in racism and anti-racism for students and faculty. Student trainings should be longitudinal integrated into the curriculum.
- Consider employing community members and outside organizations with expertise in anti-racism, intersectionality, and the history of racism in medicine to conduct workshops on these topics
- Create formal structures for soliciting URM students' feedback on curricular decisions
- Involve URM students in curriculum design and leadership, publicly recognize their efforts, and compensate them at a rate at or above the local living wage for their efforts
- Involve local community members, activists, policymakers, and organizations in curriculum design and leadership, publicly recognize their efforts, and compensate them at a rate at or above the local living wage for their efforts

Discrimination Reporting

All schools evaluated had a policy addressing racial discrimination, and all had some mechanism for students to report mistreatment. Many schools did not have an anonymous reporting mechanism, had no appropriately trained staff tasked with addressing reports, or did not provide public data on concrete actions taken to address incidents. Indeed, most schools did not provide examples of specific actions that had been taken in response to medical students complaints of mistreatment. Many schools emphasized the formation of committees and the planning of dialogues on topics such as microaggressions. While these are important actions in the process of addressing the breadth of mistreatment students experience, schools must ensure that these processes and efforts result in a safe, healthy learning environment for marginalized students.

We recommend that all medical schools and academic medical centers:

- Publicly describe the process for addressing incidents of racial discrimination on campus, including steps the school is taking to ensure all reported incidents are reviewed in a timely manner by appropriately trained individuals
- Ensure that students have the option of discussing incidents of discrimination with individuals who share their relevant identity (e.g. discussing incidents of racism with a URM staff member)
- Publicly describe all reported incidents of bias or discrimination, and the concrete steps taken to address each incident
- Ensure that all students have access to anonymous reporting systems
- Provide students with a variety of options for responding to racist incidents

URM Grade Disparity

Several schools reported not participating in the Alpha Omega Alpha Honor Medical Society (AOA) or expressed an intent to discontinue AOA elections in response to concerns about racial disparities. Most of the schools evaluated either did not assess for the existence of disparities in URM grading or did not publicly report disparities in grading. Only two schools have implemented plans to address racial grading disparities.

We recommend that all medical schools and academic medical centers:

- Collect data on grading disparities and make this information public in an aggregated, de-identified manner, alongside plans to address these inequities
- Provide all evaluators with individualized data on racial and other disparities in their grading practices, and feedback on changes they should implement
- Discontinue participation in AOA

URM Support/Resources

All but one of the schools in this report have, at minimum, a dedicated office for diversity and inclusion that is tasked with recruiting and supporting URM students. Beyond the existence of such an office, additional resources and supports, such as mentorship by faculty of color, dedicated physical space for student use, and tutoring vary widely from school to school. Similarly, the mental health needs of URM students, who face [racial battle fatigue](#) within and outside of medical school, are inconsistently considered. The medical schools evaluated in this report largely have one, but not all, of the following: dedicated support staff, mental health providers, and physical spaces.

We recommend that all medical schools and academic medical centers:

- Provide physical spaces specifically for URM students to study, hold meetings, and relax
- Hire support staff who are URM themselves and are empowered to advocate for necessary resources for URM students
- Provide mental health providers, preferably who are URM themselves, available free-of-charge for individual and group therapy for URM students
- Create infrastructure to further support URM students academically, including early identification of students who might benefit from one-on-one tutoring. Tutoring should preferably be conducted by a faculty member with teaching experience who is compensated for their time
- Remove financial barriers to URM students preparing for and taking USMLE exams, which may include subsidizing study materials and question banks

Campus Policing

Many schools reported having a campus police presence, and all had some form of security staff. While several schools reported unconscious bias training for officers or security guards, no school provided public information demonstrating that security practices in the medical school or hospital(s) are non-discriminatory.

Policing in the United States was established from slave patrols and continues to target and terrorize communities of color (Kappeler 2017, Mitrani 2015). Communities should have access to alternative systems of safety and justice that promote the well-being of people of color. These alternatives are particularly important in hospitals, where patients and families predictably experience distress that requires medical care and support, not police or security intervention.

We recommend that all medical schools and academic medical centers:

- Dismantle their police and security forces, and instead opt for alternative methods of safety and security such as restorative/transformational justice and mediation structures, unarmed intervention teams, walking escorts, and geographically-dispersed “safe spaces”
- Public information should be provided on the race of individuals with whom police or security officers interact, and any identified disparities should be addressed with a clear action plan

- Create civilian oversight committees that include students, faculty, staff, patients and families of color, which are empowered to investigate civilian complaints and patterns of discrimination

Marginalized Patient Protection

Thirteen of the seventeen schools assessed allowed preclinical (first and second year) medical students to provide patient care in the setting of student-run clinic for uninsured patients. This is not the standard of care in academic medical centers, where preclinical students are generally restricted to observation and shadowing. Moreover, students at some schools reported being provided more autonomy when caring for marginalized patients in public hospitals than they were afforded when caring for patients in the primary teaching hospital.

WC4BL affirms that healthcare is a human right and every individual deserves the same standard of care regardless of race, citizenship status, or the ability to pay. Medical centers must integrate their clinics so people of all insurance statuses have access to equitable resources and physicians of a similar level of training. With regards to the greater autonomy granted to medical students when caring for patients of color and/or poor patients, we cannot forget the history of medical education in the U.S., which includes using enslaved people as “clinical material” and placing medical schools in communities of color to attract students hoping to “learn on” these patients. Medical schools must definitively end this long and ugly history of experimentation and training on patients of color, and ensure that students are equally involved in the care of patients of all social identities.

We recommend that all medical schools and academic medical centers:

- Discontinue the practice of allowing preclinical students to provide medical care in free clinics
- Ensure that all patients have full access to care at professionally-staffed clinics and hospitals regardless of citizenship status, insurance status, or the ability to pay, thereby obviating the need for free clinics
- Teach medical students about Black activist organizations, such as the Black Panther Party, who created a free clinic model to provide much needed care for their communities when medical institutions refused to do so

Equal Access for All Patients

The majority of medical schools evaluated had some system of segregated care based on insurance status. Because of the link between racism and capitalism in the United States, segregation based on insurance status generates *de facto* racial segregation. In some cases, publicly-insured patients and patients of color were underrepresented at the academic medical center; in others, affiliated hospitals safety net hospitals were noted to have a patient population in which people of color were overrepresented. Both of these cases describe a system in which patients are segregated based on insurance status and race. Furthermore, it is common for academic medical centers to segregate Medicaid and uninsured patients in trainee (resident or fellow) practices, while privately insured patients are cared for by attending physicians; this practice was noted at several of the graded schools. Appendix D shows the share of Medicaid patients at hospitals affiliated with the graded schools as compared to the share of adults in the surrounding area with Medicaid insurance.

We recommend that all medical schools and academic medical centers:

- Integrate all clinics, so that patients of all insurance statuses are seen in a single physical location by an integrated team of trainee and attending providers
- Provide public information on quality of care metrics for patients of varying insurance status and racial groups. This may include the level of training of the primary healthcare provider, wait times for appointments, etc.
- Provide public information on patient demographics and plans to address discrepancies in Medicaid patients and/or patients of color seen at the academic medical center and affiliated clinical sites in comparison to surrounding hospitals

Immigrant Patient Protection

The hospitals evaluated varied widely in their policies and practices around treatment of immigrant patients. Some hospitals had no public commitment to immigrant patients, and no policies governing interactions between hospital staff and immigration authorities. Other hospitals had created public statements welcoming immigrant patients and assuring them of their safety within the hospital, and had made significant efforts to publicize those statements in multiple languages. Some hospitals also had clear policies prohibiting cooperation between hospital staff and immigration authorities. Many hospitals, even those with exemplary policies protecting immigrant patients, were noted to lack multilingual signage, adequate

in-person interpreters, or other services that ensure immigrant patients' meaningful access to high-quality care.

We recommend that all medical schools and academic medical centers:

- Publicly state that immigrant patients are welcome at the hospital, and make efforts to inform immigrant patients of this through multilingual outreach
- Develop a policy directing hospital staff not to cooperate with immigration authorities, and instead to refer all such authorities to hospital lawyers
- Provide multilingual signage, in-person interpreters, and written materials in all languages spoken by at least 5% of the local community. Other means of interpretation, such as phone interpreters, should be provided for all other languages.

Staff Compensation & Insurance

Nearly all of the evaluated academic medical centers paid at least some of their workers less than the living wage for the local area. In addition, there was a large variation in the health benefits available for all employees. Public information on wages and benefits for all employees was largely unavailable.

We recommend that all medical schools and academic medical centers:

- Develop a policy of paying all workers at or above the local living wage for the employee's family size
- Offer comprehensive health insurance to all full-time employees that is accepted at the academic medical center

Anti-Racist IRB Policies

Some medical centers' institutional review boards (IRBs) listed racial and ethnic minorities as "vulnerable subjects," including one school which changed its policy after being made aware in the first draft of this Report Card that its list of "vulnerable subjects" did not include people of color. However, no school required researchers to define race or how researchers planned to use race in their research prior to approval. No school is known to deny research proposals due to the presence of racialized medicine.

We recommend that all institutional review boards:

- Include people of color among their listed “vulnerable populations,” thereby requiring additional scrutiny of research involving people of color
- Require that all research submissions in which the project involves race have a *written* definition of race and a description of how race will be used in the research study
- Reject any proposed study that will explicitly or tacitly reinforce biological definitions of race

Summary

The Racial Justice Report Cards for the seventeen schools featured in this report strongly suggest there is much work to be done to ensure racial justice in medical education and care at American academic medical centers. The inequities present -- from URM representation to the disparate care provided to patients of color -- speaks to the long and active role racism plays in the American medical education and healthcare system. While this report card is not representative of all that is required to address racism and rectify inequities in medical care and education, we hope that it will spark further dialogue and action at every level of the medical system.

Several themes for improvement emerged from the seventeen evaluated schools. First, none of the evaluated medical schools had URM medical student and faculty representation proportional to the American population. Only one school met the metric for the medical student population but failed to meet the metric with regards to the faculty representation. Second, 15 out of the 17 schools had either no public information on racial disparities in medical student evaluation or were reported to have racial disparities in grading and award systems with no plans for mitigation. This speaks to the widespread presence of racism and bias in URM student and clinician evaluation and promotion. Third, 15 out of the 17 schools either give students greater independence when working with vulnerable patient populations or have policies around student supervision that are inconsistently enforced. Fourth, the vast majority of these academic medical centers have no public policy of paying all employees a living wage and providing comprehensive health insurance accepted at the academic medical center.

Conversely, several metrics were largely met across the evaluated schools. For example, every evaluated school had at least some system in place to recruit URM students. We hope that strengthening these systems will result in medical student and faculty bodies that better reflect the American population and ensure that those involved in these efforts are compensated for their time. Every evaluated school also had a mechanism to report racist or biased incidents; however, schools varied in the extensiveness and transparency of responses to these events. Lastly, 14 out of the 17 schools have at least a rudimentary curriculum on the history of racism in medicine, racial justice strategies, and race as a sociopolitical construct. It appears schools would benefit from hiring more qualified, dedicated faculty to develop these curricula, dedicate more resources to faculty development, and teach more anti-racism strategies in clinical practice.

Of note, two schools initially planned to participate in this year's Report Card subsequently did not. At one school, administrators were concerned that poor Report Card grades would compound challenges with re-accreditation. At the other, a public institution, administrators were concerned that participating in the Report Card would draw conservative lawmakers' attention and would compromise funding for care of marginalized patients. The intention of the report card is to be a nidus for change and to support current and prospective URM medical students, faculty, staff, and the patients we serve. In many cases, the act of making information publicly available leads to greater transparency and accountability from institutions. However, dialogue with students from multiple schools suggest that there are times when nondisclosure can be protective of students and patients. WC4BL maintains that local students and chapters are best positioned to advance the needs of their communities and we hope that there comes a time when this work can be shared.

Students at many schools report that the Report Card metrics are being used internally to assess the current environment and provide concrete steps going forward. One student wrote that they have been able to "meet with faculty and administrators at our school and enable us to advocate for change based on our initial report card findings. These conversations have been very productive thus far, and we plan to continue this work throughout the year."

Another student wrote, "We initially had the support of our school's administration in contributing to the national report, but a couple months into our work, we were asked not to continue due to fears over potential impacts to our school's funding stream. This change of heart gave us the opportunity to push our school to refocus on concerns raised by our student diversity group at the beginning of the year, allowing us to use the Racial Justice Report Card as a tool for change indirectly."

Ultimately, WC4BL hopes that the Racial Justice Report Card can serve as a tool for reflection, transparency, and change. We look forward to continued realignment of the U.S. medical education and healthcare system away from its racist past and towards a system that promotes the health and wellbeing of all students, faculty, and patients.

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Appendix A

Racial Justice Report Card

Appendix A: 2019 Metrics and Scoring

URM Student Representation

Medical school students are at least 13% Black, 1% Native American, and 17% Latinx (corresponding to the share of these groups in the U.S. population).

- A. All URM groups are proportionately represented among students
- B. Some URM groups are proportionately represented among students
- C. No URM groups are proportionately represented among students

URM Faculty Representation

Medical school faculty are at least 13% Black, 1% Native American, and 17% Latinx (corresponding to the share of these groups in the U.S. population).

- A. All URM groups are proportionately represented among faculty
- B. Some URM groups are proportionately represented among faculty
- C. No URM groups are proportionately represented among faculty

URM Recognition

The physical space of the medical school acknowledges the contributions of alumni and other physicians of color (through plaques, statues, portraits, and building names) and does not celebrate racist or white supremacist individuals.

- A. The above metric is fully met
- B. There are no items celebrating racist/white supremacist individuals, and also none celebrating PoC
- C. The physical space explicitly celebrates racist/white supremacist individuals

URM Recruitment

The medical school's recruitment policies promote racial justice. The medical school application does not inquire about the applicant's criminal history. The medical school recruits and admits undocumented students and students of color who attended public

high schools in the county or state where the medical school is located. Students of color who participate in recruitment are compensated for their time.

- A. The above metric is fully met
- B. Some elements of the metric are met
- C. No elements of the metric are met

Anti-Racist Training and Curriculum

The curriculum incorporates information about the history of racism in medicine, intersectional oppression, and racial justice strategies, and explicitly addresses the fact that race is a social construct, not a biological one. Lecturers avoid describing race per se (rather than racism) as a risk factor for disease, cause of health disparities, or basis for diagnostic reasoning. Community advocates and students who are underrepresented in medicine are incorporated in the planning and leadership of the pre-clinical curriculum.

- A. The above metric is fully met
- B. Some elements of the metric are met
- C. The curriculum fails to adequately address racism in medicine. Race is stated or implied to be biological. Community advocates and URM students do not participate in planning or are not compensated for their time

Discrimination Reporting

The medical school has a system for collecting student feedback on racism and other forms of oppression, and also conducts routine formal studies of institutional culture, harassment, racism in curricular content, and racial inequities in clinical and pre-clinical grades.

- A. The above metric is fully met
- B. There is some system for collecting student feedback, but there is no clear follow-up after reports are made
- C. There is no system for collecting student feedback or assessing institutional culture and policies

URM Grade Disparity

There are no racial disparities in medical students' grades or honors (including AOA election).

- A. The above metric is fully met
- B. The school regularly evaluates whether there are racial disparities, and has developed plans to address them
- C. There are significant racial disparities in grades and/or honors, or this information is not publicly available

URM Support/Resources

Black, Native American, and Latinx (URM) students have access to designated physical spaces, as well as support staff, including administrators, physician mentors, mental health providers, and peer counselors.

- A. The above metric is fully met
- B. There are some resources specifically designated to support URM students
- C. There are no designated resources for URM students

Campus Policing

There is no campus police force, or police are used as a last resort after the failure of alternative safety structures such as peer walking escorts, restorative justice councils, and mediation. If police or security officers exist, publicly-available data should demonstrate that they have not disproportionately stopped, arrested, or otherwise interacted with people of color.

- A. The above metric is fully met
- B. There are some programs designed to reduce reliance on police
- C. There is a campus police force, and no evidence that they have sought to address racism in policing, or this information is not publicly available

Marginalized Patient Population

Expectations for students' level of independence and supervision are clearly documented and are consistent across training sites (for example, students are not disproportionately given the opportunity to "practice" while rotating in VA or public hospitals or while volunteering in free clinics).

- A. The above metric is fully met
- B. Policies exist to ensure that all patients receive equally well-supervised care, but are inconsistently enforced
- C. Students are routinely given more independence when caring for marginalized patients

Equal Access for All Patients

At the primary teaching hospital, patients of color are represented in all services (including specialist services) and practices at their rate in the local population. Patients of color are not segregated in resident or student clinics.

- A. The above metric is fully met
- B. There are some efforts to ensure that all patients have equal access to care (e.g. Medicaid patients are seen in faculty clinics)
- C. Patient care is highly segregated, or this information is not publicly available

Immigrant Patient Protection

The primary teaching hospital has demonstrated a commitment to immigrant patients including multilingual public signs stating that patients are welcome regardless of immigration status, and a policy of referring immigration authorities to hospital attorneys prior to any cooperation by hospital staff.

- A. The above metric is fully met
- B. The primary teaching hospital has some symbolic commitment to immigrant patients (e.g. signs), but no policies explicitly protecting undocumented patients seeking care
- C. The primary teaching hospital has no public or policy commitment to immigrant patients

Staff Compensation and Insurance

All medical school staff and staff at the primary teaching hospital are paid a living wage as defined by local advocacy organizations. All full-time staff have comprehensive health insurance that is accepted at the health system where they work.

- A. The above metric is fully met
- B. N/A
- C. Some staff earn less than a living wage and/or do not have access to comprehensive health insurance, or this information is not publicly available

Anti-Racist IRB Policies

IRB approval process requires any research that uses race to include precise definitions of race and how it is being used in the research project. People of color are clearly identified as being a "vulnerable population" for research purposes, and IRB policies outline strategies to protect people of color from abusive practices.

- A. The above metric is fully met
- B. IRB process requires researchers to explain their use of race
- C. IRB process has no requirements regarding the treatment of race, or this information is not publicly available



Appendix B

Full Report Cards by School

Appendix B: Full Report Cards by School

Frank H. Netter School of Medicine at Quinnipiac University

This section provides further detail on each metric for the Frank H. Netter MD School of Medicine. Netter is an allopathic medical school located in Hamden, Connecticut. Quinnipiac is affiliated with Trinity Health–New England and St Vincent’s Medical Center.¹

Each metric (numbered 1–14 in the truncated report card) includes the full metric prompt, the grade for the institution, and an explanation of what that grade represents. Below each metric, we provide any relevant links to sources.

1. Medical school students are at least 13% Black, 1% Native American, and 17% Latinx (corresponding to the share of these groups in the U.S. population).

- A. All URM groups are proportionately represented among faculty and students
- B. Some URM groups are proportionately represented among faculty and/or students
- C. No URM groups are proportionately represented among faculty or students**

Black people represent only 8% of students. Latinx people represent 9% of students. Native American people represent 0.2% of students.

2. Medical school faculty are at least 13% Black, 1% Native American, and 17% Latinx (corresponding to the share of these groups in the U.S. population).

- A. All URM groups are proportionately represented among faculty
 - B. Some URM groups are proportionately represented among faculty
 - C. No URM groups are proportionately represented among faculty, or this information was not publicly available**
-

¹ <https://www.qu.edu/schools/medicine/clinical-partners.html>

There is no data to use as evidence to support the URM proportions among faculty. Based on the estimate of in house faculty and administration, no URM groups are proportionately represented. Since founded in 2010 the medical school now have fewer full-time URM faculty, particularly in leadership roles. Faculty with clinical appointments are not required to disclose their race, but collecting this data will be under consideration as it will be beneficial information.

3. The physical space of the medical school acknowledges the contributions of alumni and other physicians of color (through plaques, statues, portraits, and building names) and does not celebrate racist or white supremacist individuals.

- A. The above metric is fully met
- B. There are no items celebrating racist/white supremacist individuals, and also none celebrating people of color**
- C. The physical space explicitly celebrates racist/white supremacist individuals

Our first students entered Netter in 2013. As such, we do not have an institutional history of celebrating racist and white supremacist individuals. Our school is named for Frank H. Netter, MD, who is an internationally renowned physician artist. Dr. Netter has been celebrated for his egalitarian representation of patients from a multiplicity of races. The only portraits that hang in our school are of Dr. Netter and Edward and Barbara Netter. There is also no physical space celebrating alumni and other physicians of color throughout the whole year. With that being said, during different cultural and heritage months (i.e. Black and Latino History months), We have rotating exhibits of physicians, scientists, and other societal influencers.

Additional information may be found at the following links:

- <https://www.qu.edu/life/student/black-history-month.html#schoolofmedicineevents>

4. The medical school's recruitment policies promote racial justice. The medical school application does not inquire about the applicant's criminal history. The medical school recruits and admits undocumented students and students of color who attended public high schools in the county or state where the medical school is located. Students of color who participate in recruitment are compensated for their time.

- A. The above metric is fully met

B. Some elements of the metric are met

C. No elements of the metric are met

Statistically, the percentage of racially URM students is increasing on this campus, a testament to the hard-work and success of the recruitment efforts. Frank H. Netter School of medicine states that “our culture embraces diversity and inclusion in its broadest sense, with students from a variety of backgrounds, identities and perspectives. Quinnipiac has several pipeline programs to prepare URM students for medical school, including the Health Careers Pathway program and the MCAT Immersion program which aims to increase the number of individuals underrepresented in medicine in the local community. It is unclear whether undocumented students are prioritized at this time. It is also unclear how many pipeline students and URM students from New Haven have enrolled at Quinnipiac. URM medical students who participate in these programs are compensated for their time. Focus groups lead by a student realized that generally URM feel that more efforts need to be made in retaining students of color.

Additional information may be found at the following links:

- [Netter SOM Student life](#)
- [Health Career Pathways](#)
- [MCAT Immersion Program](#)
- [Admissions](#)

5. The curriculum incorporates information about the history of racism in medicine, intersectional oppression, and racial justice strategies, and explicitly addresses the fact that race is a sociopolitical construct, not a biological one. Lecturers avoid describing race per se (rather than racism) as a risk factor for disease, cause of health disparities, or basis for diagnostic reasoning. Community advocates and students who are underrepresented in medicine are incorporated in the planning and leadership of the pre-clinical curriculum.

A. The above metric is fully met

B. Some elements of the metric are met

C. The curriculum fails to adequately address racism in medicine. Race is stated or implied to be biological. Community advocates and URM students do not participate in planning or are not compensated for their time

The year 1 Behavior and Social Science longitudinal theme punctuates the Foundations of Medicine curriculum with discussion of race as a social construct and examples of institutional racism as a cause of health inequities. The specific educational events that include this content are:

- Introduction to Social Determinants of Health (lecture)

- Health Disparities: Prevention of Chronic Kidney Disease (lecture)
- Prostate Cancer Screening and Health Disparities (collaborative classroom)
- Health Disparities: Screening for Cervical Cancer (collaborative classroom)

Few professors acknowledge race as a social construct in their lecture, as it is their personal passion, while others lecturers specifically emphasize race as a risk factor for disease, cause of health disparities or basis for diagnostic reasoning. Overall, there is no overt discussion in the curriculum on the role of racism itself (not biological race) in health and disease.

Community advocates and students provide input and recommendations about our community health and health disparities curriculum. Majority of sessions on community health and health disparities are student run. Students are not compensated for the time spent planning and leading these sessions, which become burdensome to the students. There are no faculty positions dedicated to planning and leading community health and health disparities sessions.

Additional information may be found at the following link:

- [Curriculum](#)
- [Student Life](#)

6. The medical school has a system for collecting student and faculty reports of racism and other forms of oppression, and a clear plan for follow-up when problems are reported.

- A. The above metric is fully met
- B. There is some system for collecting reports, but there is no clear follow-up after reports are made**
- C. There is no system for collecting reports

The Frank H. Netter, MD School of Medicine Student Academic Policies states that Members of the School of Medicine encourage and respect diversity within the school, across the University and at its clinical sites; and do not allow discrimination in any activity or operation of the institution on the basis of age, race, national origin, religion, disability, sex, sexual orientation, or any other characteristic protected by law. The School of Medicine has a “Report of Concern” function that allows for students and faculty reports of unprofessionalism, racism, sexism, or other forms of oppression.

There is a follow-up plan on all reports of concern that is determined on a case by case basis as deemed appropriate. Completed forms for these members of the Quinnipiac

University community are automatically forwarded to the Dean of Student Affairs if a student is reported and Director of Administration if faculty is reported for his/her review, meaning that they are not strictly anonymous. The forms may become a part of that individual's permanent file. During focus groups of student experiences, there was expression of difficulty for some students to come forward with concerns, out of fear of conflict. The system also poses the ability for students to overuse the ability to report other students, posing a possible negative report on their file.

7. There are no racial disparities in medical students' grades or honors, including AOA election.

- A. The above metric is fully met
- B. The school regularly evaluates whether there are racial disparities, and has developed plans to address them
- C. There are significant racial disparities in grades and/or honors, or **this information is not publicly available**

Quinnipiac School of Medicine has a pass/fail preclinical curriculum during the first two years but has not shared information about the grading system for clerkship and elective rotations and has not commented on whether they collect and assess data on any disparities in evaluations by self-reported race. The SOM does not have an AOA chapter.

8. Black, Native American, and Latinx (URM) students have access to designated physical spaces, as well as support staff, including administrators, physician mentors, mental health providers, and peer counselors.

- A. The above metric is fully met
- B. There are some resources specifically designated to support students of color
- C. **There are no designated resources for students of color**

The SOM has The Inclusion and Diversity Council (IDC) acts as consultant, collaborator, and advisor to the entire School of Medicine community on issues related to inclusion and diversity, including policies, procedures, educational content, faculty development, campus climate, and information dissemination. Unlike most medical schools in this country, Netter has no dedicated Office of Multicultural Affairs with staff whose sole responsibility it is to provide support and resources to URM medical students.

There has been no acknowledgment of the relationship between the unique mental health needs/distinct stressors of URM students and the way in which these stressors impact academic performance. Black, Native American, and Latinx (URM) students have no access to designated physical spaces. Students wish for more supportive staff, including administrators, physician mentors, mental health providers of color, and peer counselors.

The SOM has taken on a strategic planning initiative that began in 2017–18. Several areas including the Student Experience Working Group and the Administrative Effectiveness working group have identified the need for dedicated space, experienced administrators, and supporting staff to address Diversity and Inclusion. Students of color seek mentorship from Physicians of color, and Netter should make more efforts to foster those experiences. Due to the lack of opportunities on campus student seeks relationships on their own through SNMA and conferences. They find frustration when there are certain academic policies in place that may prevent them from gaining inspirations and networking opportunities.

9. There is no hospital/campus police force, or police are used as a last resort after the failure of alternative safety structures such as peer walking escorts, restorative justice councils, and mediation. If police or security officers exist, publicly-available data should demonstrate that they have not disproportionately stopped, arrested, or otherwise interacted with people of color.

- A. The above metric is fully met
- B. There are some programs designed to reduce reliance on police**
- C. There is a campus police force, and no evidence that they have sought to address racism in policing, or this information is not publicly available

Quinnipiac has a campus security force 24 hours a day. The process of reporting a concern can be used to report complaints about the conduct of security officers.

The Department of Security and Safety at Quinnipiac University staff's security stations located at the two entrances to the Center for Medicine, Nursing and Health Sciences. Additional security personnel conduct regular patrols of the campus at all hours throughout the week. Access to the Center requires proper identification credentials. Members of the security staff are visibly present, and escort services are available for any student or staff member who requests such services. On a case by case incidence there have been efforts to address racist policing or pursue alternative safety structures and policy adjustments. However, there is no set program designed to reduce reliance on police.

Clinical sites employ rigorous security measures, including the use of State of Connecticut-licensed security officers, 24/7 security coverage, security cameras, access control measures (e.g., photo ID), restricted access to certain areas, patrol of the property, panic/duress stations, secure storage for student's personal belongings, and escort services. Both the university and the hospital sites use smart phone safety alert apps to report security concerns, as well as apprise students and staff of security issue.

Additional information may be found at the following links:

- [Campus Security](#)
-

10. Expectations for students' level of independence and supervision are clearly documented and are consistent across training sites (for example, students are not disproportionately given the opportunity to "practice" while rotating in VA or public hospitals or while volunteering in free clinics).

- A. The above metric is fully met**
- B. Policies exist to ensure that all patients receive equally well-supervised care, but are inconsistently enforced
- C. Students are routinely given more independence when caring for marginalized patients

There are clear policies on the supervision of medical students during required clinical rotations.

11. At the primary teaching hospital, patients of color are represented in all services (including specialist services) and practices at their rate in the local population. Patients of color are not segregated in resident or student clinics.

- A. The above metric is fully met
- B. There are some efforts to promote equal access to care (e.g. Medicaid patients seen in faculty clinics)
- C. Patient care is highly segregated, or **this information is not publicly available**

There is no publicly available information on racial segregation of care at Quinnipiac SOM clinical affiliate sites. Minorities students who participated in a focus group about experiences at the SOM, have expressed concerns about the lack of diversity among various clinical experiences, such as clinical exposure in the preclinical and clerkship years. One of these concerns, were for some sites that do not accept Medicaid/ Medicare, the student was frustrated with the perception towards Medicaid and, realized if need be, he/she could not receive care from the clinical site that she shadowed at. Collecting more data on clinical affiliates is desired.

12. The primary teaching hospital has demonstrated a commitment to immigrant patients including multilingual signs stating that patients are welcome regardless of immigration status, and a policy of referring immigration authorities to hospital attorneys prior to any cooperation by hospital staff.

- A. The above metric is fully met
- B. The hospital has some symbolic commitment to immigrant patients (e.g. signs), but no policies explicitly protecting undocumented patients
- C. The hospital has no public or policy commitment to immigrant patients or this information is not publicly available**

QU has multiple clinical affiliates. We are not aware of public policies or statements affirming their support for immigrant patients at any of the major clinical sites.

13. All medical school staff and staff at the primary teaching hospital are paid a living wage as defined by local advocacy organizations. All full-time staff have comprehensive health insurance that is accepted at the health system where they work.

- A. The above metric is fully met
- B. N/A
- C. Some staff earn less than a living wage and/or do not have access to comprehensive health insurance, or **this information is not publicly available**

Quinnipiac states that it ensures that all employees have access to high-quality medical care and have sufficient earnings to live above poverty. We do not currently collect this information from our affiliates. Unfortunately, Human Resources will not provide documentation and I was unable to locate any additional evidence.

Additional information may be found at the following link:

- [Living Wage Calculator](#)

14. IRB approval process requires researchers involved in any research that uses race to precisely define race and how it is being used in the research project. IRB approval process requires any research that uses race to include precise definitions of race and how it is being used in the research project. People of color are clearly identified as being a "vulnerable population" for research purposes, and IRB policies outline strategies to protect people of color from abusive practices.

- A. The above metric is fully met
- B. IRB process requires researchers to explain their use of race
- C. IRB process has no requirements regarding the treatment of race, or this information is not publicly available**

The Quinnipiac IRB does not have any specific language regarding anti-racist policy. It would seem to fall under the ethical principles and guidelines of the Belmont Report, which all IRBs follow. Below is a link to the QU IRB. There are no specific policies protecting research subjects of color. There is no required review of how researchers use “race” in their research, and there is no routine review of student projects for their treatment of race.

Additional information may be found at the following links:

- [IRB Policy](#)

George Washington University

This section provides further detail on each metric for George Washington University School of Medicine & Health Sciences. GW is an allopathic medical school located in Washington, D.C. The primary teaching hospital is the George Washington University Hospital.

Each metric (numbered 1-14 in the truncated report card) includes the full metric prompt, the grade for the institution, and an explanation of what that grade represents. Below each metric, we provide any relevant links to sources.

1. Medical school students are at least 13% Black, 1% Native American, and 17% Latinx (corresponding to the share of these groups in the U.S. population).

- A. All of the above groups are proportionately represented among students
- B. Some of the above groups are proportionately represented among students
- C. None of the above groups are proportionately represented among students, or this information is not publicly available**

Current GW medical student makeup is not representative of the U.S. or the Washington, D.C. Population. Among medical students, 8.68% identify as African American, 2.8% identify as Latinx; there is no data for Native Americans (2018 data).

Additional information may be found at the following links:

- [The Office of Diversity and Inclusion](#)
 - [GW SMHS 2018 Class Profile](#)
-

2. Medical school faculty are at least 13% Black, 1% Native American, and 17% Latinx (corresponding to the share of these groups in the U.S. population).

- A. All of the above groups are proportionately represented among faculty
- B. Some of the above groups are proportionately represented among faculty
- C. None of the above groups are proportionately represented among faculty, or this information is not publicly available**

Current GW medical school faculty makeup is not representative of the U.S. or the Washington, D.C. Population. Among full-time faculty, 8.4% identify as African American, 3.7% identify as Latinx; there was no data for Native American faculty (2016 data). Of note, there is no publicly available data for faculty representation. Data comes from direct talks with the Office of Admissions, reported by the Office of Diversity and Inclusion.

Additional information may be found at the following links:

- [The Office of Diversity and Inclusion](#)
-

3. The physical space of the medical school acknowledges the contributions of alumni and other physicians of color (through plaques, statues, portraits, and building names) and does not celebrate racist or white supremacist individuals.

- A. The above metric is fully met
- B. There are no items celebrating racist/white supremacist individuals, and also none celebrating people of color

C. The physical space explicitly celebrates racist/white supremacist individuals

The current portraits of individuals and alumni who have contributed directly to the school of medicine primarily consist of white men, despite the fact that GW has in its history other alumni and faculty of diverse backgrounds who have made impactful contributions to medicine and public health such as Dr. Carlos Santos-Burgoa.

Additionally, GW's school mascot is the "Colonial". This mascot inappropriately celebrates a practice that is rooted in racism, violence, and systematic oppression. Per the Director of Diversity and Inclusion, there has been informal conversation about changing this mascot for the last two decades. Additionally, in March 2019, 54% of students who participated in the GW student government election voted in favor of urging the university to change the mascot. However, no concrete action has been taken by the administration to correct this issue.

Despite the fact that GW has been given a "C" grade for this metric, it should be noted that newer imagery of students and faculty appear to have been chosen with the intention of highlighting diversity and underrepresented minorities. The SMHS could address the aforementioned issues by refraining from having the Colonial mascot attend SMHS events and incorporating portraits honoring URM faculty and alumni.

Data Source: In-person data collection of imagery in Ross Hall and Himmelfarb Health Sciences Library

Additional information may be found at the following links:

- [GW Nicknames and Mascots](#)
 - [Referendum in Favor of Mascot Change](#)
 - [ASPHH Article Discussing Dr. Santos-Burgoa's Research](#)
-

4. The medical school's recruitment policies promote racial justice. The medical school application does not inquire about the applicant's criminal history. The medical school recruits and admits undocumented students and students of color who attended public high schools in the county or state where the medical school is located. Students of color who participate in recruitment are compensated for their time.

- A. The metric is fully met
- B. Some elements of the metric are met**
- C. No elements of the metric are met

GWU's recruitment policies largely promote racial justice, but the school does not meet all of the above criteria. GWU has a clear admissions pathway for undocumented students listed on its website. Additionally, the school of medicine actively works to recruit high school URM students through the pipeline programs such as DC HAPP and other opportunities that expose students to varying scientific and medical careers. Students of color who participate in these recruitment efforts are compensated for their time. However, the school of medicine does inquire about each applicant's criminal record, which is contrary to the best practice set forth by WC4BL within this metric.

*Please note that the students involved in grading GWU SMHS had substantial discussion around whether or not "inquiry into criminal history" should be a part of this metric. There was no final consensus reached. Ultimately, the grade given was based on the fact that the metric (as set forth by WC4BL) was only partially met.

Additional information may be found at the following links:

- [GWU Policy Regarding Undocumented Students](#)
 - Recruitment Programs
 - [DC HAPP](#)
 - [Upward Bound](#)
 - [The Governor's Health Sciences Academy](#)
 - [Health Education Leadership Program](#)
-

5. The curriculum incorporates information about the history of racism in medicine, intersectional oppression, and racial justice strategies, and explicitly addresses the fact that race is a sociopolitical construct, not a biological one. Lecturers avoid describing race per se (rather than racism) as a risk factor for disease, cause of health disparities, or basis for diagnostic reasoning. Community advocates and students who are underrepresented in medicine are incorporated in the planning and leadership of the pre-clinical curriculum.

A. The above metric is fully met

B. Some elements of the metric are met

C. The curriculum fails to adequately address racism in medicine. Race is stated or implied to be biological. Community advocates and URM students do not participate in planning or are not compensated for their time.

The GW SMHS curriculum has undergone sweeping changes within the past five to six years and yet an in-depth education and exploration of the enduring influence of racism on medicine is lacking. The curriculum includes a diversity and cultural competence “theme”, however the lectures that fall under this theme are thinly spread over the course of four years and focus more on the social determinants of health rather than addressing racism in medicine specifically. Race is identified as a social construct, however the history of racism, intersectional oppression, and racial justice strategies are not addressed.

Although full time faculty are required to participate in trainings regarding unconscious bias and how to add cultural competency to the curriculum, many clinicians at the GW Medical Faculty Associates are enlisted to teach specific topics and are not required to complete these trainings. For this reason, while the content of the mandatory lectures addressing race may be strong, the message is contradicted by many other lecturers who continue to use race as a risk factor for disease without due explanation or substantiating evidence. Recent steps have been taken to rectify this by convening a taskforce on the use of race in the curriculum, comprised of students and faculty, with the aim of creating standards and accountability for all lecturers. The efficacy of the recommendations remain to be seen but the curriculum leadership have been proactive in facilitating the process.

With respect to the involvement of URM community advocates, the “Patients, Populations, and Systems” course series covers community health and health disparities and is required for medical students as of 2018. This course was designed to highlight multiple viewpoints and there is some intentionality about incorporating underrepresented minorities to offer their expertise on certain topics as patient and practitioner panelists (ex: HIV Summit and Asthma Summit). However, it is the students’ perception that these community advocates are often invited to participate, but within a preset framework in which they may not have had any input. These

individuals present and participate but there is no concrete evidence that they have any leadership roles or that they are incorporated in the planning of the curriculum.

Data source: The Office of Diversity and Inclusion

Additional information may be found at the following links:

- [The MD Program Curriculum](#)
 - [Curriculum Structure for Class of 2018, 2019, 2020, and 2021](#)
 - Please note that this publicly available chart does not show the mandatory lectures but shows that diversity is an integral theme embedded throughout the curriculum.
 - [Patients, Populations, and Systems Course Information](#)
 - [The George Washington University Response Action Plan for Diversity, Equity and Inclusion](#)
 - Please note that this report is a collaboration between faculty and staff on the university scale, extending beyond the School of Medicine and Health Sciences.
-

6. The medical school has a system for collecting student and faculty reports of racism and other forms of oppression, and a clear plan for follow-up when problems are reported.

- A. The above metric is fully met
- B. There is some system for collecting reports, but there is no clear follow-up after reports are made**
- C. There is no system for collecting reports

GW has an established discrimination reporting system and students appear to generally know which administrators they can reach out to in the event of a discriminatory event. However, the reporting tool (the listening post) could be better advertised to students. In addition, there are regular, formal, in-person feedback sessions with the medical school faculty and a clear open-door policy with the Office of Diversity and Inclusion which allows students to share their thoughts and comments. With regard to follow-up, student concerns are typically followed up on but there is some lack of transparency involved as well as some indication that this process is not enough to force change.

Data source: The Office of Diversity and Inclusion, Student Interviews

Additional information may be found at the following links:

- [The George Washington University Student Grievance Procedures](#)
- [SMHS Mistreatment Policy and Procedures](#)
- [Office of Diversity Resources for Coping with Mistreatment](#)
- [The Listening Post](#)

7. There are no racial disparities in medical students' grades or honors (including AOA election)

- A. The above metric is fully met
- B. The school regularly evaluates whether there are racial disparities, and has developed plans to address them
- C. There are significant racial disparities in grades and/or honors, or **this information is not publicly available****

There is no publicly available information about racial disparities in grades or AOA election.

8. Black, Native American, and Latinx students have access to designated physical spaces, as well as support staff, including administrators, physician mentors, mental health providers, and peer counselors.

- A. The above metric is fully met**
- B. There are some resources specifically designated to support students of color
- C. There are no designated resources for students of color

GW SMHS provides a wide breadth of mental health services, mentoring, and networking opportunities for the student body, with the Office of Diversity and Inclusion (ODI) playing a critical role in supplementing and facilitating further opportunities for URM students. Through the ODI, URM students have access to a structured support system and an “open-door” culture that contributes to their success.

Data source: Student interviews

Additional information may be found at the following links:

- [The Office of Diversity and Inclusion](#)
 - [Opportunities for SMHS Students](#)
 - [Professional Development for M.D. Students](#)
-

9. There is no hospital/campus police force, or police are used as a last resort after the failure of alternative safety structures such as peer walking escorts, restorative justice councils, and mediation. If police or security officers exist, publicly-available

data should demonstrate that they have not disproportionately stopped, arrested, or otherwise interacted with people of color.

- A. The above metric is fully met
- B. There are some programs designed to reduce reliance on police**
- C. There is a campus police force, and no evidence that they have sought to address racism in policing

Although GW does have a campus police force, their general presence is appreciated and warranted based on the embedded nature of GW in the city of DC. here is a publicly available daily crime and fire log, however this log does not give any identifying information of those who were stopped/arrested, making it impossible to assess whether or not police interactions with people of color are disproportionate. It should be noted that campus officers undergo unconscious bias training during their onboarding. While there has been a new policy set forth to conduct regular bias training, this training has not been implemented in a visibly consistent manner.

Data source: Multicultural Student Services Center and Division of Safety and Security (provided through the Office of Diversity and Inclusion)

Additional information may be found at the following links:

- [GW Police](#)
 - [Division of Safety and Security Crime and Fire Log](#)
-

10. Expectations for students' level of independence and supervision are clearly documented and are consistent across training sites (for example, students or residents are not disproportionately given the opportunity to "practice" while rotating in VA or public hospitals or while volunteering in free clinics).

- A. The above metric is fully met**
- B. Policies exist to ensure that all patients receive equally well-supervised care, but are inconsistently enforced
- C. Students are routinely given more independence when caring for marginalized patients

GW has a clear policy on supervision of medical students during their clinical training. End of rotation surveys and 4th year exit surveys indicate that supervision by an attending or senior clinician is on par with the national average and further is consistent across all rotation sites. A high level of supervision is maintained in the student-staffed GW Healing Clinic as well.

Additional information may be found at the following links:

- [GW Healing Clinic](#)

- [Policy on Medical Student Supervision by Residents, Fellows, and Faculty](#)
 - [GW MD Program Current Policies](#)
 - [AAMC Graduation Questionnaire](#)
-

11. At the primary teaching hospital (s), patients of color are represented in all services (including specialist services) and practices at their rate in the local population. Patients of color are not segregated in resident or student clinics.

- A. The above metric is fully met**
- B. There are some efforts to promote equal access to care (e.g. Medicaid patients seen in faculty clinics)
- C. Patient care is highly segregated or this information is not publicly available

The George Washington University Hospital, the school of medicine's primary teaching hospital, accepts both Medicaid and Medicare insurances. While the hospital appears to serve patients relatively evenly across D.C. as well as those from the surrounding Maryland and Virginia areas based on zip code, patients with private insurance also appear to be represented at a higher proportion within GW Hospital than what exists in the overall DC population.

Additional information may be found at the following links:

- [GW Hospital Insurance Information](#)
 - [DC Health Systems Plan 2017](#)- GW Hospital Patient Distribution by Zip Code (Page 162)
 - [DC Health Systems Plan 2017](#)- GW Hospital Discharge Distribution by Zip Code and Payer (Figures 8 & 9, Pages 36-37)
 - [DC Health Systems Plan 2017](#)- GW Hospital Admissions by Payer (Figure 5, Page 34)
 - [Health Insurance Coverage of the Total Population](#)
-

12. The primary teaching hospital has demonstrated a commitment to immigrant patients including multilingual signs stating that patients are welcome regardless of immigration status, and a policy of referring immigration authorities to hospital attorneys prior to any cooperation by hospital staff.

- A. The above metric is fully met
- B. The hospital has some symbolic commitment to immigrant patients (e.g. signs), but no policies explicitly protecting undocumented patients**
- C. The hospital has no public or policy commitment to immigrant patients

The GW Hospital does not have any visible signage welcoming immigrants to the hospital, regardless of documentation status. As of right now, there is no policy in

place to refer immigration authorities to hospital attorneys prior to cooperation by hospital staff. Within the hospital, translator phones are actively used and there is a culture of connecting staff and patients who share a common language, though there is no guarantee that someone on staff will be available for any given language. GW Hospital has also translated their entire website into Spanish to facilitate patient access for the Latinx population.

Additional information may be found at the following links:

- [GW Hospital Interpretation Services](#)
 - [GW Hospital International Patient Program](#)
 - [GW Hospital "Spanish, For Your Convenience"](#)
-

13. All medical school staff and staff at the primary teaching hospital are paid a living wage as defined by local advocacy organizations. All full-time staff have affordable comprehensive health insurance that is accepted at the health system where they work.

- A. The above metric is fully met
- B. N/A
- C. Some staff earn less than a living wage and/or do not have access to comprehensive health insurance, or this information is not publicly available**

This grade was given because, although GW adheres to minimum wage guidelines for contractors of the District of Columbia Government, there are some full-time staff members who are not paid a living wage as defined by MIT's Living Wage Calculator. It should be noted that GW University and Hospital staff are offered health insurance packages which are accepted at GW's own health system.

Additional information may be found at the following links:

- [MIT Living Wage Calculator](#)
 - [Government of the District of Columbia - Living Wage Act Fact Sheet](#)
 - [D.C. Living Wage per D.C. Department of Employment Services](#)
-

14. IRB approval process requires any research that uses race to include precise definitions of race and how it is being used in the research project. People of color are clearly identified as being a "vulnerable population" for research purposes, and IRB policies outline strategies to protect people of color from abusive practices.

- A. The above metric is fully met
- B. IRB process requires researchers to explain their use of race

C. IRB process has no requirements regarding the treatment of race, or this information is not publicly available

This grade was given because GW's IRB application does not specifically require researchers applying for approval (using race) to precisely define race and how it is being used in the research project.

Additional information may be found at the following links:

- [Office of Human Research](#)

Harvard Medical School

This section provides further detail on each metric for the Harvard Medical School. Harvard is an allopathic medical school located in Boston, Massachusetts. Students rotate at several affiliated hospitals for their clinical education.²

Each metric (numbered 1–14 in the truncated report card) includes the full metric prompt, the grade for the institution, and an explanation of what that grade represents. Below each metric, we provide any relevant links to sources.

1. Medical school students are at least 13% Black, 1% Native American, and 17% Latinx (corresponding to the share of these groups in the U.S. population).

- A. All of the above groups are proportionately represented among students
- B. Some of the above groups are proportionately represented among students
- C. **None of the above groups are proportionately represented among students**, or this information is not publicly available

Per the AAMC, for 2018–2019, 7.1% of HMS students are Black, 0% are Native American, 6.5% are Latinx, and 7.5% identify as multiracial. HMS reports having 729 MD students currently enrolled with the following racial demographics: 7.1% Black, 0.1% Native American, 9.5% Latinx, and 2.9% multiracial.

Additional information may be found at the following link:

- [AAMC Medical School Enrollment by Race & Ethnicity](#)
 - [Table B-5.1: Total Enrollment by U.S. Medical School and Race/Ethnicity, 2018-2019](#)
 - [Faculty Development and Diversity Task Force Recommendations](#)
-

2. Medical school faculty are at least 13% Black, 1% Native American, and 17% Latinx (corresponding to the share of these groups in the U.S. population).

- A. All of the above groups are proportionately represented among students
- B. Some of the above groups are proportionately represented among students
- C. **None of the above groups are proportionately represented among students**, or this information is not publicly available

6.1 % of full-time HMS faculty are Black, Native American, or Latinx. The HMS Task Force on Faculty Development and Diversity notes, “The faculty becomes progressively

² <https://hms.harvard.edu/about-hms/hms-affiliates>

less diverse as one moves along the spectrum from HMS student to house staff (trainees) to instructor and up the ranks to full professor.” Of note, this Task Force was initially convened in 2010 and recommended annual diversity reports including information about faculty and trainee demographics in each department, changes over time, and descriptions of diversity efforts and their effectiveness; it appears that no such reports have been published since at least 2012. HMS states the Task Force on Diversity has reviewed past recommendations. There are no publicly available plans on how the task force plans to increase the proportion of URM faculty.

Additional information may be found at the following links:

- [Harvard Faculty Demographics](#)
- [Diversity Task Force Report](#)
- [2012 Annual Report on Faculty Development and Diversity at HMS](#)

3. The physical space of the medical school acknowledges the contributions of alumni and other physicians of color (through plaques, statues, portraits, and building names) and does not celebrate racist or white supremacist individuals.

- A. The above metric is fully met
- B. There are no items celebrating racist/white supremacist individuals, and also none celebrating people of color
- C. The physical space explicitly celebrates racist/white supremacist individuals**

Oliver Wendell Holmes, after whom one of the Harvard Medical School academic societies is named, was a former dean of Harvard Medical School. When, in 1850, white students protested the admission of three Black students to Harvard Medical School, Holmes led the faculty in expelling the Black students. The overwhelming majority of individuals whose likenesses are present in Harvard Medical School public spaces are white men.

The Dean of Harvard Medical School has established the Dean’s Standing Committee on Arts and Cultural Representation, which is chaired by the Dean’s Chief of Staff and will evaluate existing artwork at Harvard Medical School and make proposals for changes to the artwork. This Committee will collaborate with the Culture, Climate, and Communication subcommittee of the Harvard Medical School Task Force on Diversity and Inclusion. Thus far, the committee has displayed paintings by medical student Pamela Chen in the office of the Dean of the Medical School, and installed a bust of Dr. Alice Hamilton, a white woman and the school’s first woman faculty member, in the medical education center. Harvard University also has a Presidential Task Force on Inclusion and Belonging that has recommended the creation of “inclusive symbols and spaces.”

HMS also has the Tosteson Medical Education center, where the school reports there are images of past and current URM faculty. The student lounge on the 4th floor of the center is named after Harold Amos, PhD, the first Black faculty member to chair a department at the medical school.

Additional information may be found at the following links:

- [Students of African descent at HMS before affirmative action](#)
- [Harvard University Presidential Task Force on Inclusion and Belonging](#)
- [Dialogue: Images at HMS - Picturing Diversity, Creating Community](#)
- [Personal Reflections: student chronicles her training through paintings](#)
- [Dr. Alice Hamilton Sculpture "Heralds New Era"](#)

4. The medical school's recruitment policies promote racial justice. The medical school application does not inquire about the applicant's criminal history. The medical school recruits and admits undocumented students and students of color who attended public high schools in the county or state where the medical school is located. Students of color who participate in recruitment are compensated for their time.

- A. The metric is fully met
- B. Some elements of the metric are met**
- C. No elements of the metric are met

The Office of Recruitment and Multicultural Affairs organizes a number of programs to recruit and retain URM students, including maintaining a registry of URM applicants, attending the AAMC recruitment fair, and entrance and exit interviews with all URM students.

URM medical students also participate in mentoring URM undergraduate students from Harvard and Northeastern University and attend the SNMA Annual Medical Education Conference to recruit URM students. The Office of Recruitment and Multicultural affairs also asks URM students to donate their time to recruiting prospective students of color in 30 min - 1 hr one-on-one sessions. Medical students of color can contact as many URM prospective students as they want, and all meetings are scheduled student-to-student. Medical students of color donate on average 2 - 3 hours per week, throughout the entire admissions cycle, to URM student recruitment. This year, Harvard medical students of color receive limited funding to purchase snacks or coffee for the prospective students they met with; this funding was secured by the advocacy of a URM medical student. However, Harvard medical students of color involved in recruitment are not compensated directly for their time.

Harvard Medical School has a policy of enrolling DACA students. It is unknown how many URM graduates of Boston Public Schools are currently enrolled at HMS. In accordance with Massachusetts state law regarding individuals with access to children or confidential medical records, all HMS students must complete a CORI background check upon matriculation.

Additional information may be found at the following links:

- [Office of Multicultural Affairs: Recruitment](#)
 - Office for Diversity & Inclusion opportunities for [middle school](#), [high school](#), [college](#), and [graduate](#) students
 - [Admissions Selection Factors: DACA](#)
 - [Article: American Dreamers: HMS DACA students concerned about future status in the U.S.](#)
 - [Article: Success for Harvard medical students in DACA could mean their parents are deported](#)
 - [Article: Dismantling DACA Could Also Destroy These Harvard Med Students' Dreams](#)
 - [Criminal Offender Record Information \(CORI\)](#)
-

5. The curriculum incorporates information about the history of racism in medicine, intersectional oppression, and racial justice strategies, and explicitly addresses the fact that race is a social construct, not a biological one. Lecturers avoid describing race per se (rather than racism) as a risk factor for disease, cause of health disparities, or basis for diagnostic reasoning. Community advocates and students who are underrepresented in medicine are incorporated in the planning and leadership of the pre-clinical curriculum.

- A. The above metric is fully met
- B. Some elements of the metric are met
- C. The curriculum fails to adequately address racism in medicine. Race is stated or implied to be biological. Community advocates and URM students do not participate in planning or are not compensated for their time.**

All students receive a workshop on unconscious bias as a part of their “Professional Development Days.” Required sessions within the courses “Essentials of the Profession 1” and “Essentials of the Profession 2” include the following:

- Social Determinants of Health
- History of Health Care in America

- The Role of Medicine
- History and Ethics of Research
- Mechanisms of Disparities
- Solving Disparities
- Ethics of Disparities
- Taking Medicine Beyond Clinic
- Liberation in the Exam Room
- Why Epidemiologists (and Other Health Professionals) Must Reckon with Racism
- Hidden Biases in Medicine

Additional electives are available for students with an interest in community health and engagement, but are not required of all students. The Equity and Social Justice lecture series is available to all members of the Longwood and Greater Boston community, but is likewise optional and is scheduled in conflict with the first year medical students required clinical curriculum on Wednesdays. Required coursework specifically addresses intersectional oppression, but inadequately educates students on anti-racism strategies.

Members of the medical student-run Racial Justice Coalition have helped to create a session on microaggressions on the medical wards, which launched in 2018 and will be a part of the curriculum for all first year students in the current school year. Harvard Medical School has a faculty theme director for health equity and cross-cultural care who works with students, including URM students, to revise the curriculum, for example by diversifying cases and incorporating content about racism. However, in the current iteration of these reforms, URM students are often inappropriately burdened with the responsibility to teach their classmates about the health disparities their communities may experience, and their extra labor is uncompensated. All MD curriculum governance committees, including the Race in the Curriculum and Health Equity in the Curriculum working groups, have student voting members. Students are also involved with the Diversity Pipeline and Community Engagement subcommittee of the Harvard Medical School Task Force on Diversity and Inclusion. Community members are involved in the planning and leadership of several community engagement programs, and the Faculty Associate Dean for Community Engagement conducts outreach to community partners. However, community members do not routinely participate in curricular design for medical students.

Students receive a lecture in their Foundations course on “Genes, Race and Ethnicity,” and some courses incorporate discussion of the fact that race is a sociopolitical, not biological construct. Moreover, as noted previously in this report, the Essentials of the Professions courses incorporate discussion of the role of history and racism in generating health disparities. However, lecturers typically describe race (rather than

racism) as a risk factor for disease, cause of health disparities, or basis for diagnostic reasoning, as there is no public policy or training for lecturers on this topic. Lecturers have dismissed student questions about the validity of using race as the basis for diagnostic reasoning.

Additional information may be found at the following links:

- [Equity & Social Justice](#)
- [Pathways Curriculum Course Summaries](#)
- [Academic Deans](#)

6. The medical school has a system for collecting student and faculty reports of racism and other forms of oppression, and a clear plan for follow-up when problems are reported.

- A. The above metric is fully met
- B. There is some system for collecting reports, but there is no clear follow-up after reports are made**
- C. There is no system for collecting reports

Students can report concerns through the anonymous university reporting system via phone (1-877-694-2275) or online (<https://reportinghotline.harvard.edu/>). All hotline reports are triaged to the medical school by Harvard University's Office of Risk Management & Audit Services. Reports triaged to the medical school are received by the Dean for Students (Dean) and the Director of Student Affairs (Director) and reviewed within 24 hours. Any Title IX issues are reported directly to the appropriate Title IX officer.

The school states immediate attention is taken on any reports that involve matters of mental or physical safety. The Dean or Director will reach out to any reporter who identifies themselves to obtain more background information on the situation. The original report is discussed with the Council of Advisory Deans and may lead to any of the following actions: investigation, individual action plan intervention or disciplinary intervention. Any cases meeting the criteria for student mistreatment are highlighted. Follow-up is provided either in person with the reporter or via the online portal in the case of an anonymous report.

The medical student handbook clearly defines "racial harassment" and encourages students to report such harassment. Students may also report mistreatment anonymously at the end of each course via the course evaluation system, and may

report incidents of discrimination through the Harvard Medical School ombudsperson. There is a clear anti-discrimination policy at Harvard Medical School, and a grievance procedure for addressing violations of this policy. Harvard Medical School participates in a Harvard University wide anonymous reporting platform that is monitored 24/7 and run by an independent, third party platform. However, it is unclear what the follow-up looks like is for this university wide reporting system. Information on the type of actions that have resulted from these reports or the time to response was not provided and is not publicly available. Additionally, whether reports from the medical school are systematically tracked to identify patterns and develop systemic change.

Harvard Medical School has an “Ombuds Office” which serves as an informal and confidential space to receive counseling around any conflict or concern, including those related to harassment and discrimination. While this Office is open and non-directory, the “Ombudsperson” focuses on neutrality and their approach focuses on conflict resolution and fairness, rather than justice.

Medical students are also encouraged to report their concerns directly to the Dean of Students. However, it is unclear how many students feel comfortable reporting racism and oppression through this method, or the degree of anonymity afforded to students who report directly to the Dean of Students.

Reports made through the online portal, the Ombuds office, or directly by email are reviewed by the Dean of Students and the Council of Advisory Deans. The procedure for follow-up on reported issues is unclear, as immediate or delayed action is made at the discretion of the council.

Additional information may be found at the following links:

- [Discrimination, Harassment, and Student Mistreatment](#)
- [Harvard Medical School and Harvard School of Dental Medicine Anti-Discrimination Policy](#)
- [Harvard Medical School and Harvard School of Dental Medicine Faculty Grievance Procedures](#)
- [Common Concerns](#)
- [Office for Academic & Research Integrity](#)
- [Online Reporting](#)
- [Ombuds Office](#)

7. There are no racial disparities in medical students' grades or honors (including AOA election)

- A. The above metric is fully met

- B. The school regularly evaluates whether there are racial disparities, and has developed plans to address them
- C. There are significant racial disparities in grades and/or honors, or **this information is not publicly available**

Harvard Medical School does not have an Alpha Omega Alpha Honor Medical Society; students are not assigned GPAs and there is no formal class ranking. Pre-clinical courses are graded unsatisfactory/satisfactory; courses in the third and fourth years are graded with distinction/honors/pass/unsatisfactory.³ Additionally, Harvard Medical School offers “honors in a special field” for a scholarly thesis. There is no publicly available information on disparities in clerkship grades or the receipt of “honors in a special field,” and no plan to address any existing disparities.

Additional information may be found at the following link:

- [Grading System -- PCE & Post-PCE](#)

8. Black, Native American, and Latinx students have access to designated physical spaces, as well as support staff, including administrators, physician mentors, mental health providers, and peer counselors.

- A. The above metric is fully met
- B. There are some resources specifically designated to support students of color**
- C. There are no designated resources for students of color

Harvard maintains an Office of Recruitment and Multicultural Affairs (ORMA), which has two full-time staff and faculty and three part-time faculty and staff. ORMA provides mentorship and leadership development activities for HMS’s racial/ethnic minority, LGBT, and disadvantaged students. The Faculty Associate Dean for Student Affairs, the Faculty Assistant Dean for Student Affairs, and the ORMA staff are available to students for personal and academic counseling. Of note, the ORMA office was previously located in its own physical space; however, consolidation of administrative offices has meant that ORMA staff are now dispersed in a large, open-plan office with other administrative staff in the Office of Student Affairs.

The Harvard University Health Services provides primary care for most medical students at the Medical Area Health Service. This facility is staffed by three internists,

³ The office of the Dean of Harvard Medical School has indicated that, as of Fall 2017, core clerkships are graded unsatisfactory/satisfactory, but this change is not documented in publicly-available policies.

one nurse, three psychiatrists, one psychologist, and two LCSWs. At least three health services clinicians identify as people of color. The Harvard Medical School Ombuds Office can also assist students in identifying appropriate support resources. There is no separate designated physical space or mental health providers specifically for URM students.

Additional information may be found at the following link:

- [Office of Recruitment & Multicultural Affairs](#)
 - [Harvard Health Services](#)
-

9. There is no hospital/campus police force, or police are used as a last resort after the failure of alternative safety structures such as peer walking escorts, restorative justice councils, and mediation. If police or security officers exist, publicly-available data should demonstrate that they have not disproportionately stopped, arrested, or otherwise interacted with people of color.

- A. The above metric is fully met
- B. There are some programs designed to reduce reliance on police
- C. There is a campus police force, and no evidence that they have sought to address racism in policing,** or this information is not publicly available

The Harvard University Police Department has diversity and community liaisons and geographically-based community policing teams; the department also conducts diversity and inclusion training. There is no publicly available information on attempts to address racism in policing, and there are no programs designed to reduce reliance on police.

Of note, an internal probe and an independent investigation into the conduct of the Cambridge branch of the Harvard University Police Department were launched in April 2018. These inquiries came in response to an incident where HUPD officers used excessive force to arrest a visibly distressed Black Harvard College student. A University task force delivered their recommendations to the University President in November 2018, and a campus climate survey to assess the University's "opportunities and challenges" in moving forward from the incident was launched in February 2019. It is unclear how these investigations and ongoing efforts will or will not affect the protocols, actions or presence of Harvard University Police at Harvard Medical School.

Additional information may be found at the following links:

- [Security and Campus Safety at Harvard Medical School](#)
- [Harvard University Police Department](#)
- [Review Committee Report 2018](#)

10. Expectations for students' level of independence and supervision are clearly documented and are consistent across training sites (for example, students or residents are not disproportionately given the opportunity to "practice" while rotating in VA or public hospitals or while volunteering in free clinics).

- A. The above metric is fully met
- B. Policies exist to ensure that all patients receive equally well-supervised care, but are inconsistently enforced
- C. Students are routinely given more independence when caring for marginalized patients**

Harvard Medical School has clear language in its agreements with affiliated teaching hospitals regarding the appropriate supervision of medical students. It is, however, unclear whether these policies extend to the Crimson Care Collaborative (CCC), the school's student-run free clinic. Although they are supervised by attending physicians, it appears that preclinical students are allowed to provide direct patient care in the setting of the CCC that is beyond what they are permitted to provide in other settings. While some students' personal experience is that they are not afforded less supervision at the CCC, there is not evidence on disparities among all CCC sites. Further evidence should evaluate.

For example, "Junior Clinicians," typically first year medical students, may conduct patient interviews and physical exams under the direct supervision of a "Senior Clinician," typically a third or fourth year medical student or Massachusetts General Hospital Program affiliated Nurse Practitioner student. Students then provide an oral presentation to the faculty attending, who joins the student team to complete the visit. While this arrangement meets the guidelines of the "immediately available direct supervision" as outlined in the student handbook, it represents a greater degree of autonomy than is typically afforded to first year medical students and a greater responsibility of teaching placed on upper level medical students than would typically be accepted in formal clinical experiences. Additionally, junior students are encouraged to attempt or practice skills, such as physical exam maneuvers, under supervision of senior students.

Additional information may be found at the following links:

- [Crimson Care Collaborative](#)
- [Responsibilities of Teachers and Learners](#)
- [Crimson Care Clinical Teams](#)

11. At the primary teaching hospital (s), patients of color are represented in all services (including specialist services) and practices at their rate in the local population. Patients of color are not segregated in resident or student clinics.

- A. The above metric is fully met
- B. There are some efforts to promote equal access to care (e.g. Medicaid patients seen in faculty clinics)
- C. Patient care is highly segregated, or this information is not publicly available**

Medicaid patients, who are disproportionately people of color, are underrepresented at some of Harvard’s flagship teaching hospitals. While 22% of Massachusetts adults rely on Medicaid insurance, only 6% of patients discharged from Beth Israel Deaconess Medical Center in 2016,⁴ and only 8% of those discharged from Brigham and Women’s Hospital, had Medicaid insurance. At Mass General, 20.9% of patients discharged in 2016 had Medicaid insurance.⁵ Boston Children’s asserts that 37% of its Massachusetts patients are covered by Medicaid/CHIP (as compared to 29% of Massachusetts children overall), but has provided no data on what share of their overall patient population is covered by Medicaid.

Patients of color are overrepresented at some Harvard teaching hospitals, and underrepresented at others. At the public hospital system Cambridge Health Alliance, 20% of patients are Latinx (vs. 17% in the communities served), and 15% are Black (vs. 9% in the community).⁶ Beth Israel Deaconess Medical Center reports that 30% of their patients are people of color, while 47% of Boston residents are people of color.⁷ Boston Children’s asserts that their “patient population racial mix is consistent with the Massachusetts population,” but has disclosed no supporting data. Per data provided by Harvard Medical School, in the 2018 fiscal year, 24.5% of inpatients treated at Brigham and Women’s Hospital were non-white (11.8% were black and 3.5% were Hispanic) and 23.7% of patients seen in the ambulatory setting at Brigham and Women’s Hospital

⁴ Medicaid populations for all hospitals were derived from Medicare Cost Reports HCRIS files. Using a different methodology, Harvard Medical School reports that in 2017, 17% of patients at Beth Israel Deaconess Medical Center were covered by Medicaid.

⁵ As noted above, Medicaid populations for all hospitals were derived from Medicare Cost Reports HCRIS files. Mass General reports that 16.4% of patients discharged from Mass General in 2016 were insured by Medicaid.

⁶ Per internal Cambridge Health Alliance data and the 2016 U.S. Census American Community Survey (ACS), provided by Harvard Medical School.

⁷ Demographics for the city of Boston are calculated using publicly available data from the 2013-2017 5-year Estimates from the American Community Survey (ACS), with all individuals not identifying as “White alone” considered to be people of color.

were non-white (9.0% were black and 5.9% were Hispanic). These percentages exclude patients who declined reporting of a race/ethnicity or if race/ethnicity was unavailable.

According to Mass General’s 2016–2017 Annual Report on Equity in Health Care Quality (the most recent report available), the breakdown of patients by race and ethnicity in different settings in 2016 was as follows:

	Inpatient	Outpatient Primary Care	Outpatient Specialty Care
White	76%	58%	76%
Latinx	8%	21%	9%
Black/African-American	6%	7%	4%
Asian	4%	6%	5%
Other	2%	3%	2%
Unknown	4%	3%	3%

In summary, patients of color appear to be overrepresented at the public hospital system Cambridge Health Alliance and underrepresented at other Harvard teaching hospitals.

Additional information may be found at the following links:

- [Color Line Persists, in Sickness as in Health](#)
- [Teaching hospitals pledge to hire, treat more minorities](#)
- [Massachusetts General Hospital Annual Report on Equity in Health Care Quality 2015](#)
- [\[zip file\] Health Care Information System \(HCIS\) Data File for 2010](#)
- [Health Insurance Coverage of Adults 19–64, Massachusetts](#)
- [U.S. Census FactFinder](#)
- [Massachusetts Snapshot of Children’s Coverage](#)
- [The MGH Annual Report on Equity in Healthcare Quality](#)

12. The primary teaching hospital has demonstrated a commitment to immigrant patients including multilingual signs stating that patients are welcome regardless of

immigration status, and a policy of referring immigration authorities to hospital attorneys prior to any cooperation by hospital staff.

- A. The above metric is fully met
- B. The hospital has some symbolic commitment to immigrant patients (e.g. signs), but no policies explicitly protecting undocumented patients**
- C. The hospital has no public or policy commitment to immigrant patients

There is significant heterogeneity across Harvard teaching hospitals, with some fully meeting this metric and others having no policies or public commitment to immigrant patients:

- Brigham and Women's Hospital (BWH) has a policy of non-cooperation with immigration authorities, and has made public statements, displayed in the hospital on digital signage in four languages, stating that undocumented immigrants are welcome at BWH. Additionally, BWH policy requires the hospital's office of general counsel to be informed of the circumstances surrounding the potential arrest of a patient for any reason, including immigration status.
- Boston Children's Hospital has a policy of non-cooperation with immigration authorities, and has publicly stated its commitment to serving patients regardless of immigration status. The hospital states that it has "extensive multilingual capabilities and translation services available in order to create a welcoming environment for children and their families," but does not further specify the nature of these services.
- Massachusetts General Hospital's statement of Patient Rights and Responsibilities affirms a policy of non-discrimination on the basis of national origin/ethnicity or citizenship. Hospital leadership have been vocal in sharing with the hospital community their opposition to executive orders and actions that threaten patients, families, staff, and community members with deportation, and have shared their policy of not voluntarily reporting immigration information about patients. There is, however, no public statement describing a policy of non-cooperation with immigration officials.
- Beth Israel-Deaconess has no publicly available (i.e. via website) published policies regarding immigration status. Per Harvard Medical School, "Beth Israel Deaconess has a written policy of treating patients regardless of their immigration status. Signs are posted in the medical center, and we have created patient materials that make it clear we treat patients regardless of immigration status. The signs and other materials include contact information for our interpreter services department, so that non-English speakers can have free access to interpreters. We also offer training to our staff to educate them in

assisting undocumented patients. In addition, we have a policy to refer immigration authorities to hospital attorneys.”

- Cambridge Health Alliance serves a large number of immigrant patients, and has multilingual signage in many of its facilities. CHA’s “We Care for All” and “Diversity Matters to Us” campaigns have sponsored multilingual banners in clinical settings and in the communities they serve that affirm the hospital system’s commitment to immigrant patients, including undocumented immigrants. CHA has a clear policy that no information regarding a patient or employee (including the whereabouts of a person) may be provided to immigration officials or any law enforcement officer without the approval of CHA attorneys. CHA has established procedures for referring all such inquiries from immigration officials to its public safety and legal departments.

In addition, Boston teaching hospitals (including all Harvard Medical School affiliates) issued a joint statement in opposition to the president’s Executive Order on immigration.

Additional information may be found at the following links:

- [Brigham and Women's Hospital: Patient Welcome](#)
- [Brigham and Women's Hospital: Notice of Nondiscrimination and Accessibility](#)
- [Massachusetts General Hospital: Patient Guide](#)
- [Massachusetts General Hospital: Patient Rights and Responsibilities](#)
- [Cambridge Health Alliance: Resources for Supporting Immigrants in Massachusetts](#)
- [Cambridge Health Alliance: Statement of Commitment to Immigrants and Refugees](#)
- [Statement of Conference of Boston Teaching Hospitals Leaders on President Trump's Executive Order on Immigration](#)
- [Diversity at Cambridge Health Alliance](#)

13. All medical school staff and staff at the primary teaching hospital are paid a living wage as defined by local advocacy organizations. All full-time staff have affordable comprehensive health insurance that is accepted at the health system where they work.

- A. The above metric is fully met
- B. N/A
- C. **Some staff earn less than a living wage and/or do not have access to comprehensive health insurance**, or this information is not publicly available

The living wage in Boston is \$14.70/hour for a single adult. The policies at several major Harvard teaching hospitals are as follows:

- Cambridge Health Alliance pays all employees at or above the living wage. All full-time staff are eligible for employer-sponsored health insurance that is accepted at CHA and other providers.
- Beth Israel Deaconess Medical Center (BIDMC) has an institution-wide minimum wage of \$15/hour, as of 2015. All full-time staff have health insurance that is accepted at BIDMC.
- Boston Children's has an institution-wide minimum wage of \$15/hour for all employees. All employees working over 20 hours per week are eligible for health insurance accepted at BCH.
- Brigham and Women's Hospital (BWH) has an institution-wide minimum wage of \$15/hour, although this wage does not apply to some research staff, fellows, postdocs, interns, and co-op students. All employees working over 20 hours per week are eligible for health insurance accepted at BWH.
- Massachusetts General Hospital (MGH) has an institutional minimum wage of \$15/hour for all regular and per-diem-status employees. All employees working over 20 hours per week are eligible for health insurance accepted at MGH.

Students note that insurance offered by these hospitals is not always affordable, and many employees choose not to use employee based health insurance because of the high premiums. In addition, though the hospitals all pay above the city minimum wage, they do not guarantee a living wage. The wage of \$14.70 considers only what would be livable for a single adult, and does not consider the expenses incurred from dependents.

Additional information may be found at the following links:

- [Living Wage by County](#)
- [Article: Which Hospitals Pay Highest Starting Wages?](#)

14. IRB approval process requires any research that uses race to include precise definitions of race and how it is being used in the research project. People of color are clearly identified as being a "vulnerable population" for research purposes, and IRB policies outline strategies to protect people of color from abusive practices.

A. The above metric is fully met

B. IRB process requires researchers to explain their use of race

- C. IRB process has no requirements regarding the treatment of race, or this information was not publicly available

Harvard Medical School includes “racial and/or ethnic minorities” in its list of specified vulnerable populations in its IRB Investigator Manual. There is, however, no policy in the Investigator Manual requiring that researchers precisely define the use of race in their research, although Harvard Medical School states that the IRB “has long required researchers to consider and explain whether and how race expects to be used in a proposed research project.” Is it also required that the IRB is “sufficiently qualified through its experience, expertise, diversity in terms of race, gender, cultural background and sensitivity to such issues as community attitudes to promote respect for its advice and counsel in safeguarding the rights and welfare” of research subjects.

Additional information may be found at the following link:

- [Investigator Manual](#)

Icahn School of Medicine at Mount Sinai

This section provides further detail on each metric for the Icahn School of Medicine at Mount Sinai (ISMMS). ISMMS is an allopathic medical school located in New York, NY. The primary teaching hospital evaluated below is the Mount Sinai Hospital. However, students also rotate at a variety of Mount Sinai hospitals across the city.

Each metric (numbered 1–14 in the truncated report card) includes the full metric prompt, the grade for the institution, and an explanation of what that grade represents. Below each metric, we provide any relevant links to sources.

1. Medical students are at least 13% Black, 1% Native American, and 17% Latinx (corresponding to the share of these groups in the U.S. population).

- A. All URM groups are proportionately represented among students
- B. Some URM groups are proportionately represented among students
- C. No URM groups are proportionately represented among students**, or this information was not publicly available

Per the Icahn School of Medicine at Mount Sinai website, 17.1% of medical students for the 2017–2018 academic year were URM. Per AAMC data, in 2018–2019, approximately 8% of Mount Sinai students were Black, 4% were Latinx, and 0.2% were Native American.⁸ Per the ISMMS registrar, the student body for the 2018–2019 academic year was 9% Black, 9.5% Latinx, 0.4% Native American, and 3.7% two or more races classified as URM.

Additional information may be found at the following links:

- [Icahn Facts & Figures](#)
 - [AAMC Medical School Enrollment by Race & Ethnicity](#)
 - [Table B-5.1: Total Enrollment by U.S. Medical School and Race/Ethnicity, 2018–2019](#)
 - [Diversity](#)
 - [The Patricia S. Levinson Center for Multicultural and Community Affairs](#)
-

⁸ Per ISMMS, in the 2017-18 academic year the ISMMS student body had the following racial/ethnic composition: 8% Black, 9% Latinx, 0.4% American Indian, 0.1% Native Hawaiian, and 1% self-identified as 2 or more races within URM groups. ISMMS reports that in 2016, approximately 8.5% faculty self-identified as Black or Latinx.

2. Medical school faculty are at least 13% Black, 1% Native American, and 17% Latinx (corresponding to the share of these groups in the U.S. population).

- A. All URM groups are proportionately represented among faculty
- B. Some URM groups are proportionately represented among faculty
- C. **No URM groups are proportionately represented among faculty**, or this information was not publicly available

ISMMS reports approximately 9.5% of faculty in 2018 identified as Black or Latinx. This percentage is not publicly available.

3. The physical space of the medical school acknowledges the contributions of alumni and other physicians of color (through plaques, statues, portraits, and building names) and does not celebrate racist or white supremacist individuals.

- A. The above metric is fully met
- B. There are no items celebrating racist/white supremacist individuals, and also none celebrating people of color
- C. **The physical space explicitly celebrates racist/white supremacist individuals**

The school bears the name of Carl Icahn, who briefly served as the economic adviser to Donald Trump in 2017, and was an early public supporter of Trump's candidacy for president. Mr. Icahn resigned as special advisor to the president amidst reports that he may have illegally profited from his role within the government. Icahn himself is well known as a corporate raider who has made his billions at the expense of low-income and unionized workers.

The school has a rotating advertising campaign in the main atrium, including the "Wall of Innovators," which includes women and/or people of color. However, the celebration of Black and Latinx people are still largely confined to diversity events and the permanent portraits, statues, and building names almost exclusively celebrate white individuals.

Additional information may be found at the following links:

- [Article: Trump regulatory advisor Carl Icahn may have a 'huge conflict' due to energy investments](#)
 - [Article: Carl Icahn Sold Steel-Related Stocks Days before Trump announced Tariffs](#)
 - [Article: Carl Icahn's Failed Raid On Washington](#)
-

4. The medical school's recruitment policies promote racial justice. The medical school application does not inquire about the applicant's criminal history. The medical school recruits and admits undocumented students and students of color who attended public high schools in the county or state where the medical school is located. Students of color who participate in recruitment are compensated for their time.

- A. The above metric is fully met
- B. Some elements of the metric are met**
- C. No elements of the metric are met

ISMMS has the Center for Excellence in Youth Education (CEYE), which provides educational pipeline programs for NYC public students who are largely URM and/or economically disadvantaged. In addition, Mount Sinai also participates in the Northeast Regional Alliance (NERA) MedPrep program, a partnership pipeline program for NYC and New Jersey URM and disadvantaged college students. This program is held in conjunction with the Columbia University College of Physicians and Surgeons and Rutgers Robert Wood Johnson Medical School. 150 students are included in the 3-year cohort program and approximately 100 of these students are from local NYC under-resourced communities, including East and Central Harlem.

However, despite having several pipeline programs, the Icahn School of Medicine at Mount Sinai has very poor representation of URM students from its local community of East Harlem. In 2015, approximately 90% of NERA Medprep students are eventually accepted to medical school, but there is no published data on the number of matriculants to Mount Sinai from this program. Mount Sinai also conducts science enrichment education programs for NYC public school students but there is no published data on matriculation to medical schools in general or Mount Sinai in particular. ISMMS reports interviewing 20-30% of pipeline graduates, with 12-16% being offered acceptance and 4-5% matriculating.

Undocumented students are able to matriculate at Mount Sinai and financial needs are met. There is no public data on the number of undocumented students recruited from local communities.

ISMMS uses the AMCAS application for the M.D. program, which inquires about the applicant's criminal history.

The medical school conducts recruitment at targeted schools (including HBCUs) and national meetings. The interview process incorporates URM lunches to recruit students of color. Students receive funding to plan recruitment and outreach events but are not compensated for their time.

Additional information may be found at the following links:

- [MD Program Admissions Process](#)
 - [Northeast Regional Alliance \(NERA\) Med Prep Program](#)
 - [Center for Excellence in Youth Education \(CEYE\)](#)
-

5. The curriculum incorporates information about the history of racism in medicine, intersectional oppression, and racial justice strategies, and explicitly addresses the fact that race is a social construct, not a biological one. Lecturers avoid describing race per se (rather than racism) as a risk factor for disease, cause of health disparities, or basis for diagnostic reasoning. Community advocates and students who are underrepresented in medicine are incorporated in the planning and leadership of the pre-clinical curriculum.

- A. The above metric is fully met
- B. Some elements of the metric are met**
- C. The curriculum fails to adequately address racism in medicine. Race is stated or implied to be biological. Community advocates and URM students do not participate in planning or are not compensated for their time

Following increasing pressure from student activists to address racism in the medical school curriculum and policies, ISMMS launched the Racism and Bias initiative in 2015. This initiative aims to undo racism and bias in all areas of the medical school.

All students receive a long-term curriculum on racism and bias in healthcare, including structural violence, health disparities, and histories of racist medical experimentation. Students are taught about the idea of race as a social and political construction in the context of social determinants of health. Anti-racism strategies are yet to be incorporated into the formal curriculum.

ISMMS reports that course and clerkship directors have received faculty development on racism and bias in health and medicine and every course presentation and exam question are reviewed formally for scientifically racist content. Medical education leadership reports working with core course and clerkship leadership faculty to ensure that race is not taught as biologic and that teaching materials do not describe race as a risk factor for disease, cause of health disparity or basis for diagnostic reasoning.

However, students have reported incidents where lecturers explicitly state or imply that race is genetic or biological. Further, few lecturers and small-group facilitators have expertise in structural competency, critical race theory, or anti-racist clinical care.

Some medical students choose to participate in medical curriculum development, but there is no clear, transparent process for ensuring that URM students voices are fairly represented. Much of the existing course content around racism and bias at ISMMS has been generated or inspired by URM student activists. There are no dedicated faculty members to ensure an anti-racist curriculum that incorporates the voices of URM students without the burden of curriculum development being placed on these students.

Community advocates are occasionally invited to speak, but are largely restricted to sessions during a week-long course every semester titled “InFocus.” ISMMS reports compensating community advocates and leaders who teach and develop curricula for their participation. Students are not compensated for their time.

Additional information may be found at the following links:

- [Racism and Bias Initiative](#)
-

6. The medical school has a system for collecting student and faculty reports of racism and other forms of oppression, and a clear plan for follow-up when problems are reported.

- A. The above metric is fully met
- B. There is some system for collecting reports, but there is no clear follow-up after reports are made**
- C. There is no system for collecting reports

There is a student mistreatment policy, and students are able to report incidents of mistreatment to the Student Mistreatment Panel. Additionally, a Confidential Compliance Hotline allows for anonymous reporting of race and bias concerns or incidents. A leadership team, including the hospital president and the deans for education, curriculum, and diversity, monitor these reported events and meets regularly to review these reports. The school releases anonymized data from the mistreatment panel quarterly. The resulting consequences of these reports have ranged from targeted faculty education to removing faculty from teaching responsibilities.

A faculty member was recently removed from teaching responsibilities based on an anonymous complaint; however, it remains unclear how this will be enforced, as anecdotal evidence from students suggests that promises that individuals will be removed from teaching responsibilities have been poorly enforced in the past. Many students feel that reporting systems at Mount Sinai are burdensome and URM students are largely unsupported in incidents of racism or bias.

Additional information may be found at the following links:

- [Student Mistreatment Guideline](#)
 - [Audit and Compliance](#)
-

7. There are no racial disparities in medical students' grades or honors (including AOA election).

- A. The above metric is fully met
- B. The school regularly evaluates whether there are racial disparities, and has developed plans to address them**
- C. There are significant racial disparities in grades and/or honors, or this information is not publicly available

Many URM students express concern about discrimination in grading, and URM students were significantly underrepresented among students elected to the Alpha Omega Alpha Honor Medical Society (AOA). After immense student activism, Mount Sinai leadership has made recent moves to address these disparities, most notably discontinuing participation in AOA with regards to medical student induction. Mount Sinai's AOA chapter remains active and allows the nomination of house staff and faculty. Information on grading disparities is not publicly available and plans to address them are still forthcoming.

Additional information may be found at the following link:

- [Article: A Medical School Tradition Comes Under Fire for Racism](#)
-

8. Black, Native American, and Latinx (URM) students have access to designated physical spaces, as well as support staff, including administrators, physician mentors, mental health providers, and peer counselors.

- A. The above metric is fully met
- B. There are some resources specifically designated to support URM students**
- C. There are no designated resources for URM students

Mount Sinai has a Center for Multicultural & Community Affairs (CMCA) whose focus is on addressing health disparities and promoting diversity in medicine and science. There are currently 8 full-time CMCA staff and another 8 staff dedicated to system-wide diversity efforts. The CMCA does provide support to URM students, however it states a commitment to diversity in general without faculty members particularly devoted to URM students. ISMMS reports that while the Associate Dean for Diversity and Inclusion in Biomedical Education's role is not exclusively limited to

URM students, her work is focused on supporting URM students. The CMCA is meant to serve all of the Mount Sinai hospital campuses in NYC, which includes at least 8 hospitals and in addition to various community locations.

Resources for URM students are insufficient. There are no designated physical spaces for URM students, and no dedicated mental health providers; within the broader Student Mental Health program, there are inadequate numbers of providers of color.

Additional information may be found at the following links:

- [The Patricia S. Levinson Center for Multicultural and Community Affairs](#)
 - [Student Groups & Programs](#)
 - [Diversity](#)
-

9. There is no hospital/campus police force, or police are used as a last resort after the failure of alternative safety structures such as peer walking escorts, restorative justice councils, and mediation. If police or security officers exist, publicly-available data should demonstrate that they have not disproportionately stopped, arrested, or otherwise interacted with people of color.

- A. The above metric is fully met
- B. There are some programs designed to reduce reliance on police**
- C. There is a campus police force, and no evidence that they have sought to address racism in policing, or this information was not publicly available

Security officers are present on campus and URM students report that they are actively profiled on campus and receive poorer treatment. Mount Sinai is aware of these issues and reports working to address these concerns with unconscious bias trainings for the security department. There are no programs designed to reduce reliance on security.

Additional information may be found at the following link:

- [The Richard Netter Diversity Education Series](#)
-

10. Expectations for students' level of independence and supervision are clearly documented and are consistent across training sites (for example, students or residents are not disproportionately given the opportunity to "practice" while rotating in VA or public hospitals or while volunteering in free clinics).

- A. The above metric is fully met
- B. Policies exist to ensure that all patients receive equally well-supervised care, but are inconsistently enforced

C. Students are routinely given more independence when caring for marginalized patients

ISMMS reports clearly documented expectations and policies regarding student supervision which are the same for all health sites and are communicated to all faculty and house staff.

However, medical students at student-run free clinics are allowed to see patients with a lower level of attending supervision than on clinical rotations. Students state that they are given more autonomy when working in clinical sites with greater numbers of patients who are of color, poor, and/or undocumented. For example, many students report a greater ability to participate in the deliveries of the mostly immigrant women at the public affiliate, Elmhurst Hospital, as compared to their role in the care of wealthy white women at Mount Sinai.

Mount Sinai reports having a Compliance Hotline for students to report experiences related to the biased treatment of patients who are of color, poor, and/or vulnerable in any way. All calls to the compliance line are investigated and reviewed by a committee that includes students underrepresented in medicine and is led by the President of The Mount Sinai Hospital. It is unclear whether these steps have impacted the differential level of supervision that medical students receive at different sites.

Additional information may be found at the following link:

- [East Harlem Health Outreach Partnership](#)

11. At the primary teaching hospital, patients of color are represented in all services (including specialist services) and practices at their rate in the local population. Patients of color are not segregated in resident or student clinics.

- A. The above metric is fully met
- B. There are some efforts to promote equal access to care (e.g. Medicaid patients seen in faculty clinics)

C. Patient care is highly segregated, or this information is not publicly available

There is no formal data available on patient racial demographics in different hospital practices. In New York City, segregation by insurance largely correlates to segregation by race. In general, academic medical centers in New York City see fewer patients with Medicaid than other hospitals in the city, and Mount Sinai is no exception. Indeed,

while 24% of New York State residents have Medicaid insurance, only 5% of patients discharged from Mount Sinai Hospital in 2016 had Medicaid insurance.⁹

Mount Sinai has responded to student concerns about segregation of care by forming a Health Equity Work Group. Some clinical practices have been integrated by insurance type, including IBD, cardiovascular, geriatrics, Visiting Doctors, Adolescent Health Center, and family medicine, with plans to integrate rheumatology. Practices segregated by insurance status persist, however. In Internal Medicine, one of Sinai's largest departments, there are two practices: the Faculty Practice on 98th street, which is staffed by attendings and is generally acknowledged to largely see patients with private insurance, and Internal Medicine Associates on 102nd street, which is staffed by residents who see patients with public insurance.

Additional information may be found at the following links:

- [Few poor or minority patients in New York City's academic hospitals](#)
- [Article: Two Hospitals are accused of Segregating by Race](#)
- https://monroecollege.edu/uploadedFiles/Site_Assets/PDF/MedicalApartheidNYC.pdf
- [\[zip file\] Health Care Information System \(HCIS\) Data File for 2010](#)
- [Fact Sheet: Medicaid in New York state](#)

12. The primary teaching hospital has demonstrated a commitment to immigrant patients including multilingual signs stating that patients are welcome regardless of immigration status, and a policy of referring immigration authorities to hospital attorneys prior to any cooperation by hospital staff.

- A. The above metric is fully met
- B. The hospital has some symbolic commitment to immigrant patients (e.g. signs), but no policies explicitly protecting undocumented patients**
- C. The hospital has no public or policy commitment to immigrant patients

Mount Sinai has publicly affirmed their a commitment to immigrant patients, students and staff, stating "Icahn School of Medicine at Mount Sinai (ISMMS) and seven hospital campuses [are] a safe haven where patients, students, and employees are free to receive care, learn, and work without fear of discrimination, harassment or intimidation." As a part of this statement, Mount Sinai outlined the following policies:

⁹ Medicaid populations for all hospitals were derived from Medicare Cost Reports HCRIS files. Using a different methodology, ISMMS reports that 28% of all hospitalized patients in 2017 were insured by Medicaid and 55% of patients seen in outpatient practices were insured by Medicaid (FFS and HMO).

“We will neither allow immigration officials on our campuses nor provide them with information about the immigration status of our patients, students, or employees, without appropriate legal process, such as a warrant or subpoena. Our Security Officers will not contact, detain, or question an individual solely on the basis of suspected undocumented immigration status or to discover their immigration status, except as required by law. We will not treat medical or graduate school applications of undocumented students any differently than those of students who are United States citizens or permanent residents. If the Deferred Action for Childhood Arrivals (DACA) policy is terminated or substantially curtailed, we pledge to continue providing financial aid and other support to undocumented students, regardless of their immigration status.”

Multilingual signage is still largely absent from the Mount Sinai Hospital campus, despite being located in East Harlem. 20% of East Harlem residents have limited English proficiency, demonstrating the need for multilingual signage and accessible care.

Additional information may be found at the following link:

- [DACA](#)
- [East Harlem Community Health Profile, 2015](#)

13. All medical school staff and staff at the primary teaching hospital are paid a living wage as defined by local advocacy organizations. All full-time staff have comprehensive health insurance that is accepted at the health system where they work.

- A. The above metric is fully met
- B. N/A
- C. Some staff earn less than a living wage and/or do not have access to comprehensive health insurance, or this information is not publicly available**

Mount Sinai complies with all New York City wages laws (under which Sinai is required to pay a minimum wage of \$12.15/ hour with health benefits or \$13.95/hour without health benefits). Mount Sinai also reports paying the vast majority of workers at the school and primary teaching hospital (99.4%) at least the NYC living wage for a single adult (\$16.14/hour). It is unclear whether employees are paid the living wage based on all family types and Mount Sinai has no public policy of paying all employees the NYC living wages. It is unclear whether all full-time Mount Sinai employees have access to comprehensive health insurance that affords them access to care from Mount Sinai providers.

Additional information may be found at the following links:

- [Living Wage: New York County](#)
 - [Living Wage Law](#)
-

14. IRB approval process requires any research that uses race to include precise definitions of race and how it is being used in the research project. People of color are clearly identified as being a "vulnerable population" for research purposes, and IRB policies outline strategies to protect people of color from abusive practices.

- A. The above metric is fully met
- B. IRB process requires researchers to explain their use of race
- C. IRB process has no requirements regarding the treatment of race, or this information is not publicly available**

Mount Sinai reports that its Program for the Protection of Human Subjects (PPHS) complies with all federal regulations and follows the ethical principles laid out in the Belmont Report. However, there are no specific IRB policies protecting research subjects of color.

Mount Sinai reports that the IRB examines the following with regards to proposed research: 1) whether race is used as an inclusion or exclusion criterion, 2) if race is indicated, how it will be defined for the project and how a determination will be made is also needed, and 3) research design, recruitment or participation with regards to race. However, this policy is not publicly available and was not provided. The extent to which it is followed is unclear, as Mount Sinai has a documented history of producing race-based medical research.

Additional information may be found at the following link:

- [Program for the Protection of Human Subjects](#)

Johns Hopkins University School of Medicine

This section provides further detail on each metric for the Johns Hopkins School of Medicine. Hopkins is an allopathic medical school located in Baltimore, Maryland. The primary teaching hospital is the Johns Hopkins Hospital.

Each metric (numbered 1-14 in the truncated report card) includes the full metric prompt, the grade for the institution, and an explanation of what that grade represents. Below each metric, we provide any relevant links to sources.

1. Medical school students are at least 13% Black, 1% Native American, and 17% Latinx (corresponding to the share of these groups in the U.S. population).

- A. All URM groups are proportionately represented among students
- B. Some URM groups are proportionately represented among students
- C. No URM groups are proportionately represented among students**

Per AAMC Data, in 2018-2019, approximately 7% of Hopkins students are Black, 4% are Latinx, and 0.2% are Native American.

According to the Johns Hopkins School of Medicine, 25 of 118 entering MD students in 2018 are URM (21.2%), where 8.5% are Black, 11% are Latinx, and 1.7% are Native American. Among all students in the medical school, 6.2% are Latinx, 7.1% are Black, and less than 1% were Native American in 2016.

Additional information may be found at the following links:

- [Class Statistics](#)
 - [Diversity Annual Report 2017](#)
 - [JHU Report on Graduate School Diversity](#)
 - [AAMC Medical School Enrollment by Race & Ethnicity](#)
 - [Table B-5.1: Total Enrollment by U.S. Medical School and Race/Ethnicity, 2018-2019](#)
-

2. Medical school faculty are at least 13% Black, 1% Native American, and 17% Latinx (corresponding to the share of these groups in the U.S. population).

- A. All URM groups are proportionately represented among faculty
- B. Some URM groups are proportionately represented among faculty
- C. No URM groups are proportionately represented among faculty**

According to the 2019 “JHU Report on Faculty Composition,” 8% of medical faculty were URM in 2017, compared to 8% in 2015. In this report, URM includes anyone who identifies as “black or African–American, Hispanic, American Indian, Hawaiian, or other Pacific Islander.”

Additional information may be found at the following links:

- [JHU Report on Faculty Composition](#)
-

3. The physical space of the medical school acknowledges the contributions of alumni and other physicians of color (through plaques, statues, portraits, and building names) and does not celebrate racist or white supremacist individuals.

- A. The above metric is fully met
- B. There are no items celebrating racist/white supremacist individuals, and also none celebrating people of color (there are items celebrating people of color; there has been no assessment of whether there are celebrations of racist or white supremacist individuals).**
- C. The physical space explicitly celebrates racist/white supremacist individuals

Johns Hopkins School of Medicine has been a part of the project, “The Indispensable Role of Blacks at Johns Hopkins,” a partnership between the university’s Black Faculty and Staff Association and the Office of the President. This project seeks to highlight the contributions of people of color to Johns Hopkins, and includes physical and virtual profiles of distinguished Black individuals affiliated with Johns Hopkins.

The JHMI Portrait Collection and Medical Archives includes portraits of Emanuel Chambers, Vivien Thomas, Levi Watkins, Ben Carson, and Fannie Gaston Johansson and one of the School of Medicine colleges is named for Vivien Thomas, a Black Hopkins surgical technician who helped develop life–saving pediatric cardiac procedures. Additionally, there are tributes to Henrietta Lacks in two on–campus locations. It is, however, unclear, whether Hopkins has undertaken any assessment of the history of the individuals commemorated on their campus to assess whether any may have promoted racist or white supremacist ideologies.

Additional information may be found at the following links:

- [Portrait Collection: Emanuel Chambers](#)
- [Portrait Collection: Vivien Theodore Thomas](#)
- [Paper Collection: Vivien Thomas](#)
- [Portrait Collection: Levi Watkins Jr](#)

- [Portrait Collection: Levi Watkins Jr 2](#)
 - [Portrait Collection: Ben Carson](#)
 - [Portrait Collection: Fannie Gaston Johansson](#)
-

4. The medical school's recruitment policies promote racial justice. The medical school application does not inquire about the applicant's criminal history. The medical school recruits and admits undocumented students and students of color who attended public high schools in the county or state where the medical school is located. Students of color who participate in recruitment are compensated for their time.

- A. The above metric is fully met
- B. Some elements of the metric are met**
- C. No elements of the metric are met

Johns Hopkins has a large number of pipeline programs to support local URM students interested in health careers, and maintains an Office of Student Pipeline Programs to support these programs. There is also targeted recruitment at HBCUs in Maryland and Washington D.C. However, it is unclear how many URM students from the local area, and Baltimore County in particular, have enrolled in the medical school.

While the university has made a general statement in support of undocumented students, the School of Medicine has made no similar statement, and it is unclear whether undocumented students may enroll in the School of Medicine.

URM students who participate in recruitment are provided with funded meals and travel, but are not compensated for their time.

Hopkins uses the AMCAS application for the M.D. program, which inquires about the applicant's criminal history.

Additional information may be found at the following links:

- [Student Pipeline Programs](#)
 - [SPP: Hopkins CARES](#)
 - [Diversity Progress Report 2018](#)
 - [DACA Immigration message](#)
-

5. The curriculum incorporates information about the history of racism in medicine, intersectional oppression, and racial justice strategies, and explicitly addresses the fact that race is a social construct, not a biological one. Lecturers avoid describing race per se (rather than racism) as a risk factor for disease, cause of health disparities, or basis for diagnostic reasoning. Community advocates and students

who are underrepresented in medicine are incorporated in the planning and leadership of the pre-clinical curriculum.

- A. The above metric is fully met
- B. Some elements of the metric are met**
- C. The curriculum fails to adequately address racism in medicine. Race is stated or implied to be biological. Community advocates and URM students do not participate in planning or are not compensated for their time

During the Health Care Disparities course for first year students, Hopkins medical students are taught that race is a social, rather than biological construct, and there is some discussion of the history of racism and its impact on health. Students participate in a small group discussion called “Worlds Apart,” for which they are required to complete background reading on racial disparities. Students also receive a lecture/panel discussion on whether the patient’s race should be included in clinical presentations; a slide describing the advantages of including race in presentations includes the bullet points, “Race is an important predisposing factor for certain medical conditions” and “Race indicates responsiveness to certain therapeutic interventions.”

There is a three-day required Intersession course for first year students that discusses “social determinants of health, implicit bias, and health disparities for specific populations and communities, and activities focused on cultural awareness.” Students are also enrolled in a Foundations of Public Health class that includes instruction about advocacy, and the Clinical Foundations of Medicine course includes discussion of cross-cultural communication. First year students discuss healthcare disparities as a part of the “Culture of Medicine” curricular strand. The school reports a new mandatory session in Transition to the Wards course for second year students, called “Bias in the Clinical Setting.” This course was created in response to student input and will be led by the Assistant Dean for Diversity, and the Assistant and Associate Deans for Undergraduate Medical Education.

However, no public course materials refer specifically to racism, intersectionality, or anti-racism strategies. The Johns Hopkins Medicine’s Office of Diversity and Inclusion offers a workshop on unconscious bias, which aims to reduce the role of bias in hiring decisions.

Some community organizations are involved in teaching the Health Care Disparities Curriculum and in monthly community walks for students, and there are some structures for promoting dialogue between patients/families and hospital leadership (Patient Family Advisory Councils, Patient Cafes, Community Conversations). However, community members and URM students are not involved in planning or leadership of mandatory MD curricular activities.

Additional information may be found at the following links:

- [Genes to Society Curriculum](#)
 - [Workshop: Patient Identifiers](#)
 - [TIME: Health Care Disparities & Service Learning](#)
 - [Curriculum: Foundations in Public Health](#)
 - [JHU Roadmap to Diversity & Inclusion](#)
 - [Curriculum: Horizontal Strands](#)
 - [MD Curriculum](#)
 - [MLK Day of Service](#)
-

6. The medical school has a system for collecting student and faculty reports of racism and other forms of oppression, and a clear plan for follow-up when problems are reported.

- A. The above metric is fully met
- B. There is some system for collecting reports, but there is no clear follow-up after reports are made**
- C. There is no system for collecting reports

Historically, students at Johns Hopkins have reported rates of mistreatment, including mistreatment based on race or ethnicity, that are higher than the national average. Johns Hopkins policy on Learner Mistreatment, Harassment, and Discrimination specifically prohibits discrimination on the basis of race. Johns Hopkins maintains the Safe at Hopkins online portal for reporting safety issues such as bullying, yelling, or threats, but does not specifically describe discrimination as a behavior that should be reported through this mechanism; rather, students who experience abuse or mistreatment are encouraged to speak with the deans in the Office of Student Affairs. Per the Johns Hopkins administration, an Ombuds program was created almost a year ago. Trainees are able to report mistreatment events to this office. It is unclear what, if any follow-up student reports receive.

Additional information may be found at the following links:

- [Teacher Learner Conduct Policy](#)
 - [Faculty Senate Meeting Minutes](#)
 - [Policy: Learner Mistreatment, Harassment and Discrimination](#)
 - [Safe at Hopkins](#)
 - [Ombuds Program at JHUSOM](#)
-

7. There are no racial disparities in medical students' grades or honors (including AOA election).

- A. The above metric is fully met
- B. The school regularly evaluates whether there are racial disparities, and has developed plans to address them
- C. There are significant racial disparities in grades and/or honors or this information is not publicly available**

There is no publicly available information about racial disparities in grades or AOA election.

8. Black, Native American, and Latinx (URM) students have access to designated physical spaces, as well as support staff, including administrators, physician mentors, mental health providers, and peer counselors.

- A. The above metric is fully met
- B. There are some resources specifically designated to support URM students**
- C. There are no designated resources for URM students

Johns Hopkins maintains an Office of Medical Student Diversity led by the Assistant Dean for Medical Student Affairs and the Director of Medical Student Diversity, an Office of Diversity & Inclusion led by the Vice President and the Chief Diversity Officer, and an Office of Graduate Student Diversity led by the Assistant Dean for Graduate Biomedical Education and Graduate Student Diversity. URM students do not have access to dedicated physical spaces, mental health providers, or peer counselors.

Additional information may be found at the following link:

- [Office of Medical Student Diversity](#)
-

9. There is no hospital/campus police force, or police are used as a last resort after the failure of alternative safety structures such as peer walking escorts, restorative justice councils, and mediation. If police or security officers exist, publicly-available data should demonstrate that they have not disproportionately stopped, arrested, or otherwise interacted with people of color.

- A. The above metric is fully met

- B. There are some programs designed to reduce reliance on police
- C. There is a campus police force, and no evidence that they have sought to address racism in policing**

Johns Hopkins University does not yet have a police force. However, the Community Safety and Strengthening Act was passed by the Maryland General Assembly on April 1, 2019, and signed on April 18, 2019 that would allow JHU to create such a force. Garnering national attention, JHU students and community members opposing the creation of a force organized a sit-in that lasted from April 3, 2019–May 8th, 2019 before over 80 police were deployed to arrest a remaining 7 sit-in participants. These participants believe that a campus with armed officers would further damage the already tumultuous relationship between the university and Baltimore neighborhoods and produce a climate of fear and intimidation.

Baltimore Police and Deputy Sheriffs are currently employed part-time in the emergency department and three outside stationary posts. All newly-hired Hopkins security staff receive a training on cultural diversity, unconscious bias, discrimination and harassment, and all security staff also receive annual refresher courses on these topics. Security officers also participate in a “simulation-based training program focused on culturally competent de-escalation.” There is, however, no public reporting on racial demographics of those with whom security officers interact.

Additional information may be found at the following link:

- [Campus Safety & Security](#)
- [JHU Roadmap on Diversity & Inclusion 2016](#)
- [Police Arrest 7 in Sit-In Protest of Campus Police Force](#)

10. Expectations for students' level of independence and supervision are clearly documented and are consistent across training sites (for example, students are not disproportionately given the opportunity to "practice" while rotating in VA or public hospitals or while volunteering in free clinics).

- A. The above metric is fully met**
- B. Policies exist to ensure that all patients receive equally well-supervised care, but are inconsistently enforced
- C. Students are routinely given more independence when caring for marginalized patients

Johns Hopkins has a clear policy on student supervision, which states:

School of Medicine Office of Student Affairs and SOURCE prohibit medical students from participating in clinical work at sites where there is not a full or part-time Johns Hopkins School of Medicine faculty member on-site and available for precepting... Stated again, medical students should not be involved in the practice of medicine (as defined by health screening, medical history gathering, physical examination, and medical decision making) unless under the guidance of a JHUSOM fulltime or part-time faculty member.

Furthermore, Hopkins maintains clear guidelines on medical students' scope of practice and required supervision, and these guidelines apply to medical students participating in extracurricular clinical activities, including free clinics or international rotations.

Additional information may be found at the following links:

- [SOM Safety Letter](#)
- [Policy: Faculty Supervising & Evaluating Medical Students](#)

11. At the primary teaching hospital (s), patients of color are represented in all services (including specialist services) and practices at their rate in the local population. Patients of color are not segregated in resident or student clinics.

- A. The above metric is fully met
- B. There are some efforts to promote equal access to care (e.g. Medicaid patients seen in faculty clinics)
- C. Patient care is highly segregated or this information is not publicly available**

Black patients are significantly underrepresented in Johns Hopkins hospitals as compared to their share of the Baltimore population (31% of Johns Hopkins hospitals' patients in 2017 were Black, as compared to 63% of the Baltimore population). Johns Hopkins hospitals care for 50% of the patients in the six zip codes immediately around the institution, 68% of whom are Black, Latinx, or Native American. Patients from these zip codes account for 18% of all Hopkins patients, and people of color from these neighborhoods are overrepresented at Hopkins relative to their share of the neighborhood population. However, patients from these six zip codes are disproportionately cared for at Johns Hopkins Bayview Medical Center rather than Johns Hopkins Hospital (JHBMC has 28% of the Hopkins beds in Baltimore, but cares for 38% of the Hopkins patients from these zip codes). There is no other publicly available data on segregation of patients across different practices within Johns Hopkins facilities. While 43% of Baltimore residents have Medicaid insurance, less

than 30% of patients discharged from Johns Hopkins Hospital in 2016 had Medicaid insurance.

JHUSOM reports the following demographics in inpatient, outpatient and emergency patients (combined) from five JHM facilities in the 2017 fiscal year: 45.3%–White; 35.7%–African American; 8.5%–Hispanic; 4.35%–Asian; and 0.15% –American Indian/Alaskan Native. The school also states 60% of patients discharged from Johns Hopkins Hospital were African American.

Additional information may be found at the following links:

- [Diversity & Inclusion Annual Report 2017](#)
 - [Baltimore Demographics](#)
 - [Maryland Medicaid Landscape](#)
 - [\[zip file\] Health Care Information System \(HCIS\) Data File for 2010](#)
 - [Baltimore City Maryland County Census Table](#)
 - [JHM Fast Facts](#)
-

12. The primary teaching hospital has demonstrated a commitment to immigrant patients including multilingual signs stating that patients are welcome regardless of immigration status, and a policy of referring immigration authorities to hospital attorneys prior to any cooperation by hospital staff.

- A. The above metric is fully met
- B. The hospital has some symbolic commitment to immigrant patients (e.g. signs), but no policies explicitly protecting undocumented patients
- C. The hospital has no public or policy commitment to immigrant patients**

The Johns Hopkins Medicine 2017 Diversity Annual Report describes health professionals' participation in rallies to support immigrants and refugees, but describes no institutional policies to improve access or safety for these patients. Per Johns Hopkins Hospital, hospital policy states that any employee contacted by a representative of a government agency, including immigration or law enforcement, should contact the Legal or Compliance Department immediately. Centro SOL, the Center for Salud/Health and Opportunities for Latinos, has working groups that focus on language access and other access-to-care issues, but it is not clear to what extent their recommendations have been adopted by the Hopkins health system. There is no hospital signage or handout addressing patients' due process rights or protections in the hospital.

Additional information may be found at the following links:

- [Diversity & Inclusion Annual Report 2017](#)
 - [Center for Salud](#)
 - [Article: An undercurrent of fear in Baltimore's immigrant communities](#)
-

13. All medical school staff and staff at the primary teaching hospital are paid a living wage as defined by local advocacy organizations. All full-time staff have comprehensive health insurance that is accepted at the health system where they work.

- A. The above metric is fully met
- B. N/A
- C. Some staff earn less than a living wage and/or do not have access to comprehensive health insurance or this information is not publicly available**

The living wage in Baltimore for a single adult is \$13.28/hour. Johns Hopkins University has committed to paying its full-time, part-time, and limited staff no less than \$12.51/hour, effective July 1, 2017. Per Johns Hopkins, almost all full-time School of Medicine employees earn at least \$13.28/hour, but it is unclear what share of part-time employees make above this wage. Full-time employees are eligible for university medical insurance. The institutional minimum wage for full-time employees is re-evaluated annually, and any changes to wages will be announced in July.

Additional information may be found at the following links:

- [JHU Exempt Salary Range Structure](#)
 - [Living Wage: Baltimore](#)
-

14. IRB approval process requires any research that uses race to include precise definitions of race and how it is being used in the research project. People of color are clearly identified as being a "vulnerable population" for research purposes, and IRB policies outline strategies to protect people of color from abusive practices.

- A. The above metric is fully met
- B. IRB process requires researchers to explain their use of race
- C. IRB process has no requirements regarding the treatment of race; or this information is not publicly available**

Policies on IRB membership emphasize the importance of drawing members with “varied backgrounds” including “diversity of race, gender, and culture.” IRB policies also state that, when reviewing research that involves “vulnerable participants,” the IRB members should include “one or more members who are knowledgeable about or experienced working with such participants.” Of note, people of color are not included in the listed vulnerable populations. There are no specific IRB policies related to race or racism, including no requirements related to how race is defined in research protocols.

Per Johns Hopkins, the IRB values community input to inform research design and interpretation, and directs researchers who do not have “established working relationships with community representatives” to the services of the Community Research Advisory Council. All student researchers are required to have a faculty member as their principal investigator (PI); students are not permitted to serve as the PI on any project.

Additional information may be found at the following links:

- [JHU IRB Policy: 107-1](#)
- [JHU IRB Organizational Policies](#)
- [JHU IRB Policy: 111-8](#)
- [JHU IRB Policy: Community Research Advisory Council](#)
- [JHU IRB Policy: 103-1](#)
- [JHU IRB Policy: 103-3](#)
- [JHU IRB Policy: Community](#)
- [JHU IRB Policy: Investigator Responsibility](#)

Sidney Kimmel Medical College at Thomas Jefferson University

This section provides further detail on each metric for the Sidney Kimmel Medical College at the Thomas Jefferson University. Sidney Kimmel is an allopathic medical school located in Philadelphia, Pennsylvania. Primary teaching hospitals include the Thomas Jefferson University hospitals.

Each metric (numbered 1–14 in the truncated report card) includes the full metric prompt, the grade for the institution, and an explanation of what that grade represents. Below each metric, we provide any relevant links to sources.

1. Medical school students are at least 13% Black, 1% Native American, and 17% Latinx (corresponding to the share of these groups in the U.S. population).

- A. All of the above groups are proportionately represented among students
- B. Some of the above groups are proportionately represented among students
- C. None of the above groups are proportionately represented among students, or this information is not publicly available**

Two percent of SKMC medical students are Black, 2.2% are Latinx, and none are Native American.

Additional information may be found at the following links:

- [AAMC Medical School Enrollment by Race & Ethnicity](#)
 - [Table B-5.1: Total Enrollment by U.S. Medical School and Race/Ethnicity, 2018-2019](#)
 - [Admissions FAQ](#)
 - [Admissions Selection Factors](#)
-

2. Medical school faculty are at least 13% Black, 1% Native American, and 17% Latinx (corresponding to the share of these groups in the U.S. population).

- A. All of the above groups are proportionately represented among faculty
- B. Some of the above groups are proportionately represented among faculty
- C. None of the above groups are proportionately represented among faculty, or this information is not publicly available**

The Office of Diversity and Inclusion Initiatives participates in recruitment, faculty search/hiring, faculty development, career counseling, and connecting faculty with student affinity groups. There is, however, no publicly-available information to indicate the success of these activities in promoting a racially representative faculty.

Additional information may be found at the following link:

- [Faculty Diversity](#)
-

3. The physical space of the medical school acknowledges the contributions of alumni and other physicians of color (through plaques, statues, portraits, and building names) and does not celebrate racist or white supremacist individuals.

- A. The above metric is fully met
- B. There are no items celebrating racist/white supremacist individuals, and also none celebrating people of color

C. The physical space explicitly celebrates racist/white supremacist individuals

The university is named for Thomas Jefferson, an man who owned slaves and committed sexual assault against enslaved women; there is a statue of Thomas Jefferson in front of the alumni hall. Additionally, J. Marion Sims, an obstetrician/gynecologist who performed experimental surgeries on enslaved Black women, is a celebrated alumnus of the school, and his work is shown in the library and archives. A celebratory profile on Sims as a notable alumnus was removed in Spring 2019 from the Jefferson website but can be accessed via a link below. There is one poster in the alumni building that commemorates Black graduates of the school.

Additional information may be found at the following links:

- [“Notable Jefferson Alumni: J. Marion Sims”](#)
 - [African American Graduates of JMC](#)
-

4. The medical school's recruitment policies promote racial justice. The medical school application does not inquire about the applicant's criminal history. The medical school recruits and admits undocumented students and students of color who attended public high schools in the county or state where the medical school is located. Students of color who participate in recruitment are compensated for their time.

- A. The metric is fully met
- B. Some elements of the metric are met**

C. No elements of the metric are met

In the past two years, SKMC has received significant donations towards the formation of a scholarship for Black students that covers tuition. For example, they have partnered with the oldest African-American fraternity to offer the only scholarship in the country specifically for African-American males in medical school.

Additionally, the Office of Diversity and Inclusion Initiatives (ODII) has made efforts to increase LGBTQ and URM student matriculation (including an ODII interview day “Meet and Greet” that students established in 2016); however, their efforts have not yet resulted in a significant increase in URM students. Furthermore, these efforts have been student-led, and students are not compensated.

SKMC notes that, “Under most circumstances, admission will not be offered to an applicant with a felony conviction,” as the state of Pennsylvania will not license physicians with a history of felony conviction. SKMC has no formal policy of admitting undocumented students. Although there is some preference in admissions for Pennsylvania residents, it is unclear whether any graduates of Philadelphia public schools are enrolled at SKMC.

Additional information may be found at the following links:

- [Pipeline Program](#)
- [Admissions Selection Factors](#)

5. The curriculum incorporates information about the history of racism in medicine, intersectional oppression, and racial justice strategies, and explicitly addresses the fact that race is a social construct, not a biological one. Lecturers avoid describing race per se (rather than racism) as a risk factor for disease, cause of health disparities, or basis for diagnostic reasoning. Community advocates and students who are underrepresented in medicine are incorporated in the planning and leadership of the pre-clinical curriculum.

- A. The above metric is fully met
- B. Some elements of the metric are met**
- C. The curriculum fails to adequately address racism in medicine. Race is stated or implied to be biological. Community advocates and URM students do not participate in planning or are not compensated for their time.

Efforts to promote education about the history of racism in medicine, intersectional oppression, and racial justice strategies have been largely extracurricular and student-led. The Office of Diversity and Inclusion Initiatives and the recently-formed Department of Humanities have highlighted some local groups (e.g. The Colored Girls Museum) and radical individuals. However, this is outside of the primary curriculum.

The new JeffMD curriculum aims to include increasing discussion of social determinants of health and of discrimination as a negative impact on health. However, much of this discussion and education remains limited to the co-curricular Population Health track.

Otherwise, race is infrequently discussed. Pre-clinical lecturers explicitly state or imply that race is genetic or biological when teaching about, for example, blood pressure medications and the earlier onset of puberty in African American children.

Additional information may be found at the following links:

- [The Colored Girls Museum: Urgent Care](#)
 - [Curriculum Overview](#)
 - [Diversity and Inclusion Newsletter](#)
 - [Diversity Lectures](#)
 - [Course Catalog 2015-2017](#)
-

6. The medical school has a system for collecting student and faculty reports of racism and other forms of oppression, and a clear plan for follow-up when problems are reported.

- A. The above metric is fully met
- B. There is some system for collecting reports, but there is no clear follow-up after reports are made**
- C. There is no system for collecting reports

Last year, SKMC changed its reporting from RUB (“Reporting Unprofessional Behavior”) to the anonymous (if so desired) AlertLine system. However, it is unclear who receives the reports and how they are followed up – if at all.

The school suggests that non-anonymous concerns be reported to the Associate Dean for Professionalism, the Student Professionalism Conduct Committee, Student Affairs Deans, or course directors. Of note, none of these faculty are people of color and the Office of Diversity and Inclusion Initiatives is not incorporated into this recommended list.

Most importantly, in the last two years, the administration has supported students who have made homophobic and transphobic comments. Students who have pointed out the offensive nature of these comments have been punished with professionalism violations. They have also been told that if they do not stop, their future careers may be in danger.

Finally, the institution is actively suppressing students who have attempted to hold vigils for deaths in Palestine. One planned vigil was shutdown by the administration less than 24 hours after it was first announced.

Additional information may be found at the following link:

- [Code of Conduct](#)
-

7. There are no racial disparities in medical students' grades or honors (including AOA election)

- A. The above metric is fully met
- B. The school regularly evaluates whether there are racial disparities, and has developed plans to address them
- C. There are significant racial disparities in grades and/or honors or **this information is not publicly available**

Unfortunately this information is not publicly available and largely anecdotal in nature. Women and people of color are significantly more likely to fail courses and/or have to repeat a year. AOA has historically had few or no URM members.

8. Black, Native American, and Latinx students have access to designated physical spaces, as well as support staff, including administrators, physician mentors, mental health providers, and peer counselors.

- A. The above metric is fully met
- B. There are some resources specifically designated to support students of color**
- C. There are no designated resources for students of color

The Office of Diversity and Inclusion Initiatives is the only official physical space for URM students, though it is primarily administrative in nature. This is where students can meet with ODII staff. Most campus diversity initiatives remain student-driven. If students take initiative to promote and maintain organizational programming, they will have support through ODII -- but the university's diversity programming is neither mandatory nor well-integrated into the curriculum.

Additional information may be found at the following link:

- [Diversity at Jefferson](#)
-

9. There is no hospital/campus police force, or police are used as a last resort after the failure of alternative safety structures such as peer walking escorts, restorative justice councils, and mediation. If police or security officers exist, publicly-available data should demonstrate that they have not disproportionately stopped, arrested, or otherwise interacted with people of color.

- A. The above metric is fully met
- B. There are some programs designed to reduce reliance on police
- C. There is a campus police force, and no evidence that they have sought to address racism in policing, or this information is not publicly available**

The campus security team has transitioned to becoming an official police force in the past three years. The available policing data describes types of crimes on campus but gives no information about race or police training.

Additional information may be found at the following link:

- [Campus Crime Report: Clery Act](#)
-

10. Expectations for students' level of independence and supervision are clearly documented and are consistent across training sites (for example, students or residents are not disproportionately given the opportunity to "practice" while rotating in VA or public hospitals or while volunteering in free clinics).

- A. The above metric is fully met
- B. Policies exist to ensure that all patients receive equally well-supervised care, but are inconsistently enforced
- C. Students are routinely given more independence when caring for marginalized patients**

SKMC has a clear written policy regarding the supervision of medical students in clinical settings. However, it is unclear whether this policy extends to student-run free clinics, where students tend to have significantly more autonomy in providing clinical care than they would have in a clinical setting that is part of the formal educational experience. These clinics disproportionately care for poor patients and patients of color.

Additional information may be found at the following links:

- [Student Handbook](#)
- [Faculty Handbook](#)
- [Community Global Medicine](#)

11. At the primary teaching hospital, patients of color are represented in all services (including specialist services) and practices at their rate in the local population. Patients of color are not segregated in resident or student clinics.

- A. The above metric is fully met
- B. There are some efforts to promote equal access to care (e.g. Medicaid patients seen in faculty clinics)

C. Patient care is highly segregated, or this information is not publicly available

Medicaid patients, who are disproportionately people of color, are underrepresented at Jefferson Hospital. While 16% of Pennsylvania adults have Medicaid insurance, only 4% of patients discharged from Jefferson Hospital in 2016 had Medicaid insurance.

Additional information may be found at the following links:

- [Health Insurance Coverage of PA Adults](#)
- [CMS Healthcare Cost Report Information System \(HCRIS\) -- Hospitals, 2010-19](#)

12. The primary teaching hospital has demonstrated a commitment to immigrant patients including multilingual signs stating that patients are welcome regardless of immigration status, and a policy of referring immigration authorities to hospital attorneys prior to any cooperation by hospital staff.

- A. The above metric is fully met
- B. The hospital has some symbolic commitment to immigrant patients (e.g. signs), but no policies explicitly protecting undocumented patients

C. The hospital has no public or policy commitment to immigrant patients

Providers in the Department of Family and Community Medicine (DFCM) provide care to refugees through the Center for Refugee Health. Jefferson is also a major partner for Puentes de Salud, which cares for Spanish-speaking immigrants (including undocumented patients). However, Jefferson's Community Health Needs Assessment describes no efforts to make the hospital broadly more accessible or safe for immigrant patients.

Jefferson has made no public statements affirming a commitment immigrant patients. Jefferson Hospital has no policy directing the behavior of hospital staff when they interact with immigration authorities.

Additional information may be found at the following links:

- [Department of Family & Community Medicine](#)
 - [Puentes de Salud](#)
 - [Community Health Needs Assessment Report 2016](#)
 - [Community Health Needs Implementation Plan 2016](#)
-

13. All medical school staff and staff at the primary teaching hospital are paid a living wage as defined by local advocacy organizations. All full-time staff have affordable comprehensive health insurance that is accepted at the health system where they work.

- A. The above metric is fully met
- B. N/A
- C. Some staff earn less than a living wage and/or do not have access to comprehensive health insurance, or this information is not publicly available**

The living wage for a single adult living in Philadelphia is \$12.64/hour. Information about staff wages and benefits at SKMC and its affiliated hospitals is not publicly available.

Additional information may be found at the following links:

- [Jefferson Hospital Employee Benefits](#)
 - [Living Wage by County](#)
-

14. IRB approval process requires any research that uses race to include precise definitions of race and how it is being used in the research project. People of color are clearly identified as being a "vulnerable population" for research purposes, and IRB policies outline strategies to protect people of color from abusive practices.

- A. The above metric is fully met
- B. IRB process requires researchers to explain their use of race
- C. IRB process has no requirements regarding the treatment of race, or this information is not publicly available**

There are no specific guidelines around treatment of race in research at Jefferson.

Additional information may be found at the following link:

- [Human Subjects Research](#)

Tulane University School of Medicine

This section provides further detail on each metric for the Tulane University School of Medicine. Tulane is an allopathic medical school located in New Orleans, Louisiana. Primary teaching hospitals include Tulane Medical Center and University Medical Center New Orleans.

Each metric (numbered 1–14 in the truncated report card) includes the full metric prompt, the grade for the institution, and an explanation of what that grade represents. Below each metric, we provide any relevant links to sources.

1. Medical school students are at least 13% Black, 1% Native American, and 17% Latinx (corresponding to the share of these groups in the U.S. population).

- A. All URM groups are proportionately represented among students
- B. Some URM groups are proportionately represented among students
- C. No URM groups are proportionately represented among students, or this information is not publicly available**

Diversity statistics show that minority groups are not proportionally represented among the student body. The demographics of the student body are: American Indian or Alaska Native (0.73%), Asian (25.79%), Black/ African American (6.69%), Hispanic/ Latino (0.49%), Native, Hawaiian or Other Pacific Islander (0.49%), White (58.64%), Unknown (4.50%), Not declared (2.68%).

2. Medical school faculty are at least 13% Black, 1% Native American, and 17% Latinx (corresponding to the share of these groups in the U.S. population).

- A. All URM groups are proportionately represented among faculty
- B. Some URM groups are proportionately represented among faculty
- C. No URM groups are proportionately represented among faculty, or this information was not publicly available**

Faculty/Staff diversity mentioned in General Medical Faculty Meeting Minutes from May 2018. "There are several positions opened in the medical school. We are working

on faculty and staff diversity. For those on search committees, there are guidelines to follow. All hires must go through Folios as per LCME and AAMC.”

Additional information may be found at the following link:

- [Tulane General Medical Faculty Meeting Minutes](#)
-

3. The physical space of the medical school acknowledges the contributions of alumni and other physicians of color (through plaques, statues, portraits, and building names) and does not celebrate racist or white supremacist individuals.

- A. The above metric is fully met
- B. There are no items celebrating racist/white supremacist individuals, and also none celebrating people of color
- C. The physical space explicitly celebrates racist/white supremacist individuals**

The Rudolph Matas library at TUSOM has explicitly racist publications available. The school itself is named after Paul Tulane, the largest donor to confederate states of America. Gibson Hall and the online portal called “Gibson” are named after Randall Lee Gibson, who was a confederate general. The mezzanine and second floor of the medical school building has an excessive amount of portraits of older white men and none depicting people of color. Ochsner hospital also has many portrait representations that do not reflect the diversity of the community.

4. The medical school's recruitment policies promote racial justice. The medical school application does not inquire about the applicant's criminal history. The medical school recruits and admits undocumented students and students of color who attended public high schools in the county or state where the medical school is located. Students of color who participate in recruitment are compensated for their time.

- A. The above metric is fully met
- B. Some elements of the metric are met**
- C. No elements of the metric are met

TUSOM’s secondary application does not inquire about misdemeanors or felonies. The Office of Multicultural Affairs has recently started a Reach Back Mentoring in Medicine

Networking Initiative. The explicit goal of this group is to recruit underrepresented minority physicians in and around New Orleans, LA. In addition to recruitment, Reach Back is also committed to pairing new URM students to current URM student mentors. Going forward, URM students who are participating in formal recruitment efforts could be compensated for their time. Emphasis should continue to be placed on recruiting URM students from New Orleans and Louisiana.

5. The curriculum incorporates information about the history of racism in medicine, intersectional oppression, and racial justice strategies, and explicitly addresses the fact that race is a social construct, not a biological one. Lecturers avoid describing race per se (rather than racism) as a risk factor for disease, cause of health disparities, or basis for diagnostic reasoning. Community advocates and students who are underrepresented in medicine are incorporated in the planning and leadership of the pre-clinical curriculum.

- A. The above metric is fully met
- B. Some elements of the metric are met**
- C. The curriculum fails to adequately address racism in medicine. Race is stated or implied to be biological. Community advocates and URM students do not participate in planning or are not compensated for their time

TUSOM's internal medicine and pediatrics residents started diversity/anti-racism curriculums for their respective program. For the medical students, there is one required session in first year through our foundations in medicine course educates students about implicit biases/racism and cultural humility/competency.

During our medical school education, race is mentioned as a risk factor for diseases frequently while racism itself is mentioned very infrequently (although this is dependent upon lecturer). There are only a handful of opportunities for interested students to pursue electives which discuss racism/social determinants of health. And unfortunately, community advocates are not incorporated in the planning and leadership of the pre-clinical curriculum.

6. The medical school has a system for collecting student and faculty reports of

racism and other forms of oppression, and a clear plan for follow-up when problems are reported.

- A. The above metric is fully met
- B. There is some system for collecting reports, but there is no clear follow-up after reports are made**
- C. There is no system for collecting reports

Anonymous reporting is available on TMedWeb and the option is given to provide an email address for follow up or students can file reports anonymously. TUSOM is committed to eliciting student feedback, and after every unit, course evaluations are sent out to all students. These evaluations include a section to report how the “learning environment” was and opportunities are given to report harassment. The follow-up plan after submitting a report is not widely known to medical students but could be clarified for students in the future. TUSOM should be as transparent as possible in reporting to the TUSOM community the issues raised by students about racism and other forms of oppression. Steps the school is making to remediate the problem and provide reparations to the reporting party should also be distributed.

7. There are no racial disparities in medical students' grades or honors (including AOA election)

- A. The above metric is fully met
- B. The school regularly evaluates whether there are racial disparities, and has developed plans to address them
- C. There are significant racial disparities in grades and/or honors, or **this information is not publicly available**

8. Black, Native American, and Latinx students have access to designated physical spaces, as well as support staff, including administrators, physician mentors, mental health providers, and peer counselors.

- A. The above metric is fully met**
- B. There are some resources specifically designated to support students of color
- C. There are no designated resources for students of color

There are many services at TUSOM which seek to support URM students. The Office of Multicultural Affairs is committed to supporting diversity and inclusion at TUSOM. This office is located in a readily accessible location for students in one of the main buildings on TUSOM's campus. In addition to their physical support space, the OMA also has a comprehensive website where students can access mental health resources. Further, Tulane Counseling and Psychological Services (CAPS) has a support group for women of color. Every student has equal access to a learning and careers in medicine specialist. Tulane has a workshop series aimed to build community and a safe space for Latinx students to identify self-care strategies and promote academic success called Salud! While this is an undergraduate initiative, medical students are encouraged to attend it as well.

9. There is no hospital/campus police force, or police are used as a last resort after the failure of alternative safety structures such as peer walking escorts, restorative justice councils, and mediation. If police or security officers exist, publicly-available data should demonstrate that they have not disproportionately stopped, arrested, or otherwise interacted with people of color.

- A. The above metric is fully met
- B. There are some programs designed to reduce reliance on police
- C. There is a campus police force, and no evidence that they have sought to address racism in policing, or this information is not publicly available

NOT ANSWERED (explanation below)

We don't view this metric from the same perspective given the location of Tulane Medical School. We didn't feel comfortable picking one of these choices. There is room for the police force to improve cultural competency and implicit bias training without abolishing their services completely.

Meeting Metric

TUSOM is located in downtown New Orleans, a higher crime area, and the campus police force exerts a protective presence for students; ex: they can be called on to accompany students and give them rides home at night

Not Meeting

Tulane University Police Department employs armed police officers.

10. Expectations for students' level of independence and supervision are clearly documented and are consistent across training sites (for example, students or residents are not disproportionately given the opportunity to "practice" while rotating in VA or public hospitals or while volunteering in free clinics).

- A. The above metric is fully met
- B. Policies exist to ensure that all patients receive equally well-supervised care, but are inconsistently enforced**
- C. Students are routinely given more independence when caring for marginalized patients

There are similar levels of independence and participation in patient care across hospitals. Differences in student autonomy depends more on the attending physician and less on any structural discrimination policies. Students in the student-run clinics are supervised by attending physicians who see patients after students do. A survey was circulated among medical students of all years to elicit anecdotal evidence. Based on survey data, students from all classes seem to be aware of the limits of their practice, for example, students do not prescribe medications or make final diagnoses. All of these decisions are overseen by a resident or attending physician. TUSOM encourages an environment where students understand their roles and limit their practice to taking history and physical, writing notes, counseling, and placing TB test and HepC/HIV tests if trained. There is no definitive document outlining students' limits of responsibility at student run clinics but should be clarified going forward.

11. At the primary teaching hospital (s), patients of color are represented in all services (including specialist services) and practices at their rate in the local population. Patients of color are not segregated in resident or student clinics.

- A. The above metric is fully met
- B. There are some efforts to promote equal access to care (e.g. Medicaid patients seen in faculty clinics)**
- C. Patient care is highly segregated, or this information is not publicly available

Translation services are offered at UMC and Tulane Hospital--both teaching hospitals affiliated with TUSOM. Also, many Medicaid and Medicare patients are seen in the faculty run clinics, ex: Formerly Incarcerated Transitions Clinic, Crescent Care, Healthcare for the Homeless.

12. The primary teaching hospital has demonstrated a commitment to immigrant patients including multilingual signs stating that patients are welcome regardless of immigration status, and a policy of referring immigration authorities to hospital attorneys prior to any cooperation by hospital staff.

- A. The above metric is fully met
- B. The hospital has some symbolic commitment to immigrant patients (e.g. signs), but no policies explicitly protecting undocumented patients
- C. The hospital has no public or policy commitment to immigrant patients**

Patients at Tulane Medical Center have access to translators of a large variety of languages. Depending on the language, these translation services may be limited. Physicians with some but limited language experience are sometimes encouraged to translate beyond their abilities. These practices should be discouraged and every effort should be taken to improve the translation services in the hospital for the highest quality of patient care. Tulane Medical Center outlines Patient Rights & Responsibilities and states that it does not discriminate on the basis of citizenship or national origin (among other factors). Tulane Medical center validates the right of patients to be free from abuse and harassment and to have access to safe and secure accommodation. However, there is no commitment to immigrant safety specifically. TMC has no public statement welcoming immigrants or policies governing interactions between hospital staff and immigration authorities. Additions to these policies to include immigrant protections should be made.

13. All medical school staff and staff at the primary teaching hospital are paid a living wage as defined by local advocacy organizations.

- A. The above metric is fully met
- B. N/A
- C. Some staff earn less than a living wage and/or do not have access to comprehensive health insurance, or this information is not publicly available**

The institution meets the metric in the following ways:

- Glassdoor posting about RN position for \$32/hr
- TMC Security Officer posting on Glassdoor for \$17 - 19/hr
- Food Service Worker position on Sodexo for \$9 -10/hr
- Central Sterile Technician \$11 - 13/hr
- Secretary on a unit at UMC is \$12-15/ hr

Some information available about Tulane’s health insurance benefits. These benefits seem comprehensive. They are stratified based on part-time/ full-time (classified as 32-80 hrs/ pay period)

However, the institution does not meet the metric in the following ways:

- UMC security guard job posting for \$10.07 an hour (LW in NO is \$11.05/hr)
- Security staff, janitorial staff, and cafeteria workers appear to be hired by subcontract
- Some information was gathered on publicly accessible, non-Tulane affiliated websites (Indeed.com) but no information was reported directly by Tulane
- Patient Care Assistant - \$10 - 13/hr
- Clinic medical assistant at UMC is \$9-12/ hr
- AraMark food service employees at UMC \$8-11/ hr
- No information available for the subcontracted employees working at Tulane Medical School and Tulane Hospital

14. IRB approval process requires any research that uses race to include precise definitions of race and how it is being used in the research project. People of color are clearly identified as being a "vulnerable population" for research purposes, and IRB policies outline strategies to protect people of color from abusive practices.

- A. The above metric is fully met
- B. IRB process requires researchers to explain their use of race
- C. **IRB process has no requirements regarding the treatment of race, or this information is not publicly available**

There are no policies that exist at TUSOM which identify people of color as a “vulnerable population.” The only time “race” was mentioned in Tulane University’s Standard Operating Procedures for its Human Research Protection Plan was in regard to selecting members of the IRB.

University of California Berkeley - University of California San Francisco Joint Medical Program

This section provides further detail on each metric for the University of California, Berkeley, University of California San Francisco joint MD program. This is a five-year graduate/allopathic medical degree program. The pre-clerkship years are spent at UC Berkeley, and the clinical years are completed at UCSF. Primary teaching hospitals include Zuckerberg San Francisco General Hospital and Trauma Center, UCSF Benioff Children's Hospital, UCSF Helen Diller Medical Center at Parnassus Heights.

Each metric (numbered 1-14 in the truncated report card) includes the full metric prompt, the grade for the institution, and an explanation of what that grade represents. Below each metric, we provide any relevant links to sources

1. Medical school students are at least 13% Black, 1% Native American, and 17% Latinx (corresponding to the share of these groups in the U.S. population).

- A. All URM groups are proportionately represented among students
- B. Some URM groups are proportionately represented among students
- C. No URM groups are proportionately represented among students**, or this information is not publicly available

For the 2018-2019 school year, the JMP has 48 enrolled students. The student population is 2% Black, 10% Latinx, and 0% Native American.

2. Medical school faculty are at least 13% Black, 1% Native American, and 17% Latinx (corresponding to the share of these groups in the U.S. population).

- A. All of the above groups are proportionately represented among faculty
- B. Some of the above groups are proportionately represented among faculty**
- C. None of the above groups are proportionately represented among faculty, or this information is not publicly available

Of 26 total teaching faculty, 15% (n=4) are Black/African-American, 4% are Latinx (n=1), and 0% are Native American.

3. The physical space of the medical school acknowledges the contributions of alumni and other physicians of color (through plaques, statues, portraits, and building names) and does not celebrate racist or white supremacist individuals.

- A. The above metric is fully met
- B. There are no items celebrating racist/white supremacist individuals, and also none celebrating people of color**
- C. The physical space explicitly celebrates racist/white supremacist individuals

The physical space of the JMP is a single floor within the Berkeley School of Public Health. To the best of student knowledge, the exam rooms and conference rooms are not named after racist or white supremacist individuals, but there are no spaces or plaques celebrating physicians of color led by the institution. Existing student-led decor celebrates the contributions of people of color and POC-led movements such as supporting DACA students and the NoDAPL movement.

4. The medical school's recruitment policies promote racial justice. The medical school application does not inquire about the applicant's criminal history. The medical school recruits and admits undocumented students and students of color who attended public high schools in the county or state where the medical school is located. Students of color who participate in recruitment are compensated for their time.

- A. The above metric is fully met
- B. Some elements of the metric are met**
- C. No elements of the metric are met

The medical school application does not inquire about the applicant's criminal history. The medical school does recruit and admit undocumented students, students of color, and those from the local community. However, there are no pipeline programs specifically for the JMP, either through UCSF or UC Berkeley.

5. The curriculum incorporates information about the history of racism in medicine, intersectional oppression, and racial justice strategies, and explicitly addresses the fact that race is a social construct, not a biological one. Lecturers avoid describing race per se (rather than racism) as a risk factor for disease, cause of health disparities, or basis for diagnostic reasoning. Community advocates and students who are underrepresented in medicine are incorporated in the planning and leadership of the pre-clinical curriculum.

- A. The above metric is fully met
- B. Some elements of the metric are met**
- C. The curriculum fails to adequately address racism in medicine. Race is stated or implied to be biological. Community advocates and URM students do not participate in planning or are not compensated for their time

The JMP curriculum concretely addresses the history of racism in medicine, intersectional oppression and racial justice strategies and explicitly addresses the fact that race is a social construct. A newly redesigned orientation has enhanced this work and ensures that all students are engaged in this learning prior to learning medicine. Within the foundational science and clinical skills curricula, many lecturers do describe race as a risk factor. However, given the JMP's unique PBL-based learning environment, much of the learning is driven by student comment and inquiry which allows students to regularly correct and address this issue as it arises within classroom spaces. While helpful for community learning, this may place an undue burden on students of color, other marginalized identities or those who have received more extensive anti-racism training previous to medical school to be responsible for their peers' learning anti-racist medicine. Students are incorporated in the planning of the curriculum, including editing of cases (which affects the cases that future classes receive), although these are not explicitly students who are underrepresented in medicine. This is in part due to the small size of the community. Community members are occasionally involved in developing the cases if they themselves were the case study, but overall there is no explicit consistent mechanism for community advocacy in the development of the curriculum.

6. The medical school has a system for collecting student and faculty reports of racism and other forms of oppression, and a clear plan for follow-up when problems are reported.

- A. The above metric is fully met

- B. There is some system for collecting reports, but there is no clear follow-up after reports are made**
- C. There is no system for collecting reports

The JMP is a small institution within the UC-Berkeley and UCSF schools. As such, both UC-Berkeley and UCSF have systems for collecting reports. However, students have not used these systems and most JMP students are unaware of how to make reports regarding racism and other forms of oppression. We cannot speak to follow-up after reports are made.

7. There are no racial disparities in medical students' grades or honors (including AOA election)

- A. The above metric is fully met
- B. The school regularly evaluates whether there are racial disparities, and has developed plans to address them
- C. There are significant racial disparities in grades and/or honors, or this information is not publicly available**

Administrators tell us that there are disparities in grades for URM students. The JMP has no honors. The school has not evaluated these racial disparities, and has not articulated a plan to address them.

8. Black, Native American, and Latinx students have access to designated physical spaces, as well as support staff, including administrators, physician mentors, mental health providers, and peer counselors.

- A. The above metric is fully met
- B. There are some resources specifically designated to support students of color**
- C. There are no designated resources for students of color

UC Berkeley and UCSF have spaces, and all the associated staff specifically designated to support students of color. However, the JMP itself does not have any specific space, support staff, administrators, physician mentors, mental health providers, or peer counselors.

9. There is no hospital/campus police force, or police are used as a last resort after the failure of alternative safety structures such as peer walking escorts, restorative justice councils, and mediation. If police or security officers exist, publicly-available data should demonstrate that they have not disproportionately stopped, arrested, or otherwise interacted with people of color.

- A. The above metric is fully met
- B. There are some programs designed to reduce reliance on police
- C. There is a campus police force, and no evidence that they have sought to address racism in policing, or **this information is not publicly available****

As stated previously, the JMP is a small school inside two large institutions. As such, the JMP has no police force of its own control. However, UC Berkeley has no publicly available information on the campus police force policies and practices regarding racism and interacting with people of color.

From UCSF RJRC:

"Security at UCSF is enforced by a team of 146 uniformed, armed police officers employed by the UCSF Police Department, UCSF Medical Center Security, and UCSF Campus Security Guards. Campus Security and Police Department offer walking support (not peer-based), and conflict mediation is offered through the San Francisco Staff Assistance Program, Student Health Services, and Ombudsman Office. The department does not release its statistics around race/ethnicity, nor does it acknowledge its responsibility to be held accountable to communities of color. There is no information about any UC-specific training police officers receive in regards to racial bias or de-escalation strategies. The UCSF Police Department has received Commission on Law Enforcement Accreditation (CLEA). Students do not report systematic problems with disproportionate stops or arrests of people of color, but do note that at the 9th Annual LGBTQIA Forum in 2017, one of the speakers was racially profiled and denied entry to the building where he was scheduled to speak. In addition,

medical students rotate at San Francisco General Hospital where security are armed and run by the same Sheriff's Deputies that cycle in and out of jail. "

10. Expectations for students' level of independence and supervision are clearly documented and are consistent across training sites (for example, students or residents are not disproportionately given the opportunity to "practice" while rotating in VA or public hospitals or while volunteering in free clinics).

- A. The above metric is fully met
- B. Policies exist to ensure that all patients receive equally well-supervised care, but are inconsistently enforced**
- C. Students are routinely given more independence when caring for marginalized patients

As JMP students train at UCSF sites, this response & explanation is from the UCSF RJRC:

"The UCSF Student Education Policy Supervision of Medical Students policy covers required and elective clinical rotations, including students working at free clinics, and states that medical students may not provide care in an unsupervised fashion, may not perform procedures without direct observation/supervision, and that supervisors must hold a faculty appointment or be supervised in their teaching/assessment by a faculty appointment. Pre-clinical students at student-run free clinics, primarily serving marginalized patients, are allowed to see patients with resident supervision and a lower level of attending supervision than required at other facilities. In addition, students' level of independence can vary significantly across training sites, typically depending on faculty discretion."

11. At the primary teaching hospital (s), patients of color are represented in all services (including specialist services) and practices at their rate in the local population. Patients of color are not segregated in resident or student clinics.

- A. The above metric is fully met
- B. There are some efforts to promote equal access to care (e.g. Medicaid patients seen in faculty clinics)
- C. Patient care is highly segregated, or **this information is not publicly available**

This response and explanation is from UCSF RJRC. Note they indicate both that patient care is highly segregated and that the information is not publicly available.

"UCSF Health began collecting data in a systematic manner on patients about 18 months ago and are now trying to work with the EHR to be better able to capture that data to inform the health system. In speaking to the Data Analytics subgroup within the Clinical Health Equity group that is collecting and stratifying this data, they are still in the process of improving collection and reporting mechanisms, but this data should be available later this year. ZSFG refers to their annual report that has aggregate numbers for patients and patient visits broken down by race/ethnicity/gender, linked below.

The VA does not reliably collect this type of data, and to get permissions to look/work with what they do have requires a fair amount of special training that is offered to researchers to use these databases. So in summary, the numbers for UCSF Health are forthcoming, and the numbers for the VA, which are highly variable, require a huge amount of effort to access and are therefore not publicly available."

12. The primary teaching hospital has demonstrated a commitment to immigrant patients including multilingual signs stating that patients are welcome regardless of immigration status, and a policy of referring immigration authorities to hospital attorneys prior to any cooperation by hospital staff.

- A. The above metric is fully met
- B. The hospital has some symbolic commitment to immigrant patients (e.g. signs), but no policies explicitly protecting undocumented patients**
- C. The hospital has no public or policy commitment to immigrant patients

This response and explanation is from UCSF RJRC:

"UCSF facilities have public signage that reads in English, "We welcome: All races, All religions, All countries of origin, All sexual orientations, All genders, All ethnicities, All abilities, We stand with you."

In addition, postcards carrying the same message in English, Spanish, Russian, Chinese and Arabic are available in patient waiting rooms and lobbies, with a link to information on UCSF's inclusion policies. More recently, the UCSF Chancellor Sam Hawgood published a statement against the "public charge" proposed rule.

However, UC Health has not reliably manifested its statements in support of immigrants into action. For example, UC Health has a policy of referring immigration authorities to hospital attorneys prior to any cooperation by hospital staff, but does not provide coordinated trainings or efforts to readily disseminate this information or make it clear to all that patients don't have to forego medical care to maintain public benefits or keep themselves safe from immigration officials. Language interpretation services continue to fall short of patient needs and are regularly underutilized to save providers time. "

13. All medical school staff and staff at the primary teaching hospital are paid a living wage as defined by local advocacy organizations. All full-time staff have affordable comprehensive health insurance that is accepted at the health system where they work.

A. The above metric is fully met

B. N/A

C. Some staff earn less than a living wage and/or do not have access to comprehensive health insurance, or this information is not publicly available

The above response reflects only JMP staff (n=3). The JMP has a very small number of staff. Staff earn a living wage and access comprehensive health insurance. This does not include "environmental staff" such as custodial staff, as that is through the larger UC Berkeley institution.

The UCSF RJRC has a different response. They say some staff earn less than a living wage and/or do not have access to comprehensive health coverage:

"Despite ongoing negotiations with the UCSF Service and Patient Care Workers' Union, AFSCME Local 3299, UC Health has threatened to reduce the yearly income increase for staff from 4% to 2%, increase healthcare co-pays and premiums more than 60%, and gain the ability to cut benefits further. In sum, UC staff members cannot afford to seek care in the UC system, and they are actively making it more inaccessible with their current proposal.

Organized strikes in May and October of 2018 protested wage stagnation and income inequality perpetuated further by UC Health's push toward hiring contractors and flexible staff, who are not members of the union and receive no long-term benefits (like health care and retirement) and, on average, lower wages. Because contract staff constitute a higher percentage of people of color and women, this policy serves to

increase income disparities in San Francisco and across California. In addition, minimum wage remains at \$15/hour despite the fact that the living wage for one working adult in San Francisco is \$20.58/hour. Union representatives report that this wage is mostly seen among contractors, although some union members are consistently paid about \$16/hour. Many UCSF staff members cannot afford to live within city limits, and are increasingly commuting from further and further away. "

14. IRB approval process requires any research that uses race to include precise definitions of race and how it is being used in the research project. People of color are clearly identified as being a "vulnerable population" for research purposes, and IRB policies outline strategies to protect people of color from abusive practices.

- A. The above metric is fully met
- B. IRB process requires researchers to explain their use of race
- C. IRB process has no requirements regarding the treatment of race, or **this information is not publicly available**

The JMP relies on UC Berkeley IRB for all student and faculty research. It should be noted that the JMP conducts a very small subset of the research done at UC Berkeley, and as such the lack of information on this metric should not necessarily reflect a JMP-specific issue.

Additional Student Comments

The UCSF/UC Berkeley Joint Medical Program is a small combined MS/MD program between two large institutions (UCSF and UC Berkeley). There are 16 students per class (out of 180 in each UCSF class). Students spend 2.5 years completing preclinical education and an interdisciplinary master's thesis predominantly on the UC Berkeley campus, and then join the larger UCSF class at UCSF training hospitals for "Foundations 2 & 3" (clinical training). During preclinical training, foundational science is taught entirely through Problem-Based Learning (PBL), in which the cases are developed by faculty and the classroom learning is entirely student-led with JMP faculty support. Clinical skills during the preclinical education are led by JMP faculty on the UC Berkeley campus with clinical "preceptorship" placements in primary care clinics and hospitals in the East Bay. The JMP therefore operates within two major institutions and a different physical location (East Bay) than that of the larger UCSF medical school. Students experience both institutions relatively equally and take a very

active role in their preclinical foundational science learning. Administration has a high degree of control over certain aspects of the program and very little control over the two larger institutions, although they are given input at many levels. Recently the JMP has initiated a Diversity, Equity, Inclusion, and Justice working group comprised of students, faculty and staff to address many of the issues noted within the RJRC.

For more information: <http://sph.berkeley.edu/jmp/home>

For this report, we focus on the JMP preclinical curriculum, unless otherwise noted. The UCSF RJRC reflects the clinical portion of JMP student training.

University of California, San Francisco School of Medicine

This section provides further detail on each metric for the University of California, San Francisco (UCSF). UCSF is an allopathic medical school located in San Francisco, CA. Primary teaching hospitals include Zuckerberg San Francisco General Hospital and Trauma Center, UCSF Benioff Children's Hospital, UCSF Helen Diller Medical Center at Parnassus Heights.

Each metric (numbered 1-14 in the truncated report card) includes the full metric prompt, the grade for the institution, and an explanation of what that grade represents. Below each metric, we provide any relevant links to sources.

1. Medical school students are at least 13% Black, 1% Native American, and 17% Latinx (corresponding to the share of these groups in the U.S. population).

- A. All URM groups are proportionately represented among students**
- B. Some URM groups are proportionately represented among students
- C. No URM groups are proportionately represented among students, or this information is not publicly available

Publicly available data is outdated. Accurate data were obtained after meeting with the Dean of Admissions of the School of Medicine. The percentages below reflect the cumulative demographics of the last four entering classes, which provides the best approximation of the demographics of the current student body. The 2018 incoming class was the most demographically diverse class in the history of UCSF School of Medicine.

- African American – 13%
- Hispanic – 18%
- Pacific Islander (mostly Filipino) – 3%
- Native American – 1%
- Overall Underrepresented in Medicine – 34.6%

Total number of students for the last four entering classes:

- White 224

- Asian 166
- Hispanic 108
- African American 75
- Pacific Islander 19
- Native American 4

Additional information may be found at the following links:

- [Learner Scorecard](#)

2. Medical school faculty are at least 13% Black, 1% Native American, and 17% Latinx (corresponding to the share of these groups in the U.S. population).

- A. All URM groups are proportionately represented among faculty
- B. Some URM groups are proportionately represented among faculty
- C. **No URM groups are proportionately represented among faculty**, or this information was not publicly available

We attempted to contact the Office of Diversity and Outreach for demographic information of the current faculty, but have not received a response. As such, we are working with data from 2017 from the source linked below.

The percentages below reflect the demographics of UCSF School of Medicine Faculty from 2017:

- African American – 2.5%
- Hispanic – 6%
- Native American – 0.5%

UCSF also has initiatives that aim to increase diversity among faculty members, including the Watson Scholars program, which provides eight faculty members committed to addressing issue of diversity, equity, and inclusion with three years of support. This aims to increase faculty recruitment and retention to broaden the diversity represented overall for future years. Holistic review of residency applications has increased the proportions of UIM students in major USCF residencies from 15% to 30% over two years, which serves as a pipeline for UIM faculty.

Additional information may be found at the following links:

- [Faculty Scorecard](#)
 - [John A. Watson Faculty Scholars](#)
-

3. The physical space of the medical school acknowledges the contributions of alumni and other physicians of color (through plaques, statues, portraits, and building names) and does not celebrate racist or white supremacist individuals.

- A. The above metric is fully met
- B. There are no items celebrating racist/white supremacist individuals, and also none celebrating people of color (*the physical spaces at UCSF celebrate people of color, as well as some oppressive/white supremacist individuals*)**
- C. The physical space explicitly celebrates racist/white supremacist individuals

As was the case last year, pillars within the medical school at UCSF are decorated with photographs of alumni (including students of color) who have contributed to the community, UCSF publications and campus shuttles celebrate community members of color, and there is a campus mural of the 'Basement People' recognizing hospital workers who organized to desegregate the hospital and fight for more students of color at UCSF.

This year, students organized events to celebrate migration which included an installation photo project celebrating students' histories of immigration. Student activism like this has helped make the physical space at UCSF more inclusive.

Students continue to be concerned about the ways that UCSF is contributing to the rapid gentrification of San Francisco and displacement of people of color. UCSF has a long history of establishing relationships with problematic entities with problematic entities; examples include Genentech and the Chan Zuckerberg Initiative. Most

recently, UCSF Helen Diller Family Comprehensive Cancer Center carries the name of Helen Diller, whose husband Sanford Diller is the founder of Prometheus Real Estate Group which has fought against rent control and contributed to rapid gentrification in the Bay Area and other cities in the West Coast.

Additional information may be found at the following links:

- [Medicine for Migration](#)
 - [UCSF Receives 500M Commitment from Helen Diller](#)
 - [UCSF Community Saddened by Loss of Quiet Champion Sanford Diller](#)
 - [In California, Big Real Estate Spent 77.3M to Stop Rent Control](#)
 - [Hope - but also fear over Changes in East Palo Alto](#)
 - [Take the Zuckerberg Name off Our City's Hospital](#)
-

4. The medical school's recruitment policies promote racial justice. The medical school application does not inquire about the applicant's criminal history. The medical school recruits and admits undocumented students and students of color who attended public high schools in the county or state where the medical school is located. Students of color who participate in recruitment are compensated for their time.

- A. The above metric is fully met
- B. Some elements of the metric are met**
- C. No elements of the metric are met

All students, including students of color, who give tours to interviewees are paid \$8 in the form of a cafeteria gift card. The Schools of Medicine Admissions Department attempts to recruit Black students by visiting HBCUs.

The UCSF secondary does not inquire about applicant's criminal history. Undocumented students, specifically DACA students, are accepted. Interested high school groups are hosted on campus and the Office of Admissions recruits at public universities. The Office of Admissions has stated that they do not have a budget

specifically for recruitment of applicants from communities that are underrepresented in medicine. However, when representatives are traveling to areas with large concentrations of UIMs, they often plan an extra day of travel to talk to potential applicants (e.g. will visit Howard University if already in Washington, D.C.).

The Office of Admissions believes that the best recruitment technique is to have UIMs in the student body. They want to have a diverse community of students to show potential applicants that they will be comfortable in this learning environment and that they will not be “tokens.” Therefore, they encourage UIM student retention through an additional \$5000 in annual funding specifically for affinity groups (in addition to the funding provided to registered campus organizations) -- such as the SNMA and LMSA student groups -- and supplements for travel to national meetings.

Additional information may be found at the following links:

- [Admissions: MD Program](#)

5. The curriculum incorporates information about the history of racism in medicine, intersectional oppression, and racial justice strategies, and explicitly addresses the fact that race is a social construct, not a biological one. Lecturers avoid describing race per se (rather than racism) as a risk factor for disease, cause of health disparities, or basis for diagnostic reasoning. Community advocates and students who are underrepresented in medicine are incorporated in the planning and leadership of the pre-clinical curriculum.

- A. The above metric is fully met
- B. Some elements of the metric are met**
- C. The curriculum fails to adequately address racism in medicine. Race is stated or implied to be biological. Community advocates and URM students do not participate in planning or are not compensated for their time

Similar to previous years, there is variability in how race is approached in written materials, lectures, and small-group environments. Some course materials clearly

define race as a sociopolitical construct. There are lectures during the “Health and the Individual” block that mention structural oppression and racism as risk factors for disease.

Unfortunately, few lecturers and even fewer small-group facilitators have expertise in public health, epidemiology, or critical race theory. In these environments, race is sometimes presented as the basis for diagnostic reasoning, a risk factor in and of itself, and occasionally treated as genetic. However, some lecturers and facilitators have taught to use race in diagnostic reasoning with the caveat that it is simply being used as a proxy for sociopolitical factors, and not ancestry.

Students are provided stipends and support to conduct systematic reviews of the approach to race in the curriculum, although it is unclear whether this research is implemented and who is held accountable for it. Progress towards an anti-racist curriculum is slow, but faculty and leadership have shown an overall willingness to work with students to improve the curriculum.

Additional information may be found at the following links:

- [Foundational Sciences \(description of each block, including H&I and H&S\)](#)

6. The medical school has a system for collecting student and faculty reports of racism and other forms of oppression, and a clear plan for follow-up when problems are reported.

- A. The above metric is fully met
- B. There is some system for collecting reports, but there is no clear follow-up after reports are made**
- C. There is no system for collecting reports

SAFE (Supporting a Fair Environment) is a currently utilized survey for collecting episodes of student mistreatment which can include racism and other forms of oppression, but is not specifically aimed at collecting racism or microaggressions. Following a student report through SAFE, the Dean of Students is notified and follows up with the student who reported.

There is not necessarily a “clear plan for follow-up,” although the Dean of Students has removed certain faculty from working with students following reports made on SAFE. Whether or not they retain faculty positions or have disciplinary action taken against them has not been made public to the student body. Anecdotal reports of students delaying complaints remain -- in some cases, out of fear of compromised anonymity due to their circumstances and retaliation in grading.

A student-led initiative is currently underway for generating a system for reporting incidents of microaggressions. While the administration is being supportive and working with students, this system was spearheaded by students and no compensation has been made available for their time.

Faculty are intended to report to the Office for Prevention of Harassment and Discrimination, which has a process for responding to reports.

Additional information may be found at the following links:

- [SAFE Reporting Site](#)
 - [Violence in the Work Place](#)
 - [Equal Opportunity Complaint Resolution](#)
 - [Discrimination Complaint Form](#)
 - [UCSF Office for Prevention of Harassment and Discrimination](#)
-

7. There are no racial disparities in medical students' grades or honors (including AOA election)

- A. The above metric is fully met
- B. The school regularly evaluates whether there are racial disparities, and has developed plans to address them**
- C. There are significant racial disparities in grades and/or honors, or this information is not publicly available

UCSF conducted a study of disparities in honors grading and AOA election and found significant disparities for UIM students in both for the classes of 2013–2016 (half as likely to receive honors, 3x less likely to receive AOA). Since then, AOA election has been restructured to be blinded where possible and more holistic (last year's class was 40% UIM per 2018 RJRC, an overrepresentation) and removing AOA election is actively under consideration. UCSF has also examined disparities in shelf exam scores and passing rates for UIM students. In the class of 2020, no differences related to race and ethnicity were identified. In the last four years of scores from the California Clinical Performance Exam (OSCE), one class experienced disparities in grading related to race and ethnicity. Lastly, UCSF recently removed honors grading from 3rd year clerkships, so grading is now pass or fail.

However, removing honors does not remove disparities, and the school has not explicitly committed to collecting data about clerkship disparities that center student experiences of discrimination -- for example, students of color report being expected to do more administrative labor at the expense of hands-on experience. UCSF is testing an additional question for faculty on the clerkship grading form intended to recognize the additional work that is often done by UIM students. The administration is considering a commitment to wider research about student experiences, although the parameters of the study are not clear.

Additional information may be found at the following links:

- [UCSF Study: How Small Differences in Assessed Clinical Performance Amplify to Large Differences in Grades and Awards](#)
- [Core Clerkships 2019 Assessment and Grading](#)

8. Black, Native American, and Latinx students have access to designated physical spaces, as well as support staff, including administrators, physician mentors, mental health providers, and peer counselors.

- A. The above metric is fully met
- B. There are some resources specifically designated to support students of color**
- C. There are no designated resources for students of color

The Multicultural Resource Center (MRC) and LGBTQ Resource Centers support medical student organizations including SNMA, LMSA, NAHA, LGBTQSA, GAPDA, and WC4BL. A number of staff members have worked particularly hard to ensure that there is a welcoming community for students with intersectional identities, such as queer students of color. Additionally, staff from these centers have consistently provided financial and staff support for student initiatives, and host a wide range of events.

Even so, there are concerns that the MRC and LGBTQ Resource Center is underfunded, understaffed, and may be moving its physical location (it is scheduled to undergo renovation for seven months during the 2019-2020 school year, after which an additional space is scheduled to open on the Mission Bay campus), which would make it more difficult for students of color to access support. Currently, there are four full-time staff members: two directors, a shared assistant director and additional administrative support. They receive some additional support from the Office of Diversity and Outreach. Furthermore, there are concerns that UCSF has inadequate resources, mentorship, and counselors designated for Native students.

UCSF maintains a “Diversity Hub,” an online database to help connect UCSF community members with appropriate organizations and resources, including scholarships and grant funding. In addition, the School of Medicine hired a new Equity and Inclusion Program Manager this year for the Student Experience Team, who will advise, mentor, and support students.

Additional information may be found at the following links:

- [Diversity Hub](#)
 - [UCSF LGBTQ Resource Center](#)
 - [Welcome to the Multicultural Resource Center](#)
 - [Undocumented Student Support Services](#)
-

9. There is no hospital/campus police force, or police are used as a last resort after the failure of alternative safety structures such as peer walking escorts, restorative justice councils, and mediation. If police or security officers exist, publicly-available data should demonstrate that they have not disproportionately stopped, arrested, or otherwise interacted with people of color.

- A. The above metric is fully met
- B. There are some programs designed to reduce reliance on police**
- C. There is a campus police force, and no evidence that they have sought to address racism in policing, or this information is not publicly available

Security at UCSF is enforced by a team of 146 uniformed, armed police officers employed by the UCSF Police Department, UCSF Medical Center Security, and UCSF Campus Security Guards. Campus Security and Police Department offer walking support (not peer-based), and conflict mediation is offered through the San Francisco Staff Assistance Program, Student Health Services, and Ombudsman Office. The department does not release its statistics around race/ethnicity, nor does it acknowledge its responsibility to be held accountable to communities of color. There is no information about any UC-specific training police officers receive in regards to de-escalation strategies, but the UCPD and the UC security officers have received education and training in Unconscious Bias delivered by Dr. LaMisha Hill, Director of the Multicultural Resource Center.

The UCSF Police Department has received Commission on Law Enforcement Accreditation (CLEA). Students do not report systematic problems with disproportionate stops or arrests of people of color. Medical students rotate at San Francisco General Hospital (SFGH) where security are armed and run by the same Sheriff's Deputies that cycle in and out of jail. That being said, SFGH has implemented several measures to reduce and monitor unnecessary use of law enforcement on

hospital grounds. These include the creation of a Behavioral Emergency Response Team composed of psychiatric RNs trained in violence prevention and de-escalation, a weekly review board to track all uses of force by Sheriff's Deputies, and a Workplace Violence committee that addresses cases of violence against staff and patients and ensures institution accountability in regards to patient safety. Overall, information on what type of situations the Ombudsman Office handles should be more clearly communicated to students and trainees.

Additional information may be found at the following links:

- [UCSF Police Department](#)
 - [Office of the Ombuds UCSF](#)
 - [Conflict Resolution Resources](#)
 - [Annual Security Report](#)
 - [UCSF Police Department Organizational Chart](#)
-

10. Expectations for students' level of independence and supervision are clearly documented and are consistent across training sites (for example, students or residents are not disproportionately given the opportunity to "practice" while rotating in VA or public hospitals or while volunteering in free clinics).

- A. The above metric is fully met
- B. Policies exist to ensure that all patients receive equally well-supervised care, but are inconsistently enforced**
- C. Students are routinely given more independence when caring for marginalized patients

The UCSF Student Education Policy Supervision of Medical Students policy covers required and elective clinical rotations, including students working at free clinics, and states that medical students may not provide care in an unsupervised fashion, may not perform procedures without direct observation/supervision, and that supervisors must hold a faculty appointment or be supervised in their teaching/assessment by a faculty appointment.

The practice has always been to integrate the care of all patients into faculty practices. All faculty at UCSF have MediCal (Medicaid in California) patients in their clinic; when MediCal patients are seen in the residency clinic, UCSF is legally required to have the faculty see the patient with the resident. Pre-clinical students at student-run free clinics, primarily serving marginalized patients, are allowed to see patients with resident supervision and a lower level of attending supervision than typically occurs at other facilities. Students' level of independence can vary significantly across training sites, typically depending on faculty discretion. In addition, even in situations with equal levels of student training and preceptor training, there have been noted disparities between the length of time that a patient spends with student vs. attending. One student writes:

“In a private insurance specialty clinic, the patient saw a student for 20 minutes and an attending for 30. In the specialty clinic that accepts MediCal, patients saw a student for 20 minutes and an attending for 5-10 minutes. My work as a student was the same, but time pressures and diminished oversight produced disparity in care was so severe that one attending unironically instructed me: ‘don’t learn anything you see here.’” – Anonymous MS3

Additional information may be found at the following links:

- [Supervision of Medical Students](#)

11. At the primary teaching hospital (s), patients of color are represented in all services (including specialist services) and practices at their rate in the local population. Patients of color are not segregated in resident or student clinics.

- A. The above metric is fully met
- B. There are some efforts to promote equal access to care (e.g. Medicaid patients seen in faculty clinics)
- C. Patient care is highly segregated, or **this information is not publicly available**

UCSF Health began collecting data in a systematic manner on patients about 18 months ago and are now trying to work with the EHR to be better able to capture that data to inform the health system. In speaking to the Data Analytics subgroup within the Clinical Health Equity group that is collecting and stratifying this data, they are still in

the process of improving collection and reporting mechanisms, but these data should be available later this year. ZSFG refers to their annual report that has aggregate numbers for patients and patient visits broken down by race, ethnicity, and gender linked below.

The VA does not reliably collect this type of data, and to get permissions to work with what they do have requires a fair amount of special training that is offered to researchers to use these databases. In summary, the numbers for UCSF Health are forthcoming, and the numbers for the VA, which are highly variable, require a huge amount of effort to access and are therefore not publicly available.

All faculty at UCSF have Medicaid patients in their clinics, although the overall proportion of Medicaid patients in the UC Health system is not publicly available.

Additional information may be found at the following links:

- [SFDPH Annual Report 2016-2017](#)

12. The primary teaching hospital has demonstrated a commitment to immigrant patients including multilingual signs stating that patients are welcome regardless of immigration status, and a policy of referring immigration authorities to hospital attorneys prior to any cooperation by hospital staff.

- A. The above metric is fully met
- B. The hospital has some symbolic commitment to immigrant patients (e.g. signs), but no policies explicitly protecting undocumented patients**
- C. The hospital has no public or policy commitment to immigrant patients

UCSF facilities have public signage that reads in English, "We welcome: All races, All religions, All countries of origin, All sexual orientations, All genders, All ethnicities, All abilities, We stand with you." In addition, postcards carrying the same message in English, Spanish, Russian, Chinese and Arabic are available in patient waiting rooms and lobbies, with a link to information on UCSF's inclusion policies. More recently, the

UCSF Chancellor Sam Hawgood published a statement against the “public charge” proposed rule from the Trump administration.

However, UC Health has not reliably manifested its statements in support of immigrants into action. For example, UC Health has a policy of referring immigration authorities to hospital attorneys prior to any cooperation by hospital staff, but does not provide coordinated trainings for providers to discuss immigrant health or efforts to readily disseminate ICE-related policies or make it clear that patients do not have to forego medical care to maintain public benefits or keep themselves safe from immigration officials. Language interpretation services continue to fall short of patient needs and are regularly underutilized to save providers’ time. Lastly, the police presence in UCSF hospitals discourages those without full citizenship from utilizing services.

Additional information may be found at the following links:

- [FAQ ICE at UC System](#)
- [Public Charge Statement](#)
- [Statement on Immigration \(2018\)](#)
- [UCSF Inclusiveness Campaign](#)

13. All medical school staff and staff at the primary teaching hospital are paid a living wage as defined by local advocacy organizations. All full-time staff have affordable comprehensive health insurance that is accepted at the health system where they work.

- A. The above metric is fully met
- B. N/A
- C. **Some staff earn less than a living wage and/or do not have access to comprehensive health insurance**, or this information is not publicly available

Despite ongoing negotiations with the UCSF Service and Patient Care Workers’ Union, AFSCME Local 3299, UC Health has threatened to reduce the yearly income increase for

staff from 4% to 2%, increase healthcare co-pays and premiums more than 60%, and gain the ability to cut benefits further. In sum, UC staff members cannot afford to seek care in the UC system, and they are actively making it more inaccessible with their current proposal.

Five organized strikes since May 2018 protested wage stagnation and income inequality perpetuated further by UC Health's push toward hiring contractors and flexible staff, who are not members of the union and receive no long-term benefits (like health care and retirement) and, on average, lower wages. Because contract staff constitute a higher percentage of people of color and women, this policy serves to increase income disparities in San Francisco and across California. In addition, minimum wage remains at \$15/hour despite the fact that the *living* wage for one working adult in San Francisco is \$20.58/hour. Union representatives report that this wage is typical among contractors, although some union members are consistently paid about \$16/hour. Many UCSF staff members cannot afford to live within city limits, and are increasingly commuting from further and further away.

Additional information may be found at the following links:

- [MIT Living Wage Calculator](#)
- [AFSCME Local 3299 October Strike FAQ](#)
- [Meet the Super Commuters](#)
- [AFSCME Local 3299 Research Reports](#)
- [Pioneering Inequality](#)
- [Limitations on Career Advancement](#)
- [Working in the Shadows](#)

14. IRB approval process requires any research that uses race to include precise definitions of race and how it is being used in the research project. People of color are clearly identified as being a "vulnerable population" for research purposes, and IRB policies outline strategies to protect people of color from abusive practices.

A. The above metric is fully met

- B. IRB process requires researchers to explain their use of race
- C. IRB process has no requirements regarding the treatment of race, or **this information is not publicly available**

Official UCSF IRB policies surrounding race in research refer to NIH policies about the topic. Policies surrounding the role of race and ethnicity in research at UCSF is not publicly available. UCSF's Differences Matter initiative has a focus group dedicated to increasing the representation of underrepresented groups in clinical trials, which has increased campus conversations about recruiting more minority patients for research, such as in the editorial linked below. The group also posts that they have collaborated with the Clinical and Translational Science Institute within UCSF to create a consultation service for UCSF researchers to increase minority accrual to clinical trials. In addition, they provide services to help researchers make their outreach materials widely accessible and visually represent diversity. There is no public report on how these initiatives are affecting the rates of minority participation in UCSF clinical trials.

Additional information may be found at the following links:

- [Protecting Human Subjects UCSF](#)
- [Diversity in Research Participation: why it's important](#)
- [Differences Matter Focus Area 5: Research Action Group for Equity](#)

University of Colorado School of Medicine

This section provides further detail on each metric for the University of Colorado School of Medicine. UCSOM is an allopathic medical school located in Aurora, CO. The primary teaching hospitals are University of Colorado Hospital, Children's Hospital Colorado, Denver Health, and Denver VAMC.

Each metric (numbered 1-14 in the truncated report card) includes the full metric prompt, the grade for the institution, and an explanation of what that grade represents. Below each metric, we provide any relevant links to sources.

1. Medical school students are at least 13% Black, 1% Native American, and 17% Latinx (corresponding to the share of these groups in the U.S. population).

- A. All URM groups are proportionately represented among students
- B. Some URM groups are proportionately represented among students**
- C. No URM groups are proportionately represented among students, or this information is not publicly available

The AAMC collects [racial and ethnic characteristics of enrolled medical students](#) in 2018-2019. For University of Colorado, enrolled medical students are 3.7% Black, 6.2% LatinX, and <1% Native American.

According to data provided by University of Colorado School of medicine, the student body has one proportionally represented group (Native Americans). The class matriculating in 2018 is constituted by 8%/3%/10% Black, Native American, and Latinx respectively. However, it is noteworthy that this information was calculated using data provided by the Office of Diversity and Inclusion which double enters students who declare themselves multiracial, thus inflating the number of minority students.

Additional information may be found at the following links:

- [UC Matriculation Data](#)
- [UC Diversity Numbers](#)

2. Medical school faculty are at least 13% Black, 1% Native American, and 17% Latinx (corresponding to the share of these groups in the U.S. population).

- A. All URM groups are proportionately represented among faculty
- B. Some URM groups are proportionately represented among faculty
- C. **No URM groups are proportionately represented among faculty, or this information was not publicly available**

According to data provided by University of Colorado School of medicine, the faculty does not have proportionally represented URiM groups. In 2018, the faculty is constituted by 1%/<1%/5%, Black, Native American and Latinx respectively. This information was calculated using data provided by the Office of Diversity and Inclusion from the School of Medicine.

3. The physical space of the medical school acknowledges the contributions of alumni and other physicians of color (through plaques, statues, portraits, and building names) and does not celebrate racist or white supremacist individuals.

- A. The above metric is fully met
- B. **There are no items celebrating racist/white supremacist individuals, and also none celebrating people of color**
- C. The physical space explicitly celebrates racist/white supremacist individuals

The vast majority of physical spaces celebrating those who have contributed to the University of Colorado School of Medicine are devoted to white individuals. Only one building on AMC is named after a person of color: the Nighthorse-Campbell Native Health Building, after Ben Nighthorse-Campbell, a Cheyenne-American politician. There are several buildings on campus named after white individuals, including the Leprino Building (after American billionaire James Leprino), Barbara Davis Center for Diabetes (after American billionaire Barbara Davis), Strauss Health Science Library (after Henry and Joan Strauss), Skaggs School of Pharmacy (after the Skaggs family),

and the Fulginiti Pavilion for Bioethics and Humanities (after Vincent Fulginiti). The dean's hallway and other areas on campus devoted to donors and CU physicians have many photographs of notable white figures, but few celebrating physicians or other individuals of color.

Based on public information, there is no evidence that any of the people represented on campus had racist or white supremacist views; however, there is not enough information available to say with certainty.

Additional information may be found at the following links:

- [Nighthorse Campbell Native Health Building](#)

4. The medical school's recruitment policies promote racial justice. The medical school application does not inquire about the applicant's criminal history. The medical school recruits and admits undocumented students and students of color who attended public high schools in the county or state where the medical school is located. Students of color who participate in recruitment are compensated for their time.

- A. The above metric is fully met
- B. Some elements of the metric are met**
- C. No elements of the metric are met

The University of Colorado School of Medicine does require applicants to consent to a criminal background check. The University of Colorado School of Medicine (CU SOM) regularly participates in minority recruitment fairs, hosts pre-admission workshops for prospective URiM students, and offers support and resources to current URiM students including DACA and undocumented students through the Anschutz Medical Campus Office of Inclusion and Outreach. Recruitment visits are made to AAMC Annual Conference Minority Recruitment Fair, AMEC (SNMA) Annual Conference and Recruitment Fair, and ATU Minority Health Professions Fair. The CU SOM admissions committee practices a holistic candidate review process (Assessing and Evaluating Applicant's Experiences, Attributes and Metrics) and offers Unconscious Bias Trainings to CU SOM Admissions Committee Members. The CU SOM also hosts two Diversity

Pipeline Programs (BA/BS to MD and Post-Baccalaureate). It is unclear whether these policies and programs have led to the admission or matriculation of a significant number of URiM students. Students who participate in recruitment are not compensated for their time.

5. The curriculum incorporates information about the history of racism in medicine, intersectional oppression, and racial justice strategies, and explicitly addresses the fact that race is a social construct, not a biological one. Lecturers avoid describing race per se (rather than racism) as a risk factor for disease, cause of health disparities, or basis for diagnostic reasoning. Community advocates and students who are underrepresented in medicine are incorporated in the planning and leadership of the pre-clinical curriculum.

- A. The above metric is fully met
- B. Some elements of the metric are met**
- C. The curriculum fails to adequately address racism in medicine. Race is stated or implied to be biological. Community advocates and URM students do not participate in planning or are not compensated for their time

CUSOM does have a few widely interspersed required sessions for students that are either explicitly or tangentially addressing the reality of systemic and individual racism and its broad implications in medicine. However, the sessions that address the topic do so relatively non-specifically. While these sessions do discuss the fact that racism exists in medical practice and has impacts on patient outcomes, the specific ways in which racism has historically and currently manifests itself is not discussed. Intersectionality as it relates to racial, ethnic, gender, and cultural identities is not addressed in curriculum or training. Activism on the whole is not addressed in required training. Faculty that participate in certain committees (for example, the admissions committee) have required racial bias/racism training. However, there is currently not required training for all faculty.

The history of racism in the medical field is not embedded into the curriculum, nor is the concept of race as a sociopolitical construct. However, faculty do attribute the prevalence of certain diseases (most often congenital) to the region of

ancestral/familial origin as opposed to race. There is also sparse, but consistent, mention of the influence of socioeconomic factors on health and access to health through case studies that are a required part of the curriculum as well as through required class sessions. However, race is not often explicitly tied into the discussion of who has access to health and why.

The School of Medicine is currently undergoing curriculum reform and URM students are volunteering their time to help administration in their reform efforts. Community members have been involved in reforming some curriculum; however, it was a student group that recruited community members, asked them to assess course material for bias and presented it to the administration which then implemented the suggested changes.

6. The medical school has a system for collecting student and faculty reports of racism and other forms of oppression, and a clear plan for follow-up when problems are reported.

- A. The above metric is fully met
- B. There is some system for collecting reports, but there is no clear follow-up after reports are made**
- C. There is no system for collecting reports

At University of Colorado, there exists an anonymous reporting system that is overseen by the Associate Dean of Diversity and Inclusion. Throughout orientation the procedures for reporting issues of discrimination and racism are outlined and are on a handout clearly defined. However, following reporting, written systematic response methods are not outlined and are at the discretion of the dean. The Office of Professionalism also investigate and addresses discriminatory behavior. Yet, there are currently no rules that specifically address consequences for individuals who engage in racist behaviors or use racist language in the school.

7. There are no racial disparities in medical students' grades or honors (including AOA election)

- A. The above metric is fully met
 - B. The school regularly evaluates whether there are racial disparities, and has developed plans to address them
 - C. There are significant racial disparities in grades and/or honors, or this information is not publicly available**
-

8. Black, Native American, and Latinx students have access to designated physical spaces, as well as support staff, including administrators, physician mentors, mental health providers, and peer counselors.

- A. The above metric is fully met
- B. There are some resources specifically designated to support students of color**
- C. There are no designated resources for students of color

The Office of Diversity and Inclusion (ODI) provides the opportunity for URM to meet via organizations such as SNMA and LMSA and offers support to them. Mental health providers are available to all students provided by the School of Medicine. The tutoring available (similar to the resources related to mental health) do not have any emphasis on URM students, elucidating a potential lack of designated resources. There are no designated physical spaces to URM students.

9. There is no hospital/campus police force, or police are used as a last resort after the failure of alternative safety structures such as peer walking escorts, restorative justice councils, and mediation. If police or security officers exist, publicly-available

data should demonstrate that they have not disproportionately stopped, arrested, or otherwise interacted with people of color.

- A. The above metric is fully met
- B. There are some programs designed to reduce reliance on police
- C. **There is a campus police force, and no evidence that they have sought to address racism in policing, or this information is not publicly available**

The University of Colorado Anschutz Campus has an active campus police force. They are required to take 2 hour long webinar on anti-racism/bias every year and are working with the Vice Chancellor of Diversity and Inclusion to develop an in-person training class to combat racism in policing. While they do publicly report annual crime statistics, there is no public information about the race of individuals who committed the crime. However, cases of racial profiling from the police have been reported by students. There are no known programs designed to reduce reliance on police. The information regarding current and potential training is not publicly available and was given by the campus police.

Additional information may be found at the following links:

- [Annual Safety Report](#)
-

10. Expectations for students' level of independence and supervision are clearly documented and are consistent across training sites (for example, students or residents are not disproportionately given the opportunity to "practice" while rotating in VA or public hospitals or while volunteering in free clinics).

- A. The above metric is fully met
- B. **Policies exist to ensure that all patients receive equally well-supervised care, but are inconsistently enforced**
- C. Students are routinely given more independence when caring for marginalized patients

CU medical students, alongside other medical professional students, provide high quality, patient centered care to marginalized patient populations at the DAWN clinic. The students are well supervised by practicing and retired preceptors. Disparities in service to these patients primarily arise due to a higher student-preceptor ratio as compared to other settings and resource limitations such as funding for tests and interpreter access.

11. At the primary teaching hospital (s), patients of color are represented in all services (including specialist services) and practices at their rate in the local population. Patients of color are not segregated in resident or student clinics.

- A. The above metric is fully met
- B. There are some efforts to promote equal access to care (e.g. Medicaid patients seen in faculty clinics)**
- C. Patient care is highly segregated, or this information is not publicly available

There is no publicly available information on racial segregation of patient care at UCHealth. Yet, in the counties included in the primary service area, 23 percent of patients rely on Medicaid, and Medicaid patients in Colorado are disproportionately Black and Hispanic (nearly 40 percent), especially in nonelderly populations. According to the Medicare Hospital Cost Report, 27% of UCHealth discharges were Medicaid patients. According to their Community Benefits Report, UCHealth is the largest provider of Medicaid services in Colorado and has set initiatives to improve access to care for Medicaid patients

Additional information may be found at the following links:

- [Medicare Cost Report](#)
 - [Colorado Health Institute Medicaid Enrollment](#)
 - [Colorado Medicare Enrollment Update](#)
 - [Community Health Needs Assessment](#)
 - [Community Benefit Report](#)
-

12. The primary teaching hospital has demonstrated a commitment to immigrant patients including multilingual signs stating that patients are welcome regardless of immigration status, and a policy of referring immigration authorities to hospital attorneys prior to any cooperation by hospital staff.

- A. The above metric is fully met
- B. The hospital has some symbolic commitment to immigrant patients (e.g. signs), but no policies explicitly protecting undocumented patients**
- C. The hospital has no public or policy commitment to immigrant patients

The UC Health system has language resources and multilingual signs. The system provides case managers and social workers to help connect patients to financial and social resources. There are non-discrimination policies against immigrants in receiving care, financial aid, and charity considerations. These commitments to immigrant populations appear symbolic, and there is much to be desired. The hospital has made no public statements or support for immigrant populations, and has no policies in place that explicitly support or protect undocumented or legal immigrant

13. All medical school staff and staff at the primary teaching hospital are paid a living wage as defined by local advocacy organizations. All full-time staff have affordable comprehensive health insurance that is accepted at the health system where they work.

- A. The above metric is fully met
- B. N/A
- C. Some staff earn less than a living wage and/or do not have access to comprehensive health insurance, or this information is not publicly available**

The University of Colorado provides all employees with options for health insurance coverage and has robust mechanisms in place to correct for any wage discrepancies that may exist. Specific salaries in each department are available through an internal search tool, although they are de-identified, which makes it difficult to assess.

Comprehensive data on all staff and contract workers is not readily accessible and needs to become more transparent in order to see if any inconsistencies are present or if any workers are earning below living wage.

14. IRB approval process requires any research that uses race to include precise definitions of race and how it is being used in the research project. People of color are clearly identified as being a "vulnerable population" for research purposes, and IRB policies outline strategies to protect people of color from abusive practices.

- A. The above metric is fully met
- B. IRB process requires researchers to explain their use of race**
- C. IRB process has no requirements regarding the treatment of race, or this information is not publicly available**

The University of Colorado and University Hospital operate under the oversight of COMIRB (Colorado Multiple Institutional Review Board) for the approval and publication of clinical research. This institution has oversight over many other Colorado hospitals and institutions. After consulting with the Technology Transfer Office (TTO) at CU, it is apparent that there are no requirements within COMIRB ethical guidelines that require publishing entities to define race or their use/understanding of race as it pertains to their research. In addition, COMIRB's ethical criteria do not include any language that protect participants of color. Their guidelines do focus on the protection of human welfare per HIPAA. Patient privacy and consent appear to be the greatest points of consideration in the COMIRB ethical criteria. Participant selection on the basis of race is permitted for clinical trials in phases I-III.

Additionally, CU School of Medicine takes no active measures to ascertain diverse inclusion in their clinical research and hold no parameters which require studies to include diverse biologies and identities (sex, genetic place(s) of origin, age, gender/sexual identity, ability).

University of Miami Miller School of Medicine

This section provides further detail on each metric for University of Miami Miller School of Medicine is an allopathic medical school located in Miami, FL. Primary teaching hospitals include: Jackson Memorial Hospital, UHealth, and the Miami VA Health Care System.

Each metric (numbered 1-14 in the truncated report card) includes the full metric prompt, the grade for the institution, and an explanation of what that grade represents. Below each metric, we provide any relevant links to sources.

1. Medical school students are at least 13% Black, 1% Native American, and 17% Latinx (corresponding to the share of these groups in the U.S. population).

- A. All URM groups are proportionately represented among students
- B. Some URM groups are proportionately represented among students
- C. No URM groups are proportionately represented among students**

The AAMC collects [racial and ethnic characteristics of enrolled medical students](#) in 2018-2019. For Miller:

- Black 7% (national pop. is 13%, Miami is 18% black)
 - 60/851
- Native American: 0%
 - 0/851
- LatinX: 10.6%; (national population is 17%; Miami is 69%)
 - 91/851

In addition to URM's,

- 23.3% Asian , Native Hawaiian or Other Pacific Islander
 - 199/851
- 44.2% white
 - 376/851
- 2.1% Other
 - 18/851
- 10.3% Multiple race/ethnicity
 - 88/851
- 1.4% unknown
 - 12/851

2. Medical school faculty are at least 13% Black, 1% Native American, and 17% Latinx (corresponding to the share of these groups in the U.S. population).

- A. All URM groups are proportionately represented among faculty
- B. Some URM groups are proportionately represented among faculty**
- C. No URM groups are proportionately represented among faculty

Racial demographic information was acquired from the Office of Diversity and Inclusion and is based off of a powerpoint titled “GME Diversity Data.” The proportions of American Indian and Black medical school faculty do not correspond with the proportions of these groups in the US population. Furthermore, no underrepresented group of medical school faculty is represented in the same proportions that are found in Miami-Dade County. While Miami-Dade County is 18.2% Black, medical school faculty are 3% Black. While Miami-Dade County is 68.8% Latinx, medical school faculty are 29% Latinx.

Medical Faculty racial/ethnic characteristics (2018):

- American Indian: 0%
- Black: 3% (national pop. is 13%, Miami is 18% black)
- Latinx (no race included): 29% (national pop. is 17%, Miami is 69% black)
- Asian: 16%
- White (non-Hispanic): 49%

Active Medical Faculty Gender Characteristics (2018):

- 64% Male
- 36% Female
- 1416 total - not including adjunct, emeritus, instructors, lecturers, and voluntary.

Race/Ethnicity information for JMH Residency Programs (2018):

- 7.7% Black
- 17% Asian
- 27% Hispanic
- 35% White

3. The physical space of the medical school acknowledges the contributions of alumni and other physicians of color (through plaques, statues, portraits, and building names) and does not celebrate racist or white supremacist individuals.

- A. The above metric is fully met

- B. **There are no items celebrating racist/white supremacist individuals, and also none celebrating people of color (the physical spaces at Miami celebrate people of color, as well as some oppressive/white supremacist individuals)**
- C. The physical space explicitly celebrates racist/white supremacist individuals

The medical education building at the University of Miami's medical campus is named the Rosenstiel Medical Sciences Building. Lewis Rosenstiel was a founder of a major liquor corporation, Schenley Industries. With his wealth and social network, he [co-founded](#) the American Jewish League Against Communism (AJLAC). The AJLAC campaigned against ideological freedom and specifically [arranged](#) the blacklisting of entertainers through the right-wing [Red Channels](#) publication. Rosenstiel [was also](#) close friends with FBI Director, J. Edgar Hoover. Hoover was director of the FBI from its founding in 1937 to his death in 1972. He directed the Counter Intelligence Program (COINTELPRO) that infiltrated, discredited, and disrupted activists of the Civil Rights Movement. Its efforts targeted the Black Panthers, the Young Lords, the American Indian Movement, the Nation of Islam, and more. Hoover's COINTELPRO is known for its targeting of Martin Luther King Jr. through wiretaps, bugs, and smear campaigns.

Lewis Rosenstiel was a principal contributor to the J. Edgar Hoover Foundation— with [donations](#) amounting to over a million dollars. The [purpose](#) of the Hoover Foundation, as written in its charter, is “to safe-guard the heritage and freedom of the United States of America and to promote good citizenship through the appreciation of its form of Government and to perpetuate the ideas and purposes to which the Honorable J. Edgar Hoover has dedicated his life.” The ideas and purposes to which Hoover dedicated his life were explicitly and incontestably white supremacist. Through his support of FBI Director J. Edgar Hoover and his co-founding of the right-wing American Jewish League Against Communism, Lewis Rosenstiel upheld white supremacy and impeded freedom of others.

With this in mind, there are some forms of physical recognition for physicians of color. There is a display on the first floor of Jackson Hospital that recognizes several Black leaders of healthcare in Miami-Dade County. In addition, student programming has recognized and given platforms to Black and Latinx leaders. The University and its students would benefit from statues, portraits, and building names that acknowledge the contributions of American Indian, Black, and Latinx medical leaders.

4. The medical school's recruitment policies promote racial justice. The medical school application does not inquire about the applicant's criminal history. The medical school recruits and admits undocumented students and students of color who attended public high schools in the county or state where the medical school is

located. Students of color who participate in recruitment are compensated for their time.

- A. The above metric is fully met
- B. Some elements of the metric are met**
- C. No elements of the metric are met

The UMMSM's Office of Diversity and Inclusion (ODI) organizes several programs to recruit and retain students of color. These programs involve early exposure to careers in medicine, supplemental instruction to prepare for the medical college admission test, and related application support. One such program, the Minority Students in Health Careers Motivation Program (MSHCMP) specifically recruits underrepresented racial/ethnic groups and provides a seven-week residential experience to strengthen individuals' competitiveness for admission to medical schools. Administrators would benefit from allocating more resources in order for the ODI to provide an comprehensive analysis of the effectiveness of this program, and others, to measure how well it prepares students for medical school admissions. Data regarding program participants' matriculation to the UMMSM is also needed.

UMMSM Future Medical Scholars Fellowship Program:

- [High School Careers in Medicine Workshop](#)
- [Minority Students in Health Careers Motivation Program](#)
- [Medical College Admission Test \(MCAT\) Prep Program](#)

Future partnerships between the undergraduate campus and the medical campus may prove meaningful in fulfilling this metric. The areas for potential support are described in this quote by a student: "The way the pre-health office [on the undergraduate campus] functions and limitations it puts on students to be able to apply for a committee letter is that they require many hours of shadowing physicians, something that as a college student is highly dependent on who you know and who will allow you to shadow. It places an advantage for students who have parents, relatives, and other connections who are already physicians or otherwise in the medical field. So local Miami minorities look elsewhere before they look at UM thinking they have better shots other places (which is reinforced by our demographic numbers). Then the number accepted vs number that attend drops because courting efforts fall and again as a student you see the numbers of URM students and decide not to come if you have other options. It's hard to attract people to a place like this. Even with their efforts in high schools in Miami it's like you have to build a place ready to attract and receive minorities and they aren't doing that"

Regarding Legal Status:

The Miller School of Medicine Admissions FAQ (<http://admissions.med.miami.edu/questions>) in response to whether or not they accept international students: “No. Applicants must be US citizens, DACA students, or unconditional permanent residents of the US with an alien registration receipt (green) card in their possession when they fill out the AMCAS application. DACA applicants will need to submit a copy of their Notice of Action and an employment authorization card.” There does not seem to be any other information made available on the website that addresses prospective students regarding immigration.

The University of Miami and the Miller Medical School does admit Dreamers who have legal status through the Deferred Action for Childhood Arrivals policy. This information was also acquired through the “GME Diversity Data” powerpoint provided by the Office of Diversity and Inclusion. It is unclear whether financial support is provided for undocumented and DACA recipients enrolled at the University of Miami Miller School of Medicine. The University of Miami has a [UDreamers Program](#) in which “exceptional and academically accomplished” DACA students are eligible for 100 percent of their financial need to be met. However, this program is only available for first-year undergraduate applicants who graduated from high school in Florida. The Office of Admissions should join the lead of other medical schools, like [Yale](#) School of Medicine, that take a firm position against the denial of an education based on legal status. Financial support for these students should be comprehensive and clearly outlined on the school’s website. Finally explicit policies protecting students from Immigration and Customs Enforcement agents are not found. Despite a recent viewpoint in [JAMA](#) that encourages the concept of Sanctuary Hospitals, there is no explicit policy at the University of Miami’s Miller School of Medicine.

Students of color who participate in recruitment are not compensated for their time. This concern is a theme that appears across several metrics in the report card.

Note on Medical School Admissions Breakfasts and Lunches:

The UMMSM implements “diversity breakfasts and lunches” to attract URM applicants. Students report that these breakfasts and lunches allow for more intimate and vulnerable conversations to take place among URMs. However, multiple students, including admissions ambassadors, report non-voting members of the admissions committee sitting in on lunches and making insensitive racial comments including a joke about racial segregation and the different MD vs MD/MPH curricula. The Office of Admissions should enforce a **strict** policy barring members of the admissions committee from attending the entire duration of diversity breakfasts and lunches.

This will assist in cultivating a safe and backlash-free environment. Furthermore, diversity breakfasts and lunches should be better advertised by the Office of Admissions in the student lounge and over email. The burden of recruiting URM students to meet with URM interviewees falls on student organizations. Institutional problems must be addressed by the institution, and not just the URM students within it. Finally, diversity lunches and breakfasts must be explicitly advertised as events for URM medical students, as URM medical students report that white admissions ambassadors frequently attend the events for the purpose of acquiring free food. This indicates a disturbing sense of entitlement and diminishes the effectiveness of these recruitment strategies.

5. The curriculum incorporates information about the history of racism in medicine, intersectional oppression, and racial justice strategies, and explicitly addresses the fact that race is a social construct, not a biological one. Lecturers avoid describing race per se (rather than racism) as a risk factor for disease, cause of health disparities, or basis for diagnostic reasoning. Community advocates and students who are underrepresented in medicine are incorporated in the planning and leadership of the pre-clinical curriculum.

- A. The above metric is fully met
- B. Some elements of the metric are met**
- C. The curriculum fails to adequately address racism in medicine. Race is stated or implied to be biological. Community advocates and URM students do not participate in planning or are not compensated for their time

There is no publicly available information/curriculum that indicates that race is biological. However, this is enforced on an individual (and inconsistent) basis. Certain professors are very conscious about acknowledging race as a social category. Many state race is a biological construction without further discussion or interrogation of their statement. Race is frequently described as a risk factor for disease. There is no baseline training for faculty members to better understand the construction and implications of race, and there is no policy requiring that race be defined as a social construction.

Exam questions in numerous courses have been reported by students for racial signifiers and offensive posturing. A systematic review of courses and exams for racism is desperately needed but is not an institutional priority. Furthermore, guest lecturers who have been invited by faculty have implied and explicitly stated that

racial/ethnic minorities engage in cultural diets that lead to poorer health outcomes. Future guest lecturers should be closely screened and observed to prevent this from recurring.

An event regarding racial disparities in maternal mortality during Black History Month devolved when the Chair of OB/GYN Department stated that there is a genetic basis for racial disparities in maternal health. The University and its OB/GYN department is in need of a comprehensive professional development workshop regarding racism and its manifestations in Obstetrics and Gynecology. Guest speakers, researchers, and experts in this field should be invited, and events should be well publicized and open to the public.

The University is currently engaging in a major reconstruction of its curricula, but infrastructure to prevent the reproduction of racism in the curriculum is nonexistent. The Associate Dean for Graduate Medical Education, Dr. Joan St. Onge, verbally committed to an audience at a grand rounds to involving the voices of minority medical students, staff, and faculty in the redevelopment of the curriculum. She responded favorably to the request of the lecturer, Dr. Camara Jones, that there be a committee on anti-racism. However, her commitment was purely rhetorical and did not include any material development despite repeated inquiries from students, staff, and faculty. The university should immediately implement an anti-racism committee to oversee this process.

Published information from the school:

VOLUNTARY ATTENDANCE (not for all faculty and students)

[Diversity Training and Services](#) via the Office of Diversity and Inclusion:

- Safe Space (available to any requests throughout medical school: faculty/staff/residents/medical students); have [list of faculty who have been trained](#) as of 5/11/15
- Cultural Intelligence (medical residents only at this moment)
- Jay Weiss Institute's Health Equity Pathway (application-only for students)

Student-led training and discussion events are described in press releases, and the [website](#) details events from 2010 through January 2016. (SNMA, HAMSA, Cultural Awareness Week etc)

URM students are often involved in planning and leadership of sessions on community health and health disparities. The input of URM students has resulted in student-led lectures and additional focuses on health disparities. However, community advocates not often involved and there is not an institutional policy

encouraging partnerships with local organizations. When there's collaboration with someone from the community, administration is rarely involved; it is almost entirely student-dependent, and there are additional logistical hurdles to be circumvented by the student organizers. Furthermore, community events cannot be held in medical school spaces-- further maintaining a physical and ideological gap between the medical school and the surrounding

MANDATORY ATTENDANCE FOR MEDICAL STUDENTS

Information is not publicly available; from syllabi

In the medical school curriculum, there are a few optional lectures, courses, or trainings about the history and ongoing presence of racism in medicine. There are presently two lectures for first year medical students: Race, Gender, and modern medicine and Research, Disability, Eugenics. Attendance is not enforced.

6. The medical school has a system for collecting student and faculty reports of racism and other forms of oppression, and a clear plan for follow-up when problems are reported.

- A. **The above metric is fully met**
- B. There is some system for collecting reports, but there is no clear follow-up after reports are made
- C. There is no system for collecting reports

The medical school has a robust system for collecting student and faculty reports of racism and other forms of oppression, a system that they continuously work on in order to make more effective. The medical school uses two reporting systems. For learner's mistreatment, the medical school uses Cane Watch, which relies on a partnership with a third party incident management system called EthicsPoint. They have publicly available policy [on this system](#) and related procedures. Their policy includes a clear plan for follow-up when problems are reported. For non-learner's mistreatment, the school has a Professionalism Incident Reporting System that gathers data and provides feedback on professional behavior to students, faculty, residents, and staff. This [system](#) is available online and through a 24 hours mistreatment reporting hotline.

Despite meeting this metric, however, students feel that the quality of follow-up and restorative justice are not always satisfactory. There lacks transparency with the student body on incidents that occur that could potentially impact student perception

and wellness. Incident reports are neither publically accessible nor summarized with private information redacted. There is a lack of transparency with the student body on incidents that occur that could potentially impact the student population's wellness. For safety and awareness, students should be aware of incidents that are reported in their medical school. The inaccessibility of these reports prevents transformation of the climate and takes a "bad-apple" approach to issue of race, gender, sexuality, and more. The reporting systems should be modified to collect data regarding more nuanced types of discrimination. Upon identification of the basis of the discrimination (racial, gendered, sexuality, etc), the quantities and respective proportions of these incidents will be elucidated and will inform future interventions.

7. There are no racial disparities in medical students' grades or honors (including AOA election)

- A. The above metric is fully met
- B. The school regularly evaluates whether there are racial disparities, and has developed plans to address them
- C. **There are significant racial disparities in grades and/or honors, or this information is not publicly available**

The webpage for the [Miller AOA Honor Medical Society](#) does not report racial demographics of AOA selection, nor does it have a statement of non-discrimination or proactively addressing recent (2017) findings about AOA discrepancies by race. There is no public data that indicates that the school regularly evaluates whether there are racial disparities in grades or honors.

8. Black, Native American, and Latinx (URM) students have access to designated physical spaces, as well as support staff, including administrators, physician mentors, mental health providers, and peer counselors.

- A. The above metric is fully met
- B. **There are some resources specifically designated to support students of color**
- C. There are no designated resources for students of color

There are currently no designated physical spaces for underrepresented students, but the school is considering a new space in the near future. Support staff such as administrators, physician mentors make themselves available to URM students and this is publicly available information on the [website of diversity and inclusion](#).

Although informal and advertised systems exist in the school, there is no publicly available information on mental health providers and peer counselors especially trained and with the explicit function to support URM students. There are mental health providers available on a limited basis, a few days a week, on the medical campus. Mental health support on campus is not readily available on a walk-in basis. Students seeking long-term care are [encouraged](#) to seek counseling off-campus. Students report long waits for appointments, referrals to main-campus counseling, and inadequate quality of support. Students also report carrying the burden of mental health programming for their peers. A student-run Wellness Advisory Committee is responsible for organizing an annual [wellness week](#) that began in 2017. Some mental health programming is also led by the Student Government of the medical school.

The university is currently launching the Interactive Screening Program -- an online counseling service to help students identify anxiety, depression, and other concerns. There is a need for rigorous public evaluation of the services provided.

A nearby public medical school, Florida International University, [advertises](#) four clinical psychologists available to medical students. Furthermore, there is a full-time program specialist and a centralized Medical School Counseling and Wellness Center to facilitate psychological assessments, counseling services, and more.

9. There is no hospital/campus police force, or police are used as a last resort after the failure of alternative safety structures such as peer walking escorts, restorative justice councils, and mediation. If police or security officers exist, publicly-available data should demonstrate that they have not disproportionately stopped, arrested, or otherwise interacted with people of color.

- A. The above metric is fully met
- B. There are some programs designed to reduce reliance on police
- C. There is a campus police force, and no evidence that they have sought to address racism in policing, or this information is not publicly available**

The University of Miami Medical Campus Department of public safety at UHealth system, including Miller School of Medicine; Crime logs, which are updated through March 2018, indicate that the majority of their non-interrogative (i.e. meeting with a patient who reported something stolen or a driver in an accident on campus) interactions are with perceived or reported “trespassers”, with most descriptions involving “homeless” or “vagrants”; most descriptions that involved “homeless” or “vagrant” descriptors involved campus security asking the individual to leave, escorted off the premise, or based on medical conditions, taken for care at the

hospital. None of their crime logs include publicly available data about racial demographic of their safety force or of their interactions.

The University of Miami Medical Campus Department of Public Safety does not have publicly available data indicating that they have sought to address racism in policing. Their [Medical Campus Public Safety Policy](#) approved by their Director was last reviewed/ revised on 09/21/2015. It does not address any forms of discrimination, especially those of racial or ethnic motivation. Furthermore, the medical campus involves multiple security corporations and policing agencies. There is not a collaborative statement defining them, outlining their respective responsibilities, and collectively committing to a focus on racial justice.

The [Annual Safety Report](#) for 2018 - 2019 reports zero incidents of stalking on the Miller School Campus for 2015, 2016, and 2017. However, several incidents of [stalking](#) as well as harassment at the medical school were given national attention in 2018 and resulted in legal action. It is unknown why these incidents were not included in this report. One victim of such stalking is quoted saying "I felt violated. I felt harassed. I felt targeted... There were pictures of me with my full name on my white coat where I go to school every day."

There is an absence of restorative justice councils and other forms of accountability that do not involve policing. Existing data has not been categorized by race to allow for analyses that could identify disproportionate policing targeting people of color.

Notably, an internal, currently unpublished diversity survey of all Jackson Memorial / Miller School of Medicine faculty, staff, and students reveals that the majority of respondents feel respected by police and security force on campus. However, 5.5% do not feel that police and security are professional and respectful. It has not been explored the reasons for this disagreement and whether this dissatisfaction is disproportionately reported by POC faculty, staff and students.

10. Expectations for students' level of independence and supervision are clearly documented and are consistent across training sites (for example, students are not disproportionately given the opportunity to "practice" while rotating in VA or public hospitals or while volunteering in free clinics).

- A. The above metric is fully met
- B. Policies exist to ensure that all patients receive equally well-supervised care, but are inconsistently enforced
- C. **Students are routinely given more independence when caring for marginalized patients**

Students are routinely given more independence when caring for marginalized patients in health fair settings. Students report inadequate training prior to health fairs; on-the-job training of specific medical exams such as pap-smears has been reported. Students are more closely supervised by medical providers at training sites located on campus. There is no publicly available information regarding physician to student ratios at different training sites.

The university should support an independent rigorous analysis of the Department of Community Services (DOCS) and its relationship with the local Miami community. Racial disparities between DOCS members and patients, compounded with poor supervision and less rigorous training requirements, implicates an exploitative racialized relationship between the university and the local community. Furthermore, DOCS practices an “apolitical” position that bars advocacy for healthcare policy change to occur at fairs and clinics. This “apolitical” nature is not at all apolitical and instead is an active commitment to existing healthcare policies and disparity-creating structures. The absence of an advocacy arm of DOCS reproduces a local dependency on health fairs-- thus ensuring that DOCS will have desperate patients for years to come.

11. At the primary teaching hospital, patients of color are represented in all services (including specialist services) and practices at their rate in the local population. Patients of color are not segregated in resident or student clinics.

- A. The above metric is fully met
- B. There are some efforts to promote equal access to care (e.g. Medicaid patients seen in faculty clinics)**
- C. Patient care is highly segregated, or this information is not publicly available

Jackson Health System is the public hospital system that serves Miami-Dade. It has [more uninsured patients](#) than any other hospital system in the state of Florida. Through its Jackson Prime Card and Jackson Clinic Card, specialist services are more widely available to uninsured and low-income patients of color. Nonetheless, [administrative complaints](#) have been filed with the IRS and the Department of Health and Human services due to a time-consuming application process, a three month delay to schedule appointments, and unfair billing practices affecting patients with incomes below poverty.

Racial/ethnic demographics of patients in different clinics and specialty services are not publicly available.

12. The primary teaching hospital has demonstrated a commitment to immigrant patients including multilingual signs stating that patients are welcome regardless of immigration status, and a policy of referring immigration authorities to hospital attorneys prior to any cooperation by hospital staff.

- A. The above metric is fully met
- B. The hospital has some symbolic commitment to immigrant patients (e.g. signs), but no policies explicitly protecting undocumented patients
- C. The hospital has no public or policy commitment to immigrant patients**

There is an absence of a policy that outlines repercussions for xenophobic comments. Students report overhearing statements in the hospital by medical staff encouraging the construction of a border wall. Anonymous reporting through the Canewatch system is reported to be ineffective.

Communication with the University of Miami's General Counsel indicates that the policy of the university is to withhold information from Immigration and Customs Enforcement (ICE) or Customs and Border Protection (CBP) officers unless a court order or properly served subpoena is provided to the General Counsel. Agents seeking information and patient records in Jackson facilities must serve court orders or subpoenas upon Jackson. Staff members should contact (305)-284-2700 to communicate with the UM general counsel, or staff should direct the agents to contact the office directly. This protocol is not well known throughout the medical school or university hospitals and clinics. Institutionalized training regarding interactions with ICE or CBP should be conducted with all staff, faculty, and students. This is especially warranted with the growing presence of immigration authorities in the US and the Miami area.

There is no explicit public policy that protects immigrant patients from Immigration and Customs Enforcement (ICE) or Customs and Border Protection (CBP) officers. Multilingual signs welcoming patients of all immigration statuses do not exist. Given the documented and well-researched implications of xenophobia on health outcomes, there is justification for physical displays that outline policies regarding legal status and immigration authorities.

13. All medical school staff and staff at the primary teaching hospital are paid a living wage as defined by local advocacy organizations. All full-time staff have comprehensive health insurance that is accepted at the health system where they work.

- A. The above metric is fully met
- B. N/A
- C. Some staff earn less than a living wage and/or do not have access to comprehensive health insurance, or this information is not publicly available**

Local advocacy organizations do not have not defined a living wage in the Miami area, and full-time staff wages and health insurance benefits are not publically available.

14. IRB approval process requires any research that uses race to include precise definitions of race and how it is being used in the research project. People of color are clearly identified as being a "vulnerable population" for research purposes, and IRB policies outline strategies to protect people of color from abusive practices.

- A. The above metric is fully met
- B. IRB process requires researchers to explain their use of race
- C. IRB process has no requirements regarding the treatment of race, or this information is not publicly available**

The University of Miami IRB website has a [Human Research Protection Program Plan](#) (sept. 4, 2014) that does not, in the entire document, explicitly mention protections against the use of race in a research project. The UM IRB adheres to national IRB standards and has the statement across most IRB sites: "the fairness and equitability of the inclusion of individuals according to race, ethnicity, gender, and age"; However, the [University of Miami Human Subjects Research Office](#) has no specific and explicit policies restricting or questioning the treatment of race in research projects.

The IRB website for the institution includes [pamphlets](#) for Black and Latinx potential research participants (in English and in Spanish) that provide protection for such participants.

Their [available Guidance Documents and Policies](#) do not directly address the use of race in research.

Although CITI training may address such issues, this is outsourced training. University of Miami IRBs may question the use of race in a research project, but it is not publicly known if this is a mandatory explanation that the IRB review process must undertake every time race is used.

University of Michigan School of Medicine

This section provides further detail on each metric for the University of Michigan Medical School (UMMS), which is an allopathic medical school located in Ann Arbor, Michigan. The primary teaching hospitals are the University of Michigan Health System hospitals, including University Hospital, C.S. Mott's Children's Hospital, and Vonn Voigtlander Women's Hospital.

Each metric (numbered 1–14 in the truncated report card) includes the full metric prompt, the grade for the institution, and an explanation of what that grade represents. Below each metric, we provide any relevant links to sources.

Of note, student groups at the University of Michigan were contacted in order to lead the updated evaluation of University of Michigan. After no response, the grading for this school was completed by National Racial Justice Report Card committee members using publicly available data.

1. Medical school students are at least 13% Black, 1% Native American, and 17% Latinx (corresponding to the share of these groups in the U.S. population).

- A. All URM groups are proportionately represented among students
- B. Some URM groups are proportionately represented among students
- C. No URM groups are proportionately represented among students, or this information is not publicly available**

Per the AAMC, the racial demographics of University of Michigan School of Medicine Students during the 2018–2019 Academic Year is as follows¹⁰:

- African American / Black – 6.1%
- Latinx – 4.2%
- Native American – 0.25%

¹⁰ For all schools, the percentage of URM students was calculated based on the numbers of Black, Latinx, and Native American students as documented by the Association of American Medical Colleges. Using a different methodology, University of Michigan states that 6.5% of current students are Black, 7.8% are Latinx, and 0.5% are Native American/Native Hawaiian.

Black students represent 6% of enrolled medical students at University of Michigan, up from 4% last year. There was no significant change in Latinx and Native American enrollment from the 2018 to 2019 report.

UMMS reports the following student demographics for the 2018–2019 school year: 7.2% Black, 8.6% Latinx, and 0.25–1% Native American. Five students fell into two categories and were counted twice.

Additional information may be found at the following links:

- [UM-UHR: Demographic Trends](#)
 - [Diversity, Equity & Inclusion Year 2 Plan](#)
 - [AAMC Medical School Enrollment by Race & Ethnicity](#)
 - [Table B-5.1: Total Enrollment by U.S. Medical School and Race/Ethnicity, 2018–2019](#)
-

2. Medical school faculty are at least 13% Black, 1% Native American, and 17% Latinx (corresponding to the share of these groups in the U.S. population).

- A. All URM groups are proportionately represented among faculty
- B. Some URM groups are proportionately represented among faculty
- C. **No URM groups are proportionately represented among faculty or this information is not publicly available**

The percentages below reflect the demographics of University of Michigan School of Medicine Faculty from 2017:

- African American / Black – 4%
- Latinx – 4%
- Native American – 0.5%

Additional information may be found at the following links:

- [UM-UHR: Demographic Trends](#)
 - [Diversity, Equity & Inclusion Year 2 Plan](#)
-

3. The physical space of the medical school acknowledges the contributions of alumni and other physicians of color (through plaques, statues, portraits, and building names) and does not celebrate racist or white supremacist individuals.

- A. The above metric is fully met**
- B. There are no items celebrating racist/white supremacist individuals, and also none celebrating people of color
- C. The physical space explicitly celebrates racist/white supremacist individuals

One of the four medical school houses is named after the school's first African-American graduate. Other large donors after whom buildings are named appear to have made commitments to racial justice (e.g. C.S. Mott, a white donor, has a foundation which is dedicated to, among other things, fighting structural racism).

In March 2018, the University of Michigan Board of Regents voted to rename a campus science building that honors former university president, C.C. Little -- a eugenics proponent and anti-immigrant spokesman during his lifetime. The building is not directly located on the medical campus.

Additional information may be found at the following link:

- [Fitzbutler House](#)
 - [Ending Honors for Racists](#)
-

4. The medical school's recruitment policies promote racial justice. The medical school application does not inquire about the applicant's criminal history. The medical school recruits and admits undocumented students and students of color who attended public high schools in the county or state where the medical school is located. Students of color who participate in recruitment are compensated for their time.

- A. The above metric is fully met
- B. Some elements of the metric are met**
- C. No elements of the metric are met

The Office of Health Equity and Inclusion (OHEI) Leaders and Learners Pathway coordinates recruitment and pipeline activities. In 2017-2018, these recruitment activities included visits to six HBCUs and five national conferences of URM organizations. The Pathways unit also has several pipeline programs to prepare students of color for medical school, including the Michigan Health Sciences Summer Institute, the Michigan Health Sciences Pre-College Exposure Academy, the Michigan Health Sciences Undergraduate Research Academy (MHSURA), and the Michigan Health Sciences Career Development Academy (MHSCDA). According to Pathways data, 38 (27%) of the students who have participated in the MHSURA and MHSCDA programs are currently in medical school, 56% of whom are Black. Nine of those students are enrolled in Michigan Medicine, two of whom are Black.

The University of Michigan has issued a statement of support for undocumented students, which states that “consistent with federal and state law, DACA students and those without proof of citizenship are welcome to seek admission and enrollment at U-M.” Moreover, the medical school explicitly encourages applications from DACA students and states its willingness to provide undocumented students with institutional loans to facilitate their enrollment in medical school. UMMS currently reports having at least 5 DACA students.

University of Michigan states that URM student groups that participate in recruitment receive \$7,500 annually, but this funding is presumably used for general activities of the group and is not compensation for recruitment. Medical students who participate in recruitment activities are reimbursed for their travel and other expenses. UMMS

reports compensating students who participate in recruitment but details were not provided.

Additional information may be found at the following links:

- [Educational Programs](#)
- [Undocumented Students](#)
- [Message: INTERNATIONAL AND UNDOCUMENTED STUDENTS AT U-M](#)
- [MD Admission Requirements](#)

5. The curriculum incorporates information about the history of racism in medicine, intersectional oppression, and racial justice strategies, and explicitly addresses the fact that race is a social construct, not a biological one. Lecturers avoid describing race per se (rather than racism) as a risk factor for disease, cause of health disparities, or basis for diagnostic reasoning. Community advocates and students who are underrepresented in medicine are incorporated in the planning and leadership of the pre-clinical curriculum.

- A. The above metric is fully met
- B. Some elements of the metric are met**
- C. The curriculum fails to adequately address racism in medicine. Race is stated or implied to be biological. Community advocates and URM students do not participate in planning or are not compensated for their time

Unconscious bias training is mandatory for the Medical School Admissions Committee, all first-year students, Doctoring faculty, and Standardized patients, but is optional for other faculty. The 2018 Diversity, Equity and Inclusion Report notes that these education programs are in the process of being expanded to cover a greater breadth of topics, but it is unclear if it will be mandatory for all faculty. First year faculty undergo inclusive language training.

First year students receive a session on “Racial Preferences and Prejudices in Medicine” in their Doctoring course, which includes among its objectives: “Consider the historical impact of racism in health care delivery, medical resource allocation and

patients' attitudes toward the medical establishment.” The Doctoring course also includes sessions on “Health Disparities,” “Bias,” and “Stigma,” although these do not include specific reference to race or racism among their objectives. Global Health coursework for medical students includes discussion of “Disparities,” although the objectives of these sessions contain no mention of racism, colonialism, or imperialism. The objectives for the discussion of the Tuskegee syphilis experiments in the Leadership and Health Systems course likewise do not include any specific mention of racism.

Medical students receive some training in the history of racism, but appear to have little exposure to teaching on the ongoing presence of racism in medicine, intersectional oppression, or anti-racism strategies. Faculty likewise do not uniformly receive such training.

There is some discussion of the “historical impact of racism in healthcare delivery” and the Tuskegee syphilis experiments. The Interprofessional Clinical Experience provides students with an opportunity to discuss the structural barriers to care that may contribute to health disparities. Moreover, as a part of their first year Doctoring course, medical students are assigned to watch Dorothy Roberts' TEDMED 2015 talk, [“The problem with race-based medicine.”](#) It does not appear, however, that there is additional discussion about the sociopolitical (i.e. non-biological) nature of race. The University of Michigan has provided a policy document, “Respectful Language: Creating Inclusive Learning Environments,” which provides medical school faculty with guidelines on language to use in their lectures. These include “people first” language and avoiding “assumptions and judgments” but make no mention of how lecturers should discuss or refer to race and its role in health and disease; it is therefore likely that, following standard medical practice, many lecturers imply that race is biological, for example by stating that it is a risk factor for disease.

URM and other students are members of the newly formed Inclusivity Steering Committee, which is charged with evaluating ways to incorporate social justice issues and health disparities into the curriculum. URM students and community members also serve on curricular, admissions, and promotions committees. Community Engagement Projects are an important part of the student-led Health Equity Scholars Program, but not all medical students participate in this program. Community members play a role in authoring the Community Health Needs Assessment and in designing health outreach projects but are not routinely involved in planning required curricular activities.

Additional information may be found at the following link:

- [Doctoring Course](#)
 - [Health Equity Scholars Program: Community Engagement Project](#)
 - [2016 Joint CHNA Report](#)
 - [RFP](#)
 - [Professional Development: Trainings](#)
 - [2018 Michigan Medicine Office for Health Equity & Inclusion Annual Report](#)
-

6. The medical school has a system for collecting student and faculty reports of racism and other forms of oppression, and a clear plan for follow-up when problems are reported.

- A. The above metric is fully met**
- B. There is some system for collecting reports, but there is no clear follow-up after reports are made
- C. There is no system for collecting reports

The Office for Institutional Equity has a clear protocol for filing and following up on complaints of discrimination or harassment, including mistreatment on the basis of race or ethnicity. There is also a campus Bias Response Team that publicly documents bias incidents and institutional responses to the incident.

Additional information may be found at the following links:

- [Discrimination & Harassment Resolution Process](#)
- [Filing a Complaint](#)
- [How to Get Help](#)
- [Prohibited Forms of Discrimination and Harassment](#)

- [Bias Incident Report Log](#)
 - [Policy 201.35: Non-Discrimination](#)
 - [Learning Environment Statement](#)
 - [Medical Student Mistreatment Policy](#)
-

7. There are no racial disparities in medical students' grades or honors (including AOA election).

- A. The above metric is fully met
- B. The school regularly evaluates whether there are racial disparities, and has developed plans to address them
- C. There are significant racial disparities in grades and/or honors, or this information is not publicly available**

There is no publicly available information on whether disparities exist in AOA membership or grades at University of Michigan Medical School. There is no evidence that the medical schools has evaluated for the existence of such disparities. UMMS reports that it is currently doing research on racial disparities in medical student selection for AOA. The school also reports that its Curriculum Policy Committee is launching a workgroup to review grading policies.

Additional information may be found at the following link:

- [Article: Racial Disparities in Medical Student Membership in the Alpha Omega Alpha Honor Society](#)
 - [AOA Michigan Medicine Student Organization Page](#)
-

8. Black, Native American, and Latinx (URM) students have access to designated physical spaces, as well as support staff, including administrators, physician mentors, mental health providers, and peer counselors.

- A. The above metric is fully met
- B. There are some resources specifically designated to support URM students**
- C. There are no designated resources for URM students

The Office of Health Equity and Inclusion (OHEI) coordinates support for URM students, including academic coaching, wellness initiatives, workshops, and lecture series. The OHEI has two dedicated faculty mentors and multiple staff members, as well as a dedicated physical space for URM medical students. All medical students have access to confidential mental health services, but there are no specific mental health services for URM students, and no formal peer mentoring programs.

The Health Equity Scholars Program reports progress in fostering peer mentorship among its program member students. However, this program is not mandatory for all medical students and does not mention specific peer mentorship among URM students.

Additional information may be found at the following link:

- [Office of Healthy Equity and Inclusion](#)
- [Health Equity Scholars Program](#)

9. There is no hospital/campus police force, or police are used as a last resort after the failure of alternative safety structures such as peer walking escorts, restorative justice councils, and mediation. If police or security officers exist, publicly-available data should demonstrate that they have not disproportionately stopped, arrested, or otherwise interacted with people of color.

- A. The above metric is fully met
- B. There are some programs designed to reduce reliance on police**
- C. There is a campus police force, and no evidence that they have sought to address racism in policing

As noted above, University of Michigan has a Bias Response Team that facilitates responses to incidents without law enforcement involvement in some cases. In addition, there is a campus Police Department Oversight Committee composed of students, faculty, and staff, and a Student Advisory Board. Non-university-affiliated community members are not included in these oversight structures. There is no evidence that there have been explicit attempts to address racism in policing.

Additional information may be found at the following links:

- [Police Department Oversight Committee](#)
 - [Police Department](#)
-

10. Expectations for students' level of independence and supervision are clearly documented and are consistent across training sites (for example, students are not disproportionately given the opportunity to "practice" while rotating in VA or public hospitals or while volunteering in free clinics).

- A. The above metric is fully met
- B. Policies exist to ensure that all patients receive equally well-supervised care, but are inconsistently enforced
- C. Students are routinely given more independence when caring for marginalized patients**

The University of Michigan has no publicly published policies on student supervision. UMMS provided the following excerpts from their policy on clinical supervision:

“It is understood that this institution is training students to become doctors and therefore, the experiences should be with that in mind. Medical student participation in the care of patients, including procedures, is at the discretion of the attending physicians and residents who are supervising the students.”

“Medical students participate in the clinical care of patients. Due to their student status, they must always be under the supervision of a licensed provider acting within their scope of practice.”

In the UM Student-Run Free Clinic (SRFC), preclinical (first and second year) medical students are permitted to take patient histories with upper level (third and fourth year) medical students acting as “peer educators.” On the UM SRFC website, there is no language explaining to potential patients the level of supervision that students receive.

By contrast, in most clinical settings, preclinical medical students are not supervised by other medical students in providing patient care. Furthermore, first year medical students participating in the Michigan Medicine Community Health Services Flu and Wellness Clinics are permitted to conduct diabetes, hyperlipidemia, and hypertension screening for vulnerable patients and are responsible for ensuring follow-up for those found to be a risk for diabetes or hypertension; however, in most clinical settings, preclinical medical students are permitted only to shadow or observe clinicians, and do not provide direct patient care.

Despite inconsistent documentation of expectations of supervision and level of independence as pre-clinical students, student competency expectations do include “Demonstrate awareness of the patient vulnerability and the inherent power differentials in organizational and interpersonal relationships and respect the boundaries that define therapeutic relationships”.

Additional information may be found at the following links:

- [UM Student Run Free Clinic](#)
- [UM SRFC Medical Student Volunteers - Info Sheet](#)
- [UM Policies and Procedures](#)
- [2019-2020 UM Medical Student Competencies](#)

11. At the primary teaching hospital, patients of color are represented in all services (including specialist services) and practices at their rate in the local population. Patients of color are not segregated in resident or student clinics.

- A. The above metric is fully met
- B. There are some efforts to promote equal access to care (e.g. Medicaid patients seen in faculty clinics)**
- C. Patient care is highly segregated or this information is not publicly available

There is no publicly available information on racial segregation of care at University of Michigan facilities. Patients with Medicaid, who are disproportionately people of color, are underrepresented at UM hospitals; while 19% of Michigan adults rely on Medicaid health insurance, only 10% of patients discharged from University Hospital in 2016 had Medicaid.¹¹

Per the University of Michigan, there are no separate trainee (resident/fellow) clinics at Michigan Medicine, and all patients are seen in attending clinics, regardless of insurance status.

The Office of Health Equity & Inclusion Annual Report does not mention any effort to systematically examine current representation of patients of color across affiliated clinical sites, nor is there mention of efforts to directly promote equal access to care.

Additional information may be found at the following links:

- [Michigan State Indicator: Health Insurance Coverage of Adults 19-64](#)
- [2017 U-M Financial Report](#)
- [\[zip file\] Health Care Information System \(HCIS\) Data File for 2010](#)
- [2018 Michigan Medicine Office for Health Equity & Inclusion Annual Report](#)

¹¹ Medicaid populations for all hospitals were derived from Medicare Cost Reports HCRIS files. Using a different methodology, University of Michigan reports that 20.1% of their patients have traditional Medicaid or Medicaid HMO insurance coverage. It is unclear whether this number refers to hospitalized patients, outpatients, or both.

12. The primary teaching hospital has demonstrated a commitment to immigrant patients including multilingual signs stating that patients are welcome regardless of immigration status, and a policy of referring immigration authorities to hospital attorneys prior to any cooperation by hospital staff.

- A. The above metric is fully met
- B. The hospital has some symbolic commitment to immigrant patients (e.g. signs), but no policies explicitly protecting undocumented patients**
- C. The hospital has no public or policy commitment to immigrant patients

There are many multilingual signs displayed throughout Michigan Medicine, and there are attorneys affiliated with Michigan Medicine that are designated contacts for faculty, staff, student, patient, and other community members' concerns regarding immigration. Despite this, there are no public policies or statements affirming the health system's support for immigrant patients.

UMMS reports that the University considers immigration authorities as "Law Enforcement" and workforce members encountered with requests or demands from law enforcement, including immigration authorities, are directed to and have an attorney on call available to them. Workforce members may also contact Hospital Security who works with the hospital attorneys in directing law enforcement to a central entrance.

Additional information may be found at the following links:

- [Health Law](#)

13. All medical school staff and staff at the primary teaching hospital are paid a living wage as defined by local advocacy organizations. All full-time staff have comprehensive health insurance that is accepted at the health system where they work.

- A. The above metric is fully met
- B. N/A

C. Some staff earn less than a living wage and/or do not have access to comprehensive health insurance, or this information is not publicly available

It is University of Michigan policy to “ensure that all regular staff are paid at or above the minimum full-time rate of \$25,225 per year or \$12.13 per hour”; temporary staff are ensured a wage of only \$9.45/hour. At time of this publishing in 2019, the Washtenaw County living wage is \$13.24/hour for a single adult. UMMS reports the lowest paid full time staff member is paid at \$26,000 (\$12.50/hour).

UMMS reports that all benefits eligible faculty and staff (includes part-time and full-time) have access to comprehensive UM health insurance that is accepted at Michigan Medicine. There is no publicly-available information on employee access to health insurance.

Additional information may be found at the following links:

- [Union Contracts & Wage Schedules](#)
- [Salary Disclosure 2017](#)
- [Living Wage: Washtenaw County](#)

14. IRB approval process requires any research that uses race to include precise definitions of race and how it is being used in the research project. People of color are clearly identified as being a "vulnerable population" for research purposes, and IRB policies outline strategies to protect people of color from abusive practices.

- A. The above metric is fully met
- B. IRB process requires researchers to explain their use of race
- C. IRB process has no requirements regarding the treatment of race, or this information is not publicly available**

The University of Michigan Office of Research Ethics & Compliance does not include people of color among its examples of vulnerable research subjects, and there are no specific policies protecting research subjects of color. There is no required review of how researchers use “race” in their research, and there is no routine review of student projects for their treatment of race. IRBMED, the IRB of the University of Michigan Medical campus, offers a variety of optional courses to support researchers, but these

do not include courses discussing race and racism in scientific research. All student projects are mentored by faculty members, but there is no special scrutiny of students' treatment of race.

Additional information may be found at the following links:

- [Operations Manual: Participant Protection](#)
- [IRB Education](#)

Perelman School of Medicine at the University of Pennsylvania

This section provides further detail on each metric for the Perelman School of Medicine at the University of Pennsylvania. Penn is an allopathic medical school located in Philadelphia, Pennsylvania. Primary teaching hospitals are those of the University of Pennsylvania Health System, which includes the Hospital of the University of Pennsylvania, Pennsylvania Hospital, and Penn Presbyterian Medical Center.¹²

Each metric (numbered 1-14 in the truncated report card) includes the full metric prompt, the grade for the institution, and an explanation of what that grade represents. Below each metric, we provide any relevant links to sources.

1. Medical school faculty and students are at least 13% Black, 1% Native American, and 17% Latinx (corresponding to the share of these groups in the U.S. population).

- A. All of the above groups are proportionately represented among students
- B. Some of the above groups are proportionately represented among students
- C. None of the above groups are proportionately represented among students, or this information is not publicly available**

Among current Perelman School of Medicine students, 8.4% are Black, 7.6% are Latinx, and none are Native American. PSOM states that the number of URM students has increased by 40% since 2013, and that URM students comprised 28% of the students in the 2018 entering class.

Additional information may be found at the following links:

- [AAMC Medical School Enrollment by Race & Ethnicity](#)
- [Table B-5.1: Total Enrollment by U.S. Medical School and Race/Ethnicity, 2018-2019](#)
- [Inclusion & Diversity Annual Report 2017-2018](#)
- [PSOM Diversity Profile](#)

¹² [PSOM Teaching Facilities](#)

2. Medical school faculty are at least 13% Black, 1% Native American, and 17% Latinx (corresponding to the share of these groups in the U.S. population).

- A. All of the above groups are proportionately represented among faculty
- B. Some of the above groups are proportionately represented among faculty
- C. None of the above groups are proportionately represented among faculty, or this information is not publicly available**

Overall, Black, Latinx, and Native American people comprise less than 10% of full-time PSOM faculty (7.2% as of 2018). PSOM states that the number of URM standing faculty has increased by 38% since 2013. The Faculty Opportunity Fund, Diversity Search Advisors, and Presidential Professor programs are three initiatives aimed at increasing faculty diversity.

Additional information may be found at the following links:

- [Inclusion & Diversity Annual Report 2017-2018](#)
- [Diversity Search Advisory Program](#)

3. The physical space of the medical school acknowledges the contributions of alumni and other physicians of color (through plaques, statues, portraits, and building names) and does not celebrate racist or white supremacist individuals.

- A. The above metric is fully met
- B. There are no items celebrating racist/white supremacist individuals, and also none celebrating people of color
- C. The physical space explicitly celebrates racist/white supremacist individuals**

John Morgan, the founder of the medical school, is featured prominently on the walls of the Jordan Medical Education Center, and a medical school building bears his name. He is quoted in *Stamped From: The Definitive History of Racist Ideas in America* as asserting the inferiority of Black people. There are some images of Black alumni and faculty in public spaces, including Dr. Helen Dickens and Dr. Bernett Johnson, and there is a lecture series named for Dr. Nathan Mossell.

Additional information may be found at the following link:

- [Facilities: John Morgan Building](#)
-

4. The medical school's recruitment policies promote racial justice. The medical school application does not inquire about the applicant's criminal history. The medical school recruits and admits undocumented students and students of color who attended public high schools in the county or state where the medical school is located. Students of color who participate in recruitment are compensated for their time.

- A. The metric is fully met
- B. Some elements of the metric are met**
- C. No elements of the metric are met

The University of Pennsylvania has very poor representation of URM students from Philadelphia; despite the existence of a number of pipeline programs, they have not allowed meaningful numbers of Philadelphia public school alumni to enroll at Penn Med. Per PSOM, the medical school collaborates with the School of Social Policy and Practice to conduct ongoing evaluation of these programs.

In addition, the medical school has conducted recruitment at targeted schools (including HBCUs) and national meetings. Current medical students participating in these recruitment efforts receive funded travel and meals but are not compensated for their time. Finally, applicants to the medical school who identify as Black, Latinx, and/or LGBTQ are invited to attend a Diversity Breakfast. Current URM students are asked, but not required, to attend these breakfasts as part of the school's recruitment strategy but are not compensated for their time and, in some cases, must excuse themselves from academic activities such as morning lectures and required small groups in order to participate.

Undocumented students are not able to matriculate at Penn Med.

Additional information may be found at the following links:

- [Article about undocumented medical students at Penn Med](#)
 - [Educational Pipeline Program](#)
 - [The Provost Summer Mentorship Program \(SMP\)](#)
-

5. The curriculum incorporates information about the history of racism in medicine, intersectional oppression, and racial justice strategies, and explicitly addresses the fact that race is a social construct, not a biological one. Lecturers avoid describing race per se (rather than racism) as a risk factor for disease, cause of health disparities, or basis for diagnostic reasoning. Community advocates and students who are underrepresented in medicine are incorporated in the planning and leadership of the pre-clinical curriculum.

A. The above metric is fully met.

B. Some elements of the metric are met.

C. The curriculum fails to adequately address racism in medicine. Race is stated or implied to be biological. Community advocates and URM students do not participate in planning or are not compensated for their time.

There is some discussion of privilege and racism in the mandatory Doctoring course, but marginalized students often find these sessions traumatizing and ineffective. The history of racism in medicine is discussed in a very limited fashion in bioethics coursework (largely confined to discussion of Nazi doctors and the Tuskegee syphilis experiments). There is no discussion for students about intersectionality or anti-racism strategies in the formal curriculum.

Pre-clinical lecturers frequently explicitly state or imply that race is genetic or biological. Notable examples of disease processes for which race is described as a risk factor include type II diabetes, hypertension, and a variety of malignancies.

Some fourth year students are involved in helping to plan sessions for the Doctoring course, but there is no clear, transparent process for ensuring that URM students are represented among these students. Other lectures and sessions touching on community health or health disparities have no clear student or community input.

Because of these curricular shortcomings, in 2015, Penn Med student Dorothy Charles (class of 2019) first conceptualized the first annual Racism in Medicine Conference, which she organized along with colleagues at Temple and Jefferson medical schools (Victor Rivera and Alex Rowan, respectively) in order to supplement the formal social medicine curriculum. Since then, the conference remains a student-driven and student-organized effort across Philadelphia-area medical schools and has been hosted at different campuses over the years; it was hosted at Penn in 2017. The Racism in Medicine conference includes workshops on a variety of topics related to structural racism, racism in public policies and the healthcare system, and anti-racism strategies. This conference is not, however, formally organized by the medical school and is not mandatory for all students.

Outside of undergraduate medical education, PSOM offers optional implicit bias workshops for faculty, and as of 2017–2018, there are plans for a mandatory Cultural Competency Online Module to launch in 2018–2019.

Additional information may be found at the following links:

- [A Cultural Competency Medical Education Program](#)
 - [Inclusion & Diversity Annual Report 2017–2018](#)
 - [Preclinical Psychiatry Curriculum](#)
-

6. The medical school has a system for collecting student and faculty reports of racism and other forms of oppression, and a clear plan for follow-up when problems are reported.

- A. The above metric is fully met
- B. There is some system for collecting reports, but there is no clear follow-up after reports are made**
- C. There is no system for collecting reports

There is a student mistreatment policy, and students are able to report incidents of mistreatment through the Safety Net system. Anecdotal evidence suggests that students often report mistreatment and receive some follow-up about their reports if they choose to report non-anonymously, but that these reports rarely result in significant action (e.g. removal of a faculty member from medical student teaching or revision of a grade).

Additional information may be found at the following links:

- [Safety Net](#)
-

7. There are no racial disparities in medical students' grades or honors (including AOA election)

- A. The above metric is fully met
- B. The school regularly evaluates whether there are racial disparities, and has developed plans to address them
- C. There are significant racial disparities in grades and/or honors, or this information is not publicly available**

URM students are significantly underrepresented among students elected to the Alpha Omega Alpha Honor Medical Society. Selection of inductees has historically been based solely on GPA from the preclinical, organ systems-based courses (“MOD 2”) and from clerkships (“MOD 4”), with the top 1/6th of the class selected for AOA. Using this system, in 2017, URM students comprised 2 of the 32 inductees (6%), and in 2018, 3 of the 29 inductees (10%).

But as of 2019, per PSOM report to WC4BL, a “new holistic methodology” is in place that uses GPA to determine AOA eligibility (top 1/4 of the class). From this list of eligible students, a “new Selection Committee consisting of 14 AOA faculty” reviews data on “student engagement, citizenship, scholarship, and humanism/professionalism” “in a blinded manner to select the inductees.” Using this new methodology, 3 of 25 AOA inductees in 2019 were URM students (12%).

While this more holistic approach is indeed an improvement on the previous process, it must be noted that the new system does not address the fact that many URM students have concerns about discrimination in grading, especially in clerkship evaluations, which are often subjective in nature. In addition, it is unclear how the more holistic data are collected, how these more qualitative criteria are defined and assessed -- and by whom, and who sits on the Selection Committee.

8. Black, Native American, and Latinx students have access to designated physical spaces, as well as support staff, including administrators, physician mentors, mental health providers, and peer counselors.

- A. The above metric is fully met
- B. There are some resources specifically designated to support students of color**
- C. There are no designated resources for students of color

The Program for Diversity and Inclusion (PDI) employs two dedicated full-time staff members and is led by four Deans for Diversity and Inclusion, three of whom are URM faculty. While URM students are specifically encouraged to reach out to PDI deans and staff for support and/or mentorship, PDI’s stated purpose is to serve all medical students without an exclusive focus on URM students. There are formal URM mentoring programs and supportive programs through the Alliance of Minority Physicians and through PDI. There are no designated physical spaces for URM students and no dedicated mental health providers.

Additional information may be found at the following links:

- [Program for Diversity & Inclusion](#)
 - [Petition to save the Office for Diversity & Community Outreach](#)
-

9. There is no hospital/campus police force, or police are used as a last resort after the failure of alternative safety structures such as peer walking escorts, restorative justice councils, and mediation. If police or security officers exist, publicly-available data should demonstrate that they have not disproportionately stopped, arrested, or otherwise interacted with people of color.

- A. The above metric is fully met
- B. There are some programs designed to reduce reliance on police
- C. There is a campus police force, and no evidence that they have sought to address racism in policing, or this information is not publicly available**

All Penn public safety officers undergo state-mandated Municipal Police Officers training, which includes some training around diversity. Per Penn Med, the University of Pennsylvania Police Department is “held accountable for university initiatives related to diversity,” but it is unclear what this accountability process is. There are no alternative safety structures to reduce reliance on police.

Additional information may be found at the following links:

- [Security](#)
 - [Public Safety](#)
-

10. Expectations for students' level of independence and supervision are clearly documented and are consistent across training sites (for example, students or residents are not disproportionately given the opportunity to "practice" while rotating in VA or public hospitals or while volunteering in free clinics).

- A. The above metric is fully met
- B. Policies exist to ensure that all patients receive equally well-supervised care, but are inconsistently enforced
- C. Students are routinely given more independence when caring for marginalized patients**

Preclinical students at student-run free clinics are allowed to see patients with resident supervision, whereas, at UPHS facilities, they are only able to shadow or

observe. The existing policies on student supervision do not explicitly address free clinics.

Additional information may be found at the following links:

- [Student Supervision Policy](#)
 - [Student-Led Clinics](#)
-

11. At the primary teaching hospital (s), patients of color are represented in all services (including specialist services) and practices at their rate in the local population. Patients of color are not segregated in resident or student clinics.

- A. The above metric is fully met
- B. There are some efforts to promote equal access to care (e.g. Medicaid patients seen in faculty clinics)

C. Patient care is highly segregated, or this information is not publicly available

There is no formal data available on patient demographics in different hospital practices. However, anecdotal evidence suggests that, in many departments, patients are segregated by insurance status, which, in the city of Philadelphia, correlates closely with race. One notable example is within the OB/GYN department, in which Medicaid and uninsured patients are seen at the Helen O. Dickens Center for Women (a resident clinic), while privately insured patients are seen at Penn OB/GYN Associates (staffed by attending physicians). Additionally, Penn provides significantly less uncompensated and Medicaid care than other Philadelphia hospitals; while 16% of Pennsylvania adults have Medicaid insurance, only 3% of patients discharged from the Hospital of the University of Pennsylvania in 2015 had Medicaid insurance.

Additional information may be found at the following links:

- [Article on low percentage of "charity care" provided at Penn hospitals](#)
 - [2016 Financial Report on PA Hospitals](#)
 - [Health Insurance Coverage of PA Adults](#)
 - [CMS Healthcare Cost Report Information System \(HCRIS\) -- Hospitals, 2010-19](#)
-

12. The primary teaching hospital has demonstrated a commitment to immigrant patients including multilingual signs stating that patients are welcome regardless of immigration status, and a policy of referring immigration authorities to hospital attorneys prior to any cooperation by hospital staff.

- A. The above metric is fully met
- B. The hospital has some symbolic commitment to immigrant patients (e.g. signs), but no policies explicitly protecting undocumented patients
- C. The hospital has no public or policy commitment to immigrant patients**

Signage at UPHS facilities is monolingual, and the most recent UPHS Community Health Needs Assessment includes no strategies to ensure that undocumented patients are well-served at UPHS facilities. Furthermore, UPHS has made no public statements affirming a commitment to immigrant patients.

Additional information may be found at the following link:

- [2016 Community Health Needs Assessment Report](#)
-

13. All medical school staff and staff at the primary teaching hospital are paid a living wage as defined by local advocacy organizations. All full-time staff have affordable comprehensive health insurance that is accepted at the health system where they work.

- A. The above metric is fully met
- B. N/A
- C. Some staff earn less than a living wage and/or do not have access to comprehensive health insurance, or this information is not publicly available**

The living wage in Philadelphia for a single adult is \$12.64/hour. Information on the wages and benefits of UPHS staff is not publicly available.

Additional information may be found at the following link:

- [Living Wage by County](#)
-

14. IRB approval process requires any research that uses race to include precise definitions of race and how it is being used in the research project. People of color are clearly identified as being a "vulnerable population" for research purposes, and IRB policies outline strategies to protect people of color from abusive practices.

- A. The above metric is fully met
- B. IRB process requires researchers to explain their use of race
- C. IRB process has no requirements regarding the treatment of race, or this information is not publicly available**

Penn IRB policies refer generally to “vulnerable populations,” but do not include people of color in this definition. There are no specific guidelines around treatment of race in research.

Additional information may be found at the following links:

- [IRB Mission Statement](#)
- [IRB Criteria of Approval](#)

University of Pittsburgh School of Medicine

This section provides further detail on each metric for the University of Pittsburgh School of Medicine, which is an allopathic medical school located in Pittsburgh, Pennsylvania. The primary teaching hospitals are the UPMC hospitals, including UPMC Presbyterian, UPMC Montefiore, UPMC Children’s Hospital of Pennsylvania, UPMC Magee–Womens Hospital the VA Pittsburgh Healthcare System, and the Western Psychiatric Institute & Clinic.

Each metric (numbered 1–14 in the truncated report card) includes the full metric prompt, the grade for the institution, and an explanation of what that grade represents. Below each metric, we provide any relevant links to sources.

1. Medical school students are at least 13% Black, 1% Native American, and 17% Latinx (corresponding to the share of these groups in the U.S. population).

- A. All URM groups are proportionately represented among students
- B. Some URM groups are proportionately represented among students
- C. No URM groups are proportionately represented among students, or no information is publicly available**

URM students are underrepresented; of current students, 12% are Black, 4.6% are Latinx, and none are Native American. Using a different method, University of Pittsburgh SOM’s website states only that 17% of MS1s are URM. No breakdown of Black, Latinx, or Native American representation is publicly available.

Additional information may be found at the following links:

- [AAMC Medical School Enrollment by Race & Ethnicity](#)
 - [Table B-5.1: Total Enrollment by U.S. Medical School and Race/Ethnicity, 2018–2019](#)
 - [Our Students](#)
 - [Class Profile](#)
-

2. Medical school faculty are at least 13% Black, 1% Native American, and 17% Latinx (corresponding to the share of these groups in the U.S. population).

- A. All URM groups are proportionately represented among faculty
- B. Some URM groups are proportionately represented among faculty
- C. **No URM groups are proportionately represented among faculty, or no information is publicly available**

There is no publicly available information on faculty diversity statistics. UPSOM's "Framework for Diversity" mentions a "Provost Diversity Fellows Program", but no information about this program is publicly available.

Additional information:

[Diversity Framework](#)

3. The physical space of the medical school acknowledges the contributions of alumni and other physicians of color (through plaques, statues, portraits, and building names) and does not celebrate racist or white supremacist individuals.

- A. The above metric is fully met
- B. There are no items celebrating racist/white supremacist individuals, and also none celebrating people of color
- C. **The physical space explicitly celebrates racist/white supremacist individuals**

The primary medical school building, Scaife Hall, is still named for a past chair of the board and major donor, Alan Magee Scaife. Alan Scaife's wife contributed to the eugenicist Population Council. Cordelia Scaife May and Richard Mellon Scaife, Alan Scaife's children, are well-known for their funding and support for anti-immigrant organizations. Richard Scaife is also known as the "funding father of the Right" and has made large financial contributions to organizations supporting a variety of white supremacist causes (e.g. advocacy for "welfare reform" and opposition to affirmative action).

Additional information may be found at the following links:

- [Article: Late heiress' anti-immigration efforts live on](#)
 - [Article: Scaife: Funding Father of the Right](#)
-

4. The medical school's recruitment policies promote racial justice. The medical school application does not inquire about the applicant's criminal history. The medical school recruits and admits undocumented students and students of color who attended public high schools in the county or state where the medical school is located. Students of color who participate in recruitment are compensated for their time.

- A. The above metric is fully met
- B. There are some efforts to recruit/retain students of color**
- C. There are no efforts to recruit/retain students of color

University of Pittsburgh School of Medicine has a stated commitment to recruiting and retaining URM students, as outlined in their “Framework for Diversity” statement. To this end, the Office of Diversity Programs coordinates a number of programs for pre-med and matriculating medical students to recruit and support students of color, including the Health Sciences Career Exploration Institute, Biomedical Informatics for URM Students, the Journey to Medicine program, the Summer Premedical Academic Enrichment Program, and the Doris Duke Foundation Academy for Clinical Research. Recruitment visits are made to historically Black colleges and universities (HBCUs) and to Hispanic-serving institutions (HSIs), and the Office of Student Affairs/Diversity Programs (SADP) uses the Medical Minority Applicant Registry to conduct outreach to URM applicants. The SADP also collaborates with the Pre-Health Organization of Minority Students at Pitt. It is unclear whether significant numbers of URM students from Pittsburgh have matriculated to the medical school. A UPSOM faculty member indicated there are nine students currently enrolled who went to local public schools, but did not indicate if these students identify as URM. The University of Pittsburgh School of Medicine accepts applications from international students, but requires that

they place a sum of money equivalent to two years of medical school tuition in an escrow account prior to enrolling in medical school, effectively barring undocumented students from enrolling. Students who participate in recruitment are not financially compensated for their time, but receive meal vouchers for the cafeteria .

Additional information may be found at the following links:

- [Framework for Diversity](#)
 - [Office of Diversity Programs](#)
 - [Office of Diversity: Student Support](#)
 - [Health Sciences Diversity: High-School Students](#)
 - [International Student Policy](#)
 - [Summer Short-Term Trainee Program](#)
 - [Post: Journey to Medicine Program Featured in New Pittsburgh Courier](#)
 - [UPMC: The Hillman Academy](#)
 - [Summer Premedical Academic Enrichment Program](#)
-

5. The curriculum incorporates information about the history of racism in medicine, intersectional oppression, and racial justice strategies, and explicitly addresses the fact that race is a social construct, not a biological one. Lecturers avoid describing race per se (rather than racism) as a risk factor for disease, cause of health disparities, or basis for diagnostic reasoning. Community advocates and students who are underrepresented in medicine are incorporated in the planning and leadership of the pre-clinical curriculum.

- A. The above metric is fully met
- B. Some elements of the metric are met**
- C. The curriculum fails to adequately address racism in medicine. Race is stated or implied to be biological. Community advocates and URM students do not participate in planning or are not compensated for their time.

UPSOM's "Framework for Diversity" outlines the goal of "[ensuring] that the curriculum content considers contemporary social issues facing medicine and that it fosters inter-cultural and intracultural insight." The following initiatives are listed:

- Increase faculty participation in the Provost Diversity Fellows Program
- Infuse cultural competence and diversity into the curriculum as appropriate (PBL, TBL, standardized patients, elective and Area of Concentration courses)
- Ensure graduates understand health disparities in the contemporary social context of medicine
- Utilize the Diversity Workshop to introduce MS1s to the diversity and inclusion concepts that will be reinforced throughout the curriculum

Issues of implicit & explicit racial bias are introduced and discussed during orientation for MS1s, but these issues are reinforced inconsistently in subsequent classes throughout the preclinical years, largely at the discretion of the instructors and group facilitators. There is a significant lack of oversight and quality control in regards to portrayals of race and racism in course materials and lectures. Lecturers have stated blatantly racist information both verbally and in written course materials.

There are opportunities for students to give feedback and alter curricula (curriculum committee, meetings with course directors, etc) but these roles are not compensated, and no special efforts appear to be made to involve URM students.

Students and community organizations are involved in the development of the Behavioral Health, Populations Health, and Transitions courses, although their precise roles are unclear. Fourth year medical students who choose to participate in the "Changing Science, Changing Society" elective work at a community site in Pittsburgh, where community advocates lead the course and serve as faculty. These community members are reimbursed by the medical school for their planning and teaching time.

Additional information may be found at the following link:

- [Curriculum: Changing Science, Changing Society: A Guide to 21st Century Medicine](#)
- [The Office of Diversity Programs](#)
- [Diversity Framework](#)

6. The medical school has a system for collecting student and faculty reports of racism and other forms of oppression, and a clear plan for follow-up when problems are reported.

- A. The above metric is fully met
- B. There is some system for collecting reports, but there is no clear follow-up after reports are made**
- C. There is no system for collecting reports

The Professionalism or Mistreatment Incident Report Form is available to students for reporting mistreatment or unprofessional behavior, and students may make either confidential or anonymous reports. There are no public guidelines about the follow-up that occurs after students report an incident, and no individuals are publicly identified as being responsible for addressing student concerns. UPSOM also conducts quarterly surveys of third and fourth year students to obtain additional information about possible mistreatment (of patients, students, or staff) in specific clerkships at specific locations, although follow-up is likewise poorly defined.

Students can also report behavior they feel violates the Code of Professionalism to the Honor Council, a group of students and faculty empowered to address such concerns either through informal resolution or disciplinary action. However, some students report that Honor Council has been used in the past to silence students who speak out against racism and sexism among their peers and UPSOM faculty.

In January 2018, Evelyn Reis was hired as Assistant Dean of Learning Environment, a new position which includes in its purview the handling of mistreatment reports. Students have reported an improvement since the advent of this role.

Beyond the School of Medicine, students may report incidents of discrimination, bias, harassment, accessibility barriers, or retaliation to the university's Office of Diversity and Inclusion.

Students indicated discomfort with reporting harassment and discrimination, and felt uncertain their anonymity would be protected, or that the UPSOM administration would take meaningful steps to address these incidents. Some students also reported that complaints about racist and culturally insensitive lecturers and lecture materials

had been largely dismissed by administrators, and in some cases even resulted in professionalism complaints against the students who raised concern.

Significantly, the University of Pittsburgh School of Medicine has no ombudsperson, and the current system for expressing concerns over the conduct of faculty puts a heavy burden on students with few clear guarantees of protection.

Additional information may be found at the following links:

- [Incident Report Form](#)
 - [Make a Report](#)
 - [Code of Professionalism & Honor Council](#)
-

7. There are no racial disparities in medical students' grades or honors (including AOA election).

- A. The above metric is fully met
- B. The school regularly evaluates whether there are racial disparities, and has developed plans to address them
- C. There are significant racial disparities in grades and/or honors, or this information is not publicly available**

Racial disparities in AOA exist, and have been brought to the attention of faculty by students. No formal plan exists to further assess or address these disparities, though faculty members have expressed willingness to work with students on this matter.

8. Black, Native American, and Latinx (URM) students have access to designated physical spaces, as well as support staff, including administrators, physician mentors, mental health providers, and peer counselors.

- A. The above metric is fully met

- B. There are some resources specifically designated to support URM students**
- C. There are no designated resources for URM students

The Office of Diversity Programs offers some tutoring and mentorship programming to URM students, including Advisory Deans, the FAST (Faculty and Students Together) program, the Prologue to Medicine Program, and Man to Man, a program which provides mentoring to black, male-identified students. These programs collaborate with other individuals and offices to form the Student Success Management Network for all medical students. The Office of Diversity Programs is co-located with the Office of Student Affairs and Medical Education; URM students do not have designated physical spaces, mental health providers, or peer counselors. SNMA & LMSA facilitate URM students meeting physicians of color for the purpose of mentorship & networking, but these are student-led organizations, and leadership roles are uncompensated. The Office of Diversity Programs provides IT support and catering for SNMA and LMSA events.

Additional information may be found at the following link:

- [The Office of Diversity Programs](#)
- [Diversity Framework](#)
- [Assistant Dean of Diversity Programs](#)

9. There is no hospital/campus police force, or police are used as a last resort after the failure of alternative safety structures such as peer walking escorts, restorative justice councils, and mediation. If police or security officers exist, publicly-available data should demonstrate that they have not disproportionately stopped, arrested, or otherwise interacted with people of color.

- A. The above metric is fully met
- B. There are some programs designed to reduce reliance on police
- C. There is a campus police force, and no evidence that they have sought to address racism in policing, or no information is publicly available**

University of Pittsburgh has a campus police force. There are no publicly published reports on racism in policing, and there is no public information on efforts to reduce racism. Per Pitt, officers are required to undergo training in “cultural awareness,” “anti-bias training,” “racial profiling,” and “investigating hate crimes.” UPMC also employs police officers, who are required to participate in “anti-bias training” mandated for all UPMC employees. There are no structures or programs in place to reduce reliance on police.

Additional information may be found at the following link:

- [Safety at Pitt](#)
-

10. Expectations for students' level of independence and supervision are clearly documented and are consistent across training sites (for example, students are not disproportionately given the opportunity to "practice" while rotating in VA or public hospitals or while volunteering in free clinics).

- A. The above metric is fully met
- B. Policies exist to ensure that all patients receive equally well-supervised care, but are inconsistently enforced**
- C. Students are routinely given more independence when caring for marginalized patients

The University of Pittsburgh has a very clear and recently updated policy on medical student supervision, which extends to medical students working in free clinics (such as the Birmingham Free Clinic). However, at the Birmingham Free Clinic pre-clinical medical students are permitted to obtain intake information and vital signs from patients (under faculty supervision); in other clinical settings, pre-clinical students are generally not permitted to participate beyond observation or shadowing.

Additional information may be found at the following links:

- [Policy on Clinical Supervision](#)
- [Birmingham Free Clinic](#)

11. At the primary teaching hospital, patients of color are represented in all services (including specialist services) and practices at their rate in the local population. Patients of color are not segregated in resident or student clinics.

- A. The above metric is fully met
- B. There are some efforts to promote equal access to care (e.g. Medicaid patients seen in faculty clinics)**
- C. Patient care is highly segregated, or this information is not publicly available

Although UPMC maintains a website describing "Community Benefits Fast Facts," there is no publicly available information on racial segregation of patient care. Medicaid patients, who are disproportionately patients of color, may be underrepresented at UPMC Presbyterian, the system's flagship hospital. While 16% of Pennsylvania adults have Medicaid insurance, only 2% of patients discharged from UPMC Presbyterian in 2016 had Medicaid insurance.¹³ University of Pittsburgh SOM faculty indicated that in 2018, 14% of patients discharged from UPMC Presbyterian had Medical Assistance, mostly in the form of "UPMC for You", an approved Medical Assistance Plan affiliated with the UPMC health plan. There is no available data on racial or insurance status-based segregation of patients within UPMC practices.

Additional information may be found at the following links:

- [Community Benefits](#)

¹³ Medicaid populations for all hospitals were derived from Medicare Cost Reports HCRIS files. Per UPMC, this number for UPMC only includes patients with traditional Medicaid, and excludes the 80% of Pennsylvania Medicaid recipients who are covered by Medicaid Managed Products (data from the Kaiser Family Foundation indicates that more than 80% of PA residents are covered by managed care). Per UPMC, in FY16 and FY17, 16-19% of inpatients and 25% of outpatients at UPMC Presbyterian and UPMC Shadyside had Medicaid insurance (UPMC did not provide disaggregated data for UPMC Presbyterian). UPMC states that at other primary teaching hospitals – Children's Hospital of Pittsburgh of UPMC, Magee-Women's Hospital of UPMC and Western Psychiatric Institute and Clinic of UPMC – approximately 20% of patients had Medicaid in 2017 and that, thus far in 2018, 17.8% of patients admitted to UPMC Presbyterian had Medicaid. They further note 15.33% of net patient revenues from UPMC Presbyterian/Shadyside in 2016 was from Medical Assistance, and that, given that the reimbursement rate by Medical Assistance is lower than other insurance, this suggests that the share of low income patients is higher than 15%.

- [Financial Analysis 2016](#)
 - [Pennsylvania State Indicator: Health Insurance Coverage of Adults 19-64](#)
 - [\[zip file\] Health Care Information System \(HCIS\) Data File for 2010](#)
-

12. The primary teaching hospital has demonstrated a commitment to immigrant patients including multilingual signs stating that patients are welcome regardless of immigration status, and a policy of referring immigration authorities to hospital attorneys prior to any cooperation by hospital staff.

- A. The above metric is fully met
- B. The hospital has some symbolic commitment to immigrant patients (e.g. signs), but no policies explicitly protecting undocumented patients
- C. The hospital has no public or policy commitment to immigrant patients**

The UPMC policy on patient financial assistance states that “The granting of financial assistance will not take into account age, gender, race, social or immigration status, sexual orientation, gender identity or religious affiliation,” but immigration status is not included among the protected identities in the hospital’s nondiscrimination policy on patient care and employment. Moreover, UPMC has not issued any public statements about access to care or safety for immigrant patients and has no public policies governing how employees interact with immigration authorities.

The UPMC Financial Aid Policy states policy materials and applications “can be offered in English, Spanish, Arabic, French, Italian, Nepali, Russian, Chinese, Large Print, and Braille. UPMC may give translation aids, translation guides, or provide assistance through use of qualified bilingual interpreter by request.” However, the primary teaching hospitals have sparse/inconsistent multilingual signage.

Still, some outreach to immigrant communities has been initiated. Magee Women’s Hospital recently hosted a forum “to connect immigrant and refugee communities with local agency leaders, community advocates and health care providers” with the goal of “[improving] health and wellness of Pittsburgh’s immigrants and refugees”. Additionally, the medical school offers elective courses on refugee health, and students can further focus on the topic by completing an Areas of Concentration (AOC), a

program that “allows students to pursue in depth an area of personal interest during their four years of medical school... through a series of longitudinal elective experiences.”

Additional information may be found at the following links:

- [Upmc Fast Facts: Commitment To The Community](#)
 - [Upmc Policy And Procedure Manual](#)
 - [Nondiscrimination in Patient Care and Employment](#)
 - [Magee Immigrant/Refugee Health Community Forum](#)
 - [Area of Concentration in Refugee Health](#)
-

13. All medical school staff and staff at the primary teaching hospital are paid a living wage as defined by local advocacy organizations. All full-time staff have comprehensive health insurance that is accepted at the health system where they work.

- A. The above metric is fully met**
- B. N/A
- C. Some staff earn less than a living wage and/or do not have access to comprehensive health insurance, or this information is not publicly available

UPMC has committed to raising its institutional minimum wage to \$15/hour by 2021. As of 2016, the average starting salary at UPMC was \$11.73/hour; UPMC has stated that the current starting salary for UPMC employees in urban hospitals is \$13.00/hour. The current living wage in Pittsburgh for a single adult is \$10.34/hour. It is unclear whether all staff have access to comprehensive health insurance.

Additional information may be found at the following link:

- [Article: UPMC Pledges to Boost Starting Wage to 15 an Hour by 2021](#)
-

14. IRB approval process requires any research that uses race to include precise definitions of race and how it is being used in the research project. People of color

are clearly identified as being a "vulnerable population" for research purposes, and IRB policies outline strategies to protect people of color from abusive practices.

- A. The above metric is fully met
- B. IRB process requires researchers to explain their use of race**
- C. IRB process has no requirements regarding the treatment of race, or this information is not publicly available

UPSOM IRB policy requires a diverse IRB committee, stating, “The membership of the IRB will be sufficiently qualified through the experience and expertise of its members and the diversity of its members, including consideration of race, gender, and cultural backgrounds and sensitivity to such issues as community attitudes, to promote respect for its advice and counsel in safeguarding the rights and welfare of human research subjects.” The policies and procedures also state, “The possibility for benefits and the potential burdens of the research should be equitably distributed among the potential research subjects. Application of this principle requires the close scrutiny of the enrollment process to ensure that particular classes (welfare patients, racial and ethnic minorities, or persons confined to institutions) are not selected for their compromised position or convenience to the research investigator.” The IRB policy on recruitment states, “Recruitment plans for research projects should be designed to fully encompass racial, ethnic, and gender diversity. Efforts to identify and recruit potential human research subjects should be designed with respect personal rights to privacy and confidentiality,” and the renewal application asks, “Has subject accrual reflected the racial/gender/ethnic subgroups as outlined in your protocol? If you answer ‘No,’ address the steps that will be taken to correct this deficiency.” All student research projects require a faculty mentor, although it is not required that student projects be specifically reviewed for their use of race. International (but not domestic) research studies require a memo of cultural appropriateness.

Additional information may be found at the following links:

- [IRB Committee Membership](#)
- [Chapter 1 - Ethical and Regulatory Mandates to Protect Human Research Participants](#)
- [Requirements for a Memo of Cultural Appropriateness](#)

University of Rochester School of Medicine & Dentistry

This section provides further detail on each metric for the University of Rochester School of Medicine and Dentistry (URSMD). URSMD is an allopathic medical and dental school located in Rochester, New York. The primary teaching hospital is the Strong Memorial Hospital.

Each metric (numbered 1–14 in the truncated report card) includes the full metric prompt, the grade for the institution, and an explanation of what that grade represents. Below each metric, we provide any relevant links to sources.

1. Medical school students are at least 13% Black, 1% Native American, and 17% Latinx (corresponding to the share of these groups in the U.S. population).

A. All of the above groups are proportionately represented among students

B. Some of the above groups are proportionately represented among students

C. None of the above groups are proportionately represented among students, or this information is not publicly available

At URSMD in the 2018–2019 school year, only 10.8% of students identify as Black, only 6.7% of students identify as Latinx, and 0% of students identify as Native American.

Total Enrollment = 464

Black: 48 (10.3%)

Hispanic/Latino: 20 (4.3%)

Native Hawaiian/Other Pacific Islander: 0 (0%)

Black/African-American AND Hispanic/Latino: 1 (0.2%)

Black/African-American AND White: 2 (0.4%)

Hispanic/Latino AND White: 10 (2.2%)

Additional information may be found at the following links:

- [AAMC Medical School Enrollment by Race & Ethnicity](#)
 - [Table B-5.1: Total Enrollment by U.S. Medical School and Race/Ethnicity, 2018-2019](#)
-

2. Medical school faculty are at least 13% Black, 1% Native American, and 17% Latinx (corresponding to the share of these groups in the U.S. population).

- A. All of the above groups are proportionately represented among faculty
- B. Some of the above groups are proportionately represented among faculty
- C. None of the above groups are proportionately represented among faculty, or this information is not publicly available**

The University of Rochester Medical Center has 1979 faculty members (including 1746 full-time and 233 part-time). Including all faculty members, only 2.7% of faculty identify as Black, only 2.6% of faculty identify as Latinx, and 0.05% of faculty identify as Native American.

Additional information may be found at the following links:

3. The physical space of the medical school acknowledges the contributions of alumni and other physicians of color (through plaques, statues, portraits, and building names) and does not celebrate racist or white supremacist individuals.

- A. The above metric is fully met

- B. There are items celebrating racist/white supremacist individuals and very few items celebrating people of color.**
- C. The physical space explicitly celebrates racist/white supremacist individuals.

The physical space of the medical school acknowledges the contributions of primarily white figures. There is little to no celebration or recognition of people of color, although in March 2019 a new exhibit featuring African American alumni of the medical school was put on display in the centrally-located Flaum Atrium. Alumni Hall, a well-lit and well-traveled passage through the medical school, prominently features the faces of (mostly white, mostly male) graduates, while more recent graduation photos with better representation of URM graduates are displayed in a dark hallway without much foot traffic.

Notably, the school and hospital widely celebrate the success of George H. Whipple, MD, the Founder and Dean of the Medical School who was openly anti-Semitic and anti-Black and who “systematically excluded students based on race and religion until 1940, when the New York State Legislative Commission threatened to take away the school’s tax exemption status if it did not open its doors to all.” This figure currently has several landmarks and organizations named after him, including Whipple Auditorium, Whipple Circle, George H. Whipple Lab for Cancer Research and The George H. Whipple Society. The school has acknowledged the racist history of its founding dean in alumni publications and combats that legacy with current efforts to recruit URM students and faculty, as well as through the work of the Office for Inclusion and Culture Development such as the Tana Grady-Weliky, MD Lecture on Women and Diversity in Medicine series. However, Dr. Whipple’s name is still firmly celebrated.

Additional information may be found at the following links:

- [Rochester Medicine 2016, Volume 2](#), P. 21
- [Tana Grady-Weliky Lecture](#)

4. The medical school's recruitment policies promote racial justice. The medical school application does not inquire about the applicant's criminal history. The medical school recruits and admits undocumented students and students of color

who attended public high schools in the county or state where the medical school is located. Students of color who participate in recruitment are compensated for their time.

- A. The above metric is fully met
- B. Some elements of the metric are met**
- C. No elements of the metric are met

The University of Rochester School of Medicine and Dentistry (URSMD) does not recruit or accept undocumented students.

The URSMD invites students into the medical program contingent upon a required and approved background check facilitated by the AAMC. According to the student handbook, an approved background check consists of no record of sexual offenses, criminality, or aliases. The URSMD has an institutional policy to ensure the safety of the public and patients entrusting their care in the institution. Medical students approve the administration of a background check as part of their acceptance to the medical school. If an applicant has history of a felony, their case is not automatically disqualified but rather is reviewed by a sub-committee of the admissions panel which decides whether or not to continue consideration of the application.

Much of the URSMD's recruitment of medical students of color is done through summer "pipeline" programs that are mostly directed towards URM students. It is unclear how many students of color who attended public high schools in Monroe County are included in these programs or ultimately matriculate to the school. Programs include:

- What's up Doc? (A summer program for high school students from the city of Rochester)
- STEP (Science and Technology Entry Program) for high school students
- SURF (Summer Undergraduate Research Fellowship) for college students

Students of color who participate in recruitment (tours, interviews) are not compensated for their time, but those who are hired to run summer pipeline programs are compensated.

The URSMD has Early Acceptance Programs (EAP) with schools traditionally known to have largely URM populations, including Xavier University of Louisiana and Spelman

College. Other schools participating in this program which are not traditionally known to have largely URM populations include Amherst, Bowdoin, Carleton, Colgate, Hamilton, Haverford, Middlebury, Swarthmore and Williams. On average, 6–8 students from these 11 institutions matriculate through the EAP each year.

The URSMD is also one of ten schools in New York that participate in the Associated Medical Schools of New York's (AMSNY) Post-Baccalaureate enrichment program for socioeconomically disadvantaged and/or URM applicants who have applied for the current admissions cycle. Following review of an application and interview, the school may recommend qualifying students to the free, 12-month Post-Bac program at University of Buffalo for additional enrichment which takes the form of formal mentoring, advising, and a tailored curriculum with a stipend. Upon completion of the program, the student is accepted into the referring medical school.

Additional information may be found at the following links:

- [URSMD Student Handbook](#), P. 8–9
- [AMSNY Post-Baccalaureate Program](#)

5. The curriculum incorporates information about the history of racism in medicine, intersectional oppression, and racial justice strategies, and explicitly addresses the fact that race is a social construct, not a biological one. Lecturers avoid describing race per se (rather than racism) as a risk factor for disease, cause of health disparities, or basis for diagnostic reasoning. Community advocates and students who are underrepresented in medicine are incorporated in the planning and leadership of the pre-clinical curriculum.

- A. The above metric is fully met
- B. Race is sometimes acknowledged to be a social, rather than a biological category. Some parts of the curriculum discuss the role of history and racism in generating health disparities.
- C. Race is implied or stated to be biological, and is described as a risk factor for disease**

The curriculum does not explicitly address racism in medicine, but instead talks about “diversity” or “implicit bias” or more recently, “micro aggression” which alone do not fully acknowledge the history of racism that is a foundation of modern biomedicine nor the complicated intersectionality of oppression and the structural nature of institutionalized racism. These trainings instead focus on individual person to person interactions and fail to recognize the larger context or influence of structural racism. No guidelines are enforced for instructors on how to discuss race. Race is frequently referenced as a risk factor without being challenged or discussing the difference between genetic inheritance and the social construction of race. Most instructors avoid the topic altogether. How racism is discussed is inconsistent and highly dependent on individual lecturer’s personal views.

The social determinants of health are taught early on but lack any decoding of racism. Instead, the curriculum focuses on acknowledging that race may affect a patient’s health experience/outcome. The curriculum does not name racism as the factor influencing health disparities, but rather points to race. Race is more commonly used as a risk factor/diagnostic reasoning tool/predictor of treatment response. Racialized medical guidelines are consistently not challenged. They are generally taught as fact and students are expected to use those guidelines to correctly answer exam questions, explicitly and especially in preparation for board exams. The School of Medicine and Dentistry does not advocate publically for the removal of racialized medicine from all shelf and board exams.

The sociopolitical nature of race is not taught in the curriculum. It is left as a possible question in team based learning environments, but rarely discussed appropriately in those settings because they lack adequate time and/or facilitation. “Racialization as a sociopolitical process” is never discussed implicitly or explicitly. Acknowledgement of the history of racism in research is briefly included in an online module “Human Subjects Training” required of all first year students in order to complete research.

URM students and organizations work to fill these gaps by offering lectures, workshops and discussions on racism and decoding race. They are in no way compensated for their work or activism. Students working with administration to improve existing course content are not compensated. Community experts or advocates are generally not hired or consulted.

Additional information may be found at the following links:

6. The medical school has a system for collecting student and faculty reports of racism and other forms of oppression, and a clear plan for follow-up when problems are reported.

- A. The above metric is fully met
- B. There is some system for collecting reports, but there is no clear follow-up after reports are made**
- C. There is no system for collecting reports

Students are encouraged to consult their Advisory Dean about any acts of mistreatment, sexual harassment, misconduct, harassment, intolerance and discrimination. Follow-up is case dependent.

For more specific reporting, medical students are encouraged to make reports of racism and other forms of oppression to the Lynnett VanSlyke (l.vanslyke@rochester.edu), Kathryn Castle, PhD (kathryn_castle@urmc.rochester.edu), and Frederick Jefferson, EdD (jefferson@admin.rochester.edu). For violations of the Teacher-Learner Policy and incidents of medical mistreatment, they should contact David Lambert, MD (david_lambert@urmc.rochester.edu). For incidents of sexual discrimination, they should contact Morgan Levy, JD (morgan.levy@rochester.edu) and Linda Chaudron, MD (linda_chaudron@urmc.rochester.edu). All of these contacts are listed in the Student Handbook.

Specifically for matters of racism or oppression involving faculty members, students may contact Jeffrey Lyness, MD (jeffrey_lynness@urmc.rochester.edu), the Chair of Academic Affairs and the AAMC Group on Faculty Affairs. Dr. Lyness and the Faculty Professionalism Committee review reports of faculty behavior that go against the University commitment to inclusion and have the power to make decisions regarding punitive measures.

Finally, for acts of discrimination involving patients, students and faculty can make reports via RL solutions, an online collection database.

Additional information may be found at the following links:

- [URSMD Student Handbook](#), P. 114
-

7. There are no racial disparities in medical students' grades or honors (including AOA election).

- A. The above metric is fully met
- B. The school regularly evaluates whether there are racial disparities, and has developed plans to address them
- C. There are significant racial disparities in grades and/or honors, or this information is not publicly available**

There are racial disparities in medical students' grades and honors, including AOA election. This information is not made publicly available. There are some plans to address grade disparities but no plans to address disparities in AOA selection.

To address grade disparities in the pre-clinical years and to facilitate a smoother transition to medical school, the URSMD offers a two-week Meliora Professional Development Course to URM students and others who they identify may benefit from the course (i.e. non-traditional applicants who have not been in school for many years). The MPD course covers study techniques, test-taking, wellness strategies, mentorship and includes small group labs focusing primarily on anatomy and physiology. The course is free (all expenses covered) and optional for those to whom it is offered.

With regards to grade disparities in the clinical years, there have been previous investigations into grade disparities in individual clerkships prompted by student reports of bias from those departments. Those clerkships were investigated on a case-by-case basis, the outcomes of which are not publicly available. There is no current, overarching structure in place to ensure that clerkships do not exhibit future bias in grading.

Finally, the school acknowledges that AOA selection at the University of Rochester is not uniformly representative of the student population, but this data is not publicly available. The selection process follows the loose guidelines laid out by AOA: the Rochester AOA Selection Committee, comprised of faculty AOA members, selects up to one-sixth of the projected number of graduating students from the top quartile of students based on academic performance in clerkships. Those elected are picked “not only for their high academic performance, but as well for leadership among peers, professionalism and a firm sense of ethics, promise of future success in medicine, and a commitment to service in the school and community.” The committee is given information about Letters of Achievement received by students in medical school courses. Notably, the election committee does not include Advisory Deans or administrators from Student Services who interact with students often and may exhibit bias in the selection process. However, the selection process is not blind.

Additional information may be found at the following links:

- [AOA - How Members Are Chosen](#)

8. Black, Native American, and Latinx (URM) students have access to designated physical spaces, as well as support staff, including administrators, physician mentors, mental health providers, and peer counselors.

- A. The above metric is fully met
- B. There are some resources specifically designated to support URM students**
- C. There are no designated resources for URM students

There are no designated physical spaces available for URM medical students. The Center for Advocacy, Community Health, Education and Diversity has staff, administrators and resources available to support student-run local chapters of national URM affinity groups including Student National Medical Association (SNMA) and Latinx Medical Student Association (LMSA). Peer counseling is also facilitated through these student-run groups. Furthermore, students have access to mentors from organizations like the Black Physician's Network of Greater Rochester, the Association of Minority Residents and Fellows and the Male Minority Leadership Association. These groups offer scholarships, emergency funds, and fellowship events for medical students of color. Mentorship for Latinx students is facilitated by events put on by the Latinx Medical Student Association, but there is a lack of formal programming otherwise. There is no known existing mentorship for Native American students. There are no specific mental health providers made available to URM students and students of color, but the University Counseling Center at University Health Services can assist students in finding mental health providers in the community.

Additional information may be found at the following links:

- [Center for Advocacy, Community Health, Education and Diversity](#)
 - [Student National Medical Association at URSMD](#)
 - [Black Physicians' Network of Greater Rochester](#)
 - [URMC Association of Minority Residents and Fellows](#)
-

9. There is no hospital/campus police force, or police are used as a last resort after the failure of alternative safety structures such as peer walking escorts, restorative justice councils, and mediation. If police or security officers exist, publicly-available data should demonstrate that they have not disproportionately stopped, arrested, or otherwise interacted with people of color.

- A. The above metric is fully met
- B. There are some programs designed to reduce reliance on police
- C. There is a campus police force, and no evidence that they have sought to address racism in policing**

The University of Rochester Department of Public Safety (DPS) consists of approximately 134 uniform officers, including 47 non-sworn public safety officers and 87 sworn peace officers. DPS authorized the arming of officers in January 2017, and currently 43 of the sworn peace officers are armed as part of the Medical Center's arming implementation. As of 12/10/18, there were 10 incidents of unholstering of arms. There is a current proposal to increase the number of armed officers to 3 per shift, with 2 assigned to undergraduate River Campus and 1 assigned to the downtown Eastman School of Music campus.

To date, there are no known internal investigations or publicly-available data demonstrating that DPS officers have not disproportionately stopped, arrested or otherwise interacted with people of color. Public Safety uses the same reports and reporting system to document crimes and arrests as the Rochester Police Department and as such are available through the same processes. Public Safety also documents non-criminal activity on a Public Safety Field Case report, which is classified as a UR business record and not publicly accessible. Public Safety additionally maintains a crime log that is available for the public to review during normal business hours at DPS Headquarters 612 Joseph C. Wilson Blvd. The crime log includes time, date, location, nature of incident and case status of crimes reported to DPS, but it does not list the race of those involved in the event of an arrest. Finally, DPS publishes an annual report "Think Safe" each fall which includes crime statistics for the past 3 years broken down by the nature of the crime and location of UR campus. This report also does not include any information on potential racial disparities in crime reporting or arrests.

The main approach of DPS to this issue is "to create an environment of diversity and inclusion" within the department and community through training. Public Safety and the Public Safety Review Board require all officers to receive Fair and Impartial Policing (6 hours), Integrated Approach to De-Escalation and Minimizing Use of Force (24 hours), Racial Diversity Training for Campus Police & Public Safety Officers (8 hours), Crisis Intervention Team Training (40 hours), and Culture Vision (4 hours).

Additional information may be found at the following links:

- [Proposal to arm additional DPS officers for River Campus and Eastman School of Music FAQ](#)
- [Think Safe 2018 Annual Report](#)

10. Expectations for students' level of independence and supervision are clearly documented and are consistent across training sites (for example, students are not disproportionately given the opportunity to "practice" while rotating in VA or public hospitals or while volunteering in free clinics).

- A. The above metric is fully met
- B. Policies exist to ensure that all patients receive equally well-supervised care, but are inconsistently enforced**
- C. Students are routinely given more independence when caring for marginalized patients

Policies exist to delineate the level of independence and supervision that students should have while completing mandated clinical experiences at numerous private and public institutions. Enforcement of these policies may depend on the individual preceptor. A feedback survey at the end of each clinical rotation provides a space for students to voice concerns about variance from the appropriate level of independence, but this is dependent on the student themselves recognizing and reporting a variance or problem.

Preclinical students do provide care in student run clinics for uninsured patients under the guidance of a team of third/fourth year medical students and one licensed provider. Students often assume more autonomy and practice skills they are not yet comfortable with or proficient in during these experiences. These patient encounters often have three or more students in the room at the same time, a departure from the normal standard of care in other clinical settings.

Additional information may be found at the following links:

- [URSMD Student Handbook](#), P. 108

11. At the primary teaching hospital, patients of color are represented in all services (including specialist services) and practices at their rate in the local population. Patients of color are not segregated in resident or student clinics.

- A. The above metric is fully met
- B. There are some efforts to promote equal access to care (e.g. Medicaid patients seen in faculty clinics)**
- C. Patient care is highly segregated or this information is not publicly available

The two main teaching affiliates at the University of Rochester School of Medicine are Strong Memorial Hospital and Highland Hospital. Although there is no available data about patient racial demographics across services at these teaching hospitals, it is notable that Strong Memorial Hospital has historically been known in Rochester as the “white hospital.” An article in *Rochester Medicine* alumni magazine reflects, “For decades, URMC’s Strong Memorial Hospital, which had separate white and black nurseries until they were abolished in the 1960s, was perceived as the ‘white hospital’ serving predominantly white, wealthy residents, while Rochester General (formerly known as Northside) Hospital, tended more to the city’s poorer, black communities.”

In order to gain some insight into the current patient populations of these hospitals, we investigated the breakdown of net patient service revenue at each, paying particular attention to the proportion of patients with Medicaid compared to the poverty rate (14.6%) and Medicaid enrollment (18% in July 2017) in Monroe County. At Strong Memorial Hospital, 18% of patients in 2017 and 17% of patients in 2018 were covered by Medicaid, similar to the proportion of people enrolled in Medicaid in the county. At Highland Hospital, these numbers were slightly lower, with 15% of patients in 2017 and 14% of patients in 2018 covered by Medicaid. (see table below)

	Strong Memorial Hospital		Highland Hospital	
	2017	2018	2017	2018
Medicaid	18%	17%	15%	14%
Medicare	34%	35%	40%	41%

Blue Cross	29%	29%	28%	27%
MVP Health Care	5%	5%	5%	5%
Other (self-pay, etc.)	14%	14%	12%	13%

The teaching hospitals have financial aid and charity care programs to assist patients in paying for services if they have trouble doing so. The Strong Memorial Hospital Code of Organization and Business Ethics Policy, Principle 5 - Patient Access to Health Care states that “registration, admission, transfer and discharge of patients are based on the patient’s welfare and personal preferences, without regard to their ability to pay.” The principle further states that the hospital will help patients find resources to help patients cover the cost of their care, including but not limited to the hospital’s financial counseling and charity care programs. Notably, eligibility for financial assistance is based on income and family size and no other factors, including insurance status and citizenship status.

Additional information may be found at the following links:

- [Rochester Medicine 2016, Volume 2, P. 22](#)
- [U.S. Census: Quick Facts Monroe County, NY](#)
- [Patient Enrolled in Mainstream Medicaid Managed Care by County, Plan, Aid Category, and NYSoH - July 2017](#)
- [Strong Memorial Hospital Financial Assistance](#)

12. The primary teaching hospital has demonstrated a commitment to immigrant patients including multilingual signs stating that patients are welcome regardless of immigration status, and a policy of referring immigration authorities to hospital attorneys prior to any cooperation by hospital staff.

- A. The above metric is fully met
- B. The hospital has some symbolic commitment to immigrant patients (e.g. signs), but no policies explicitly protecting undocumented patients**
- C. The hospital has no public or policy commitment to immigrant patients

Strong Memorial Hospital, the primary teaching hospital of The University of Rochester, states in a Non-Discrimination Policy that it “prohibits and will not engage in discrimination or harassment on the basis of age, color, disability, domestic violence status, ethnicity, gender identity or expression, genetic information, marital status, military or veteran status, national origin, race, religion or creed, sex, sexual orientation, or any other status protected by Federal civil rights law.” Administrators state that no person will be turned away for services based off of legal status, and patients with challenging legal issues may be referred to Care Management, Social Work, or Patient Relations. However, there are no formal policies or signs emphasizing that patients are welcome regardless of immigration status.

According to Strong Memorial Hospital’s Contacts with Law Enforcement Agencies Policy, requests of law enforcement agencies to contact patients will be referred to University Public Safety. Both patient and physician consent are required before allowing a law enforcement representative will be allowed to access a patient for questioning. The physician may prohibit patient questioning for medical reasons and will note it in the chart. Further, a patient whom the authorities seek to question has the constitutional right to remain silent or walk away.

With regards to communication, the hospital accommodates non-English speaking patients. Hospital walls display multilingual signs in the main entrance of the hospital, the entrance to Wilmot Cancer Center and Golisano Children’s Hospital. At the front desk of the hospital, staff members have language index cards that contain short phrases in more than 50 languages to help communicate with non-English speaking patients. Interpretation services in the hospital are provided 24 hours a day, 7 days a week for Spanish speakers and American Sign Language speakers. Additionally, CyraCom Blue Interpreter Phones are found in every hospital unit and in the Emergency Department and offer more than 160 languages.

Strong Memorial Hospital recently purchased Culture Vision, an online database giving patient-facing caregivers access to information about 75 ethnic groups, religious

groups and additional communities for use in providing culturally competent patient care. Hospital employees are encouraged to reference this resource to learn general information about specific groups, but it is unclear how individuals then use that information. We believe the potential for perpetuating stereotypes by assuming the information is applicable to all individuals in a certain group is high.

Additional information may be found at the following links:

- [Strong Memorial Hospital Non-Discrimination Policy](#)
- [Strong Memorial Hospital Interpreter Services](#)
- [Culture Vision](#)

13. All medical school staff and staff at the primary teaching hospital are paid a living wage as defined by local advocacy organizations. All full-time staff have comprehensive health insurance that is accepted at the health system where they work.

- A. The above metric is fully met
- B. N/A
- C. Some staff earn less than a living wage and/or do not have access to comprehensive health insurance or this information is not publicly available**

NYS Minimum Wage is \$11.10/hr effective 12/31/18. Monroe County living wage is \$11.66/hr for a single working adult, as defined by the MIT Living Wage Calculator. Further, Rochester City Council has set minimum wage rates for employees of companies entering into contracts for services with the City of Rochester at \$12.09 for companies offering health insurance and at \$13.51 for companies not offering health insurance. This minimum wage applies from July 1, 2018 through June 30, 2019.

For non-represented staff with at least 2 years of benefit eligible service, the University notably complies with City of Rochester living wage of \$12.09/hr with health insurance. Comprehensive medical and dental insurance are offered to full-time and part-time staff. However, staff with less than 2 years of benefit eligible service are only paid the NYS Minimum Wage of \$11.10/hr.

Workers who are represented by a union have wages subject to negotiation, and the rate at which they are currently compensated is unclear to this group. Two unions, 1199

SEU United Healthcare Workers East and SEIU Local 200 United, represent 1,800 UR staff members including patient care technicians, nursing unit secretaries, environmental services staff, food service, materials processing staff and many others. In Fall 2017, these unions ratified a new 3-year contract with UR campuses and Strong Memorial Hospital which included:

- 2% wage increase each year
- New, higher wage step for most senior employees
- Continuation of union-sponsored health insurance at no cost to employees
- Improved dental benefits, bereavement leave and long-term disability coverage
- An additional paid holiday
- Additional training programs for career advancement

Additional information may be found at the following links:

- [New York State Minimum Wage](#)
- [Living Wage Calculation for Monroe County, NY](#)
- [City of Rochester Living Wage Hourly Rates](#)
- [UR 2019 Health Plans Comparison Chart](#)
- [UR Service Workers Ratify New 3-Year Contracts \(Democrat & Chronicle\)](#)

14. IRB approval process requires researchers involved in any research that uses race to precisely define race and how it is being used in the research project. Projects based on race-based genetics or any other biological notions of race are not approved. All student research projects are evaluated with regards to responsible treatment of race by a qualified faculty member.

- A. The above metric is fully met
- B. IRB process requires researchers to explain their use of race
- C. IRB process has no requirements regarding the treatment of race or this information is not publicly available**

There are no specific IRB policies related to race or racism, including no requirements related to how race is defined in research protocols. IRB Policies define “vulnerable populations” for biomedical research as children, pregnant women, prisoners, and decisionally impaired adults. For social behavioral educational research, the additional population of students/employees is added to the aforementioned list. All student research projects are conducted with faculty member supervision, but there are no explicit guidelines by which to ensure responsible treatment of race in the studies.

All students and any faculty or staff involved in research are required to complete an online Human Subjects Research module, which includes acknowledgement of the racist history of scientific research and encourages a consideration of the ethics of using race in research. Researchers are required to have completed this training module in order to obtain IRB approval. However, there are no specific IRB policies enforcing nor facilitating this process.

Additional information may be found at the following links:

- [Policy 102 UR Human Research Protection Program](#)
- [Protocol Template Social Behavioral Educational](#)

Washington University in St. Louis School of Medicine

This section provides further detail on each metric for the Washington University School of Medicine in St Louis (WUSM), which is an allopathic medical school located in St. Louis, Missouri. Primary teaching hospitals include the Barnes–Jewish Hospital and St. Louis Children’s Hospital.

Each metric (numbered 1–14 in the truncated report card) includes the full metric prompt, the grade for the institution, and an explanation of what that grade represents. Below each metric, we provide any relevant links to sources.

1. Medical school students are at least 13% Black, 1% Native American, and 17% Latinx (corresponding to the share of these groups in the U.S. population).

- A. All of the above groups are proportionately represented among students
- B. Some of the above groups are proportionately represented among students
- C. None of the above groups are proportionately represented among students, or this information is not publicly available**

Per AAMC data, among WUSM students, 5.6% are Black, 3.2% are Latinx, and less than 1% are Native American.

WUSM reports that, among all of their medical students, 5.2% are Black, 4.6% are Latinx, and less than 1% are Native American. In the 2018–2019 medical school class, 12.9% of students are Black, 6.45% are Latinx, and 0.8% are Native Hawaiian.

Additional information may be found at the following links:

- [AAMC Medical School Enrollment by Race & Ethnicity](#)
 - [Table B-5.1: Total Enrollment by U.S. Medical School and Race/Ethnicity, 2018–2019](#)
 - [Addressing Diversity at Washington University](#)
-

2. Medical school faculty are at least 13% Black, 1% Native American, and 17% Latinx (corresponding to the share of these groups in the U.S. population).

- A. All of the above groups are proportionately represented among faculty
- B. Some of the above groups are proportionately represented among faculty

C. None of the above groups are proportionately represented among faculty, or this information is not publicly available

WUSM reports the following racial demographics for faculty: 2.4% Black, 2.6% Latinx, 0.1% Native American, and 0.2% Native Hawaiian/Pacific Islander.

Per WUSM, on March 7, 2018, “the governance group of the School of Medicine adopted the recommendations of its Senior Leadership Committee on Diversity and Inclusion and established numeric goals for increasing the number of URM faculty to 8% over the next decade, with interim metrics to monitor progress. To achieve this goal 112 new faculty will be hired.” WUSM also reports having a Faculty Diversity Scholars Programs, which incentivizes departments to hire and retain URM faculty.

Additional information may be found at the following links:

- [Addressing Diversity at Washington University](#)
- [Faculty Hiring Policy](#)
- [Faculty Diversity Scholars Program](#)

3. The physical space of the medical school acknowledges the contributions of alumni and other physicians of color (through plaques, statues, portraits, and building names) and does not celebrate racist or white supremacist individuals.

- A. The above metric is fully met
- B. There are no items celebrating racist/white supremacist individuals, and also none celebrating people of color

C. The physical space explicitly celebrates racist/white supremacist individuals

The McDonnell Medical Sciences Building is named after James S. McDonnell, the founder of an aerospace and defense contractor that was a leading producer of fighter jets for the U.S. military during the Vietnam War. His company, McDonnell Douglas, was the plaintiff in the 1973 case McDonnell Douglas Corp v. Green, in which it was accused of having illegally fired a Black worker for taking part in civil rights demonstrations in St. Louis. The case was litigated in the Supreme Court; the company won the case on the basis that there was no evidence of racial discrimination, although it admitted to having fired Green due to his participation in Civil Rights protests (McDonnell Douglas Corp v. Green, 411 U.S. 792 (1973)).

More recently, WUSM has made new efforts to acknowledge and celebrate alumni and physicians of color. In 2019, the WUSM Office of Diversity, Equity, and Inclusion co-sponsored the travelling Notable African-Americans in Science & Technology Poster Series. And in February 2019, a former WUSM faculty member returned to campus to present a lecture, “History of the Desegregation of the School of Medicine,” which “include[s] the history of African Americans as students and faculty in the WUSM.”

Additionally, each year the WUSM Office of Diversity Programs sponsors the Homer G. Phillips Lecture Series. This long-standing public lecture series is named in honor of the historic Homer G. Phillips Hospital in St. Louis, the premier training ground for African American medical professionals. In 2018, the lecture centered around the newly-produced and released film: “The Color of Medicine: The Story of Homer G. Phillips Hospital”; the discussion that followed featured former Homer G. Phillips medical professionals.

Additional information may be found at:

- *That St. Louis Thing, Vol. 2: An American Story of Roots, Rhythm and Race*, by Bruce R. Olson
- [McDonnell Douglas Corporation v. Green](#)
- [Notable African Americans in Science & Technology](#)
- Presentation slides [pdf]: [“History of the Desegregation of the School of Medicine”](#)
- [Homer G Phillips Public Health Lecture Series](#)

4. The medical school's recruitment policies promote racial justice. The medical school application does not inquire about the applicant's criminal history. The medical school recruits and admits undocumented students and students of color who attended public high schools in the county or state where the medical school is located. Students of color who participate in recruitment are compensated for their time.

- A. The metric is fully met
- B. Some elements of the metric are met**
- C. No elements of the metric are met

The Office of Diversity Programs is led by the Associate Dean for Diversity and the Assistant Dean for Student Diversity and Engagement and participates in recruitment at the AAMC Minority Medical Student Career Career Fair, American Medical Education Conference, and Summer Health Professions Education Programs. WUSM also has a robust re-visit weekend for URM students. WUSM also sponsors a number of pipeline programs for St. Louis K-12 students, including the Young Scientist Program and the Saturday Scholars program. WUSM also helped draft the curriculum for a new medical high school, the Collegiate School of Medicine and Bioscience, and WUSM medical students continue to serve as mentors and tutors at the school. However, it is unclear whether these programs are serving as meaningful pipelines for URM students from St. Louis to enroll at WUSM.

WUSM accepts applications from international students, explicitly including DACA students, but requires that, prior to enrollment, they document that they have funds sufficient to cover four years of medical school tuition and living expenses, effectively barring undocumented students from enrolling. Students who participate in recruitment are not compensated for their time.

All WUSM matriculants are required to complete a criminal background check and drug screening; any student with a confirmed positive test for THC, cocaine, opiates, amphetamines, or PCP are not permitted to enroll in the School of Medicine.

Additional information may be found at the following links:

- [Office of Diversity Programs](#)
- [Student Profiles](#)
- [Revisit Weekend](#)
- [High School Students: Saturday Scholars Program](#)
- [Application Requirements](#)

5. The curriculum incorporates information about the history of racism in medicine, intersectional oppression, and racial justice strategies, and explicitly addresses the fact that race is a social construct, not a biological one. Lecturers avoid describing race per se (rather than racism) as a risk factor for disease, cause of health disparities, or basis for diagnostic reasoning. Community advocates and students who are underrepresented in medicine are incorporated in the planning and leadership of the pre-clinical curriculum.

A. The above metric is fully met

B. Some elements of the metric are met

- C. The curriculum fails to adequately address racism in medicine. Race is stated or implied to be biological. Community advocates and URM students do not participate in planning or are not compensated for their time.

All first year medical students participate in a mandatory Diversity Retreat, which includes discussion of implicit bias, non-judgmental communication, and diverse definitions of “health.” Per WUSM, some exercises help students identify barriers faced by people of color and explore the effects of racism on access to healthcare.

During Orientation, students also participate in talks and city tours that address diversity, racial health care disparities, and challenges faced by specific communities of color in St Louis. There is also an annual “diversity week” that consists of lunch talks by student-selected speakers.

The Washington University Medical Plunge (WUMP) program includes four-day programming with specific discussions of “the historical legacy of local, state, and national policies that enabled and perpetuated segregation in St. Louis” and the ways in which segregation contributes to racial health inequities. The IDEA (Inclusion, Diversity, Equity and Advocacy) longitudinal curriculum incorporates communication strategies, providing “culturally appropriate care,” and “addressing health disparities.” There is no policy that lecturers or preceptors should avoid the implication that race is biological (e.g. by asserting race is a risk factor for disease) and no explicit discussion of the sociopolitical (i.e. non-biological) nature of race.

The Office of Diversity & Inclusion sponsors a series of one-hour “Diversity 1.0-4.0” workshops for Washington University School of Medicine community members, which cover diversity, biases, and prejudice. All current faculty, staff and students must complete the training by 2020, and Sessions 1 and 2 are part of new-employee orientation for staff; all new employees must complete the entire training sequence within their first three years of employment. The University’s Teaching Center offers faculty optional courses in creating inclusive learning environments.

URM students are highly involved in planning community celebrations such as the Homer G. Phillips Public Health Lecture and the Annual Martin Luther King Jr. Lecture but do not play any formal role in the mainstream, mandatory curriculum.

There is a full-time manager of Diversity and Community Engagement, whose role is to increase staff diversity and improve the University’s relationship with community organizations. The Office of Diversity & Inclusion states: “We invite ‘community voices’ from experts with diverse backgrounds across the St. Louis region to collaborate with us in ways that add to establishing a diverse and inclusive environment at Washington University School of Medicine.” Although there are a variety of structures for community engagement in research, it does not appear that community feedback and leadership is incorporated into formal MD curricular

activities beyond the week-long Washington University Medical Plunge (WUMP) orientation program for first year medical students. The WUMP program brings community leaders to speak to medical students and places students in nonprofit organizations to volunteer.

Additional information may be found at the following links:

- [The Office of Diversity & Inclusion](#)
 - [The Office of Diversity & Inclusion: Leadership](#)
 - [The Office of Diversity & Inclusion: Community Engagement](#)
 - [The Office of Diversity & Inclusion: In Response to Ferguson](#)
 - [Cultural Awareness](#)
 - [Diversity Retreat](#)
 - [WUSM Plunge Schedule](#)
-

6. The medical school has a system for collecting student and faculty reports of racism and other forms of oppression, and a clear plan for follow-up when problems are reported.

A. The above metric is fully met

- B. There is some system for collecting reports, but there is no clear follow-up after reports are made
- C. There is no system for collecting reports

WUSTL has a robust Bias Report & Support System which allows individuals who have experienced or witnessed bias, prejudice, or discrimination to report their experience. The BRSS team supports the individual who makes the report and provides public summary reports of incidents. It is unclear whether medical students have access to the full system and whether normal protocols are followed for reports by medical students. The website of the system states, “Non-anonymous BRSS reports on the Washington University School of Medicine campus are sent to the Assistant Provost who assists WUSM students in navigating their programs and connects them with the relevant policies and contacts within those programs.”

In addition, two Ombuds offices serve the School of Medicine, helping to resolve work-related conflicts and advocating for fair treatment and process. One office serves faculty and medical students and the other serves university staff, postdoctoral trainees and graduate students.

Additional information may be found at the following links:

- [Bias Report & Support System](#)
 - [Bias Report & Support System Summary Reports](#)
-

7. There are no racial disparities in medical students' grades or honors (including AOA election)

- A. The above metric is fully met
- B. The school regularly evaluates whether there are racial disparities, and has developed plans to address them
- C. There are significant racial disparities in grades and/or honors**, or this information is not publicly available

Per WUSTL:

“In response to national reports which demonstrated racial differences in Alpha Omega Alpha nomination and clinical grading, the WUSM conducted a review of its own data in 2018; preliminary results indicated similar racial differences with white students being more likely to receive honors grades in the clinical clerkships and more likely to be nominated for Alpha Omega Alpha than students of color.

As a result of the review, the Executive Vice Chancellor and Dean, Senior Associate Dean for Education and Associate Vice Chancellor/Associate Dean for Diversity, Equity and Inclusion announced steps that the WUSM would implement in order to examine and ensure that the system is fair to all students. The strategies included: (1) conducting focus groups with current medical students; (2) administration of an online, anonymous survey to gather additional information from students; (3) development by Medical Student Government (MSG) of an immediate process for grade challenges that may be related to racial or gender discrimination; (4) formation of a Commission of Equity in Clinical Grading (total of 20 members, including 7 students) to make suggestions for immediate, short and long-term changes to grading and AOA selection; and (5) conduct a more thorough evaluation of the underlying causes that may contribute to the disparities.

Accomplishments to date: the focus groups have been held and the surveys have been completed; the student-derived grade appeals process is in the early stages of the approval process; the Commission members identified a number of factors that they believe may contribute to the differences in clinical grading; those factors have been grouped and Commission members are researching and acquiring additional information as needed. The Commission’s goal is to develop a comprehensive set of recommendations to be finalized and implemented during the next academic year.”

WUSM states that two of the five current Executive Committee members are Black but provides no public information on the demographics of students in current or recent AOA classes.

8. Black, Native American, and Latinx students have access to designated physical spaces, as well as support staff, including administrators, physician mentors, mental health providers, and peer counselors.

A. The above metric is fully met

- B. There are some resources specifically designated to support students of color
- C. There are no designated resources for students of color

The Office of Diversity Programs provides support to URM students, including support staff and administrators, physician mentors, networking socials, an annual directory of URM individuals, a room specifically designed as a safe space for study groups or informal gatherings, and support for student-led groups that provide peer mentoring. Student Health Services provides medical care for medical students, including onsite counseling, where 66% of Student Health Services psychologists are Black. Diversity trainers, who provide mandatory training to faculty, staff, and students are also available to students for support and counseling.

Additional information may be found at the following links:

- [Post: Who You Are & Where You've Been](#)
 - [Student Affinity Groups](#)
 - [The Office of Diversity Programs](#)
 - [Mental Health Information: Counseling](#)
-

9. There is no hospital/campus police force, or police are used as a last resort after the failure of alternative safety structures such as peer walking escorts, restorative justice councils, and mediation. If police or security officers exist, publicly-available data should demonstrate that they have not disproportionately stopped, arrested, or otherwise interacted with people of color.

- A. The above metric is fully met
- B. There are some programs designed to reduce reliance on police
- C. There is a campus police force, and no evidence that they have sought to address racism in policing, or this information is not publicly available**

WUSM has a fully-armed campus police force (WUPD). The WUPD has an [Impartial Policing policy](#), which explicitly prohibits racial profiling and requires that officers receive training to address this. The policy states, “Proper stops are based on observable and articulable actions and behaviors. They are not based on ‘he/she didn’t look like they belonged there.’” All field officers must undergo 8 hours of classes and workshops related to impartial policing. Examples of classes include de-escalation workshops and cultural competency training.

The Impartial Policing Policy also includes a process of civilian complaints, though all oversight seemingly belongs to the department itself with no public transparency or accountability. The WUPD website includes guidelines about “[What to do if you are stopped by police](#)” which features language that tacitly blame civilians for police abuses.

Additional information may be found at the following links:

- [WUSTL Police](#)
 - [Impartial Policing Policy](#)
-

10. Expectations for students' level of independence and supervision are clearly documented and are consistent across training sites (for example, students or residents are not disproportionately given the opportunity to "practice" while rotating in VA or public hospitals or while volunteering in free clinics).

- A. The above metric is fully met
- B. Policies exist to ensure that all patients receive equally well-supervised care, but are inconsistently enforced
- C. Students are routinely given more independence when caring for marginalized patients**

Although WUSM has established guidelines requiring supervision of medical students during formal clinical rotations, it is unclear if the same standards are applied to students volunteering at the Saturday Neighborhood Health Clinic, a student-run free clinic. WUSTL states that “all preclinical and clinical students who volunteer at the Saturday Neighborhood Free Health Clinic are supervised by an attending physician. Three teams of students operate at the clinic, with a ratio of 1:1 preclinical to clinical student. Each team presents to the attending physician, who decides on the treatment plan and discusses the treatment and management plan with the patient and students. Policies and procedures ensure that every patient receives fully professional, optimal care.”

However, preclinical students report that they are permitted to take patient histories with upper level medical students serving to “fill in any gaps”; by contrast, in most clinical settings, preclinical medical students shadow or observe physicians providing patient care.

Additional information may be found at the following link:

- [Saturday Neighborhood Health Clinic: Volunteer Manual](#)

11. At the primary teaching hospital (s), patients of color are represented in all services (including specialist services) and practices at their rate in the local population. Patients of color are not segregated in resident or student clinics.

- A. The above metric is fully met
- B. There are some efforts to promote equal access to care (e.g. Medicaid patients seen in faculty clinics)**
- C. Patient care is highly segregated, or this information is not publicly available

There is no publicly available information about the racial demographics of patients served at WUSTL-affiliated hospitals and practices. However, WUSTL states that 22% of patients served at their institutions are URM and provides the following data from 2018 (St. Louis MSA and city data provided by the Census Bureau):

	White	Black	Latinx	Asian	Native American	Pacific Islander	Other
St Louis Metropolitan Statistical Area	74%	18%	3%	3%	0%	0%	2%
City of St Louis	43%	48%	4%	3%	0%	0%	2%
Barnes-Jewish Hospital	61%	31%	2%	1%	0%	0%	4%
St Louis Children's Hospital	58%	33%	1%	1%	0%	0%	7%

The data above demonstrate that Black patients are overrepresented and Latinx patients underrepresented at WUSTL-affiliated hospitals relative to their share of the population in the St Louis Metropolitan Statistical area, while both populations are underrepresented relative to their share of the population in the city of St Louis.

Data from the Washington University Physician Billing Service from 2018 indicate the following representation of URM patients in specific departments:

Region/Department	URM Share
St Louis Metropolitan Statistical Area	21%
City of St Louis	52%
Total WUSM	23%
Emergency Medicine	60%
Internal Medicine	22%
Neurology	25%
OB/GYN	29%
Pediatrics	31%
Psychiatry	37%
Radiology	22%
Surgery	22%

The above data demonstrate significant heterogeneity in the share of URM (Black/Latinx) patients served by different clinical departments. It is unclear whether patients of color disproportionately receive care in trainee (resident/fellow) clinics. WUSM notes that they are making efforts to expand access to care for patients of color, including opening a new cancer center at Christian Hospital in North St. Louis County.

Medicaid patients, who are disproportionately people of color, are likely underrepresented at Barnes–Jewish Hospital, the medical school’s adult teaching hospital. Overall, 10% of the patients discharged from Barnes–Jewish Hospital in 2016 had Medicaid insurance. WUSM reports that approximately 15% of Barnes–Jewish Hospital patients have a payer of Medicaid Traditional/Risk. At St Louis Children’s Hospital, Medicaid insures 44% of patient visits. WUSM also states that “the URM population served by our institutions — in excess of 22%, and higher for pediatric, emergency medicine and behavioral health services — exceeds URM representation in the St Louis Metropolitan Statistical Area.”

WUSM states that Washington University Physicians (WUSM’s physician practice group) provided charity care equivalent to 8.8% of its total clinical revenues in 2017. With regard to outpatient care, WUSM states that 16% of patient visits are insured by Medicaid at Washington University Physicians.

Although 9% of Missouri adults rely Medicaid, rates of Medicaid insurance coverage are likely much higher in St Louis, given that 21% of individuals in St Louis live below the poverty line (vs. 13% in the state of Missouri). Of note, Missouri did not expand Medicaid under the ACA, and 18% of Missouri adults lack health insurance altogether.

Additional information may be found at the following links:

- [SNHC Volunteer Manual](#)
- [Barnes–Jewish Hospital: Facts and Figures](#)
- [\[zip file\] Health Care Information System \(HCIS\) Data File for 2010](#)
- [Missouri State Indicator: Health Insurance Coverage of Adults 19–64](#)
- [Census: QuickFacts Missouri; St. Louis city, Missouri \(County\)](#)
- [Census Reporter:St. Louis, MO-IL Metro Area](#)

12. The primary teaching hospital has demonstrated a commitment to immigrant patients including multilingual signs stating that patients are welcome regardless of immigration status, and a policy of referring immigration authorities to hospital attorneys prior to any cooperation by hospital staff.

- A. The above metric is fully met
- B. The hospital has some symbolic commitment to immigrant patients (e.g. signs), but no policies explicitly protecting undocumented patients
- C. The hospital has no public or policy commitment to immigrant patients**

In order to serve the fast-growing immigrant population of St. Louis more effectively, WUSM partners with the International Institute of St. Louis, which strives to serve all immigrants without regard to country of origin, race or religion, and the St. Louis Mosaic Project, a regional initiative within the St. Louis Economic Development Partnership and the World Trade Center St. Louis, which promotes St. Louis as a cultural mosaic. WUSM is also associated with Casa de Salud, a clinic which provides care for Latinx patients.

Although WUSM states that through these partnerships they have “gained the trust of the immigrant community in St. Louis, who know they are welcome regardless of their immigrant status,” there is no formal policy of non-cooperation with ICE, and no signage or publically available statements explicitly welcome immigrant patients at hospital or clinic facilities.

In addition to the external partnerships discussed above, in 2006 Barnes-Jewish Hospital established the Center for Diversity and Cultural Competence (CDCC), which aims to “promote an inclusive environment that ensures equitable care for all.”

Per WUSM, the CDCC aims to:

1. Increase cultural competence through education and development for our team members
2. Leverage diversity to advance organizational culture at Barnes-Jewish
3. Reduce language barriers through effective utilization of Language Services for our patients and their loved ones

In 2017 (the most recent year for which data was available), CDCC staff: (1) provided support for 88 languages and dialects; (2) had over 42,000 spoken encounters with non-English speakers; (3) and 2,000 sign language encounters.

Additional information may be found at the following link:

- [Diversity & Cultural Competence](#)

13. All medical school staff and staff at the primary teaching hospital are paid a living wage as defined by local advocacy organizations. All full-time staff have

comprehensive health insurance that is accepted at the health system where they work.

- A. The above metric is fully met
- B. N/A
- C. Some staff earn less than a living wage and/or do not have access to comprehensive health insurance or this information is not publicly available**

The St. Louis living wage is \$11.57/hour for a single adult. Washington University's minimum hourly wage for all regular full time medical school staff is \$12.25 as of July 1, 2018. Full-time employees also receive comprehensive health plans that are accepted at the institution. Benefits include free public transportation passes, tuition support for continuing education offerings through University College, a 50% discount in that program for spouses and a unique tuition benefit for the children of employees of up to \$21,000 per year per child, all of which provide tremendous pathways for individual development and upward mobility.

However, part-time and temporary medical school staff do not have access to the same wages and benefits. Furthermore, there is no publicly available information on the wages and benefits of workers at affiliated hospitals.

Additional information may be found at the following link:

- [Living Wage: St. Louis](#)
- [WUSM Health Insurance Benefits](#)

14. IRB approval process requires any research that uses race to include precise definitions of race and how it is being used in the research project. People of color are clearly identified as being a "vulnerable population" for research purposes, and IRB policies outline strategies to protect people of color from abusive practices.

- A. The above metric is fully met
- B. IRB process requires researchers to explain their use of race
- C. IRB process has no requirements regarding the treatment of race or this information is not publicly available**

The Washington University Institutional Review Board Policies and Procedures requires that the IRB "is qualified through the diversity of its members including consideration of race, gender, and cultural backgrounds and sensitivity to such issues as community attitudes." People of color are not specifically included in the policy's definition of "vulnerable populations;" however, the policy does state that, when

vulnerable populations are involved in research as subjects, reviewers of the research should include at least one person “who has experience with this population.”

Researchers are not required to define race or explain how it is being used in the research.

Additional information may be found at the following link:

- [WU IRB Policies & Procedures](#)
- [Policy: §46.107 IRB membership](#)

Yale School of Medicine

This section provides further detail on each metric for the Yale School of Medicine, which is an allopathic medical school located in New Haven, Connecticut. The primary teaching hospital is the Yale–New Haven Hospital.

Each metric (numbered 1–14 in the truncated report card) includes the full metric prompt, the grade for the institution, and an explanation of what that grade represents. Below each metric, we provide any relevant links to sources.

1. Medical students are at least 13% Black, 1% Native American, and 17% Latinx (corresponding to the share of these groups in the U.S. population).

- A. All URM groups are proportionately represented among faculty and students
- B. Some URM groups are proportionately represented among faculty and/or students
- C. No URM groups are proportionately represented among faculty or students**

Per AAMC data, in 2018–2019, approximately 5% of Yale medical students were Black, 4% were Latinx, and 0.4% were Native American.

Additional information may be found at the following link:

- [AAMC Medical School Enrollment by Race & Ethnicity](#)
 - [Table B-5.1: Total Enrollment by U.S. Medical School and Race/Ethnicity, 2018–2019](#)
-

2. Medical school faculty are at least 13% Black, 1% Native American, and 17% Latinx (corresponding to the share of these groups in the U.S. population).

- A. All URM groups are proportionately represented among faculty
- B. Some URM groups are proportionately represented among faculty
- C. **No URM groups are proportionately represented among faculty**

Yale faculty is approximately 4% Black, 3% Latinx, and 0.1% Native American.

Additional information may be found at the following link:

- [Diversity Summit Report](#)
-

3. The physical space of the medical school acknowledges the contributions of alumni and other physicians of color (through plaques, statues, portraits, and building names) and does not celebrate racist or white supremacist individuals.

- A. The above metric is fully met
- B. **There are no items celebrating racist/white supremacist individuals, and also none celebrating people of color**
- C. The physical space explicitly celebrates racist/white supremacist individuals

Recent efforts have been made throughout Yale University to remove the names of white supremacist individuals from buildings and other positions of honor. It is unclear, however, whether alumni of color are publicly celebrated in the physical space of the medical school.

Additional information may be found at the following links:

- [Post: School of Medicine Honors its first African-American Women Graduates](#)
 - [Post: Yale Changes Calhoun College's Name to Honor Grace Murray Hopper](#)
-

4. The medical school's recruitment policies promote racial justice. The medical school application does not inquire about the applicant's criminal history. The medical school recruits and admits undocumented students and students of color

who attended public high schools in the county or state where the medical school is located. Students of color who participate in recruitment are compensated for their time.

- A. The above metric is fully met
- B. Some elements of the metric are met**
- C. No elements of the metric are met

Yale School of Medicine states that they “welcome applicants regardless of documented or undocumented immigration status” and endorse the University President’s commitment to financial aid policies that ensure that undocumented students can enroll at Yale.

Yale has several pipeline programs to prepare URM students for medical school, including the Yale Summer Enrichment Medical Academy, a program for local community college students, which prioritizes URM students, DACA students, and first generation college students. It is unclear how many pipeline students and URM students from New Haven have enrolled at Yale School of Medicine. URM medical students who participate in recruitment are not compensated for their time.

The Yale School of Medicine uses the AMCAS application, which inquires about criminal history, and requires a criminal background check.

Additional information may be found at the following links:

- [Admissions](#)
- [Yale Summer Enrichment Medical Academy \(YSEMA\)](#)
- [Pipeline Programs](#)
- [AMCAS Participating Schools and Deadlines](#)

5. The curriculum incorporates information about the history of racism in medicine, intersectional oppression, and racial justice strategies, and explicitly addresses the fact that race is a social construct, not a biological one. Lecturers avoid describing race per se (rather than racism) as a risk factor for disease, cause of health disparities, or basis for diagnostic reasoning. Community advocates and students who are underrepresented in medicine are incorporated in the planning and leadership of the preclinical curriculum.

- A. The above metric is fully met
- B. Some elements of the metric are met
- C. The curriculum fails to adequately address racism in medicine. Race is stated or implied to be biological. Community advocates and URM students do not participate in planning or are not compensated for their time**

Publicly available course materials make no mention of the history of race or racism in medicine, nor do they include discussion of the sociopolitical (i.e. non-biological) nature of race.

The U.S. Health Justice course is an elective offered to Yale medical students that provides some, but not all, students access to education about racial justice and racism in medicine. The “Overarching Goals” of the course include the following: “Students learn to practice medicine with cultural competence and fiscal responsibility in preparation for work in a society characterized by diverse populations and economic constraints.” There is no specific mention of race or racism.

There is no evidence that community members or URM students play a role in designing or leading curricular activities.

Additional information may be found at the following link:

- [Yale Integrated Course Curriculum](#)
- [Post: New class brings health justice to medical curriculum](#)
- [Yale Curriculum: Goals & Principles](#)
- [Yale Curriculum](#)

6. The medical school has a system for collecting student and faculty reports of racism and other forms of oppression, and a clear plan for follow-up when problems are reported.

A. The above metric is fully met

- B. There is some system for collecting reports, but there is no clear follow-up after reports are made
- C. There is no system for collecting reports

The Yale mistreatment policy explicitly protects against mistreatment on the basis of race, and describes clear follow-up steps that will be taken by the Office of Diversity, Inclusion, Community Engagement, and Equity and the Office for Equal Opportunity Programs to “combat racial and ethnic insensitivity and harassment throughout the School of Medicine.” Yale further states that, in instances of racial or ethnic harassment, “vigorous steps are taken to investigate any allegation, to counsel the offender, and to recommend disciplinary action, if necessary.” Beyond racially-motivated mistreatment, the mistreatment policy clearly names the individuals responsible for follow-up for different types of harassment, the steps that will be taken in response to reports, and the options available to students who have experienced mistreatment. There appears to be no online or otherwise anonymous reporting system.

Additional information may be found at the following link:

- [School of Medicine 2017–2018 General Information](#)
-

7. There are no racial disparities in medical students' grades or honors (including AOA election).

- A. The above metric is fully met
- B. The school regularly evaluates whether there are racial disparities, and has developed plans to address them
- C. There are significant racial disparities in grades and/or honors or this information is not publicly available**

There is a well-publicized Yale study documented significant racial disparities in AOA membership nationally. However, there is no publicly available information on whether such disparities exist in grades or other forms of student evaluation at Yale School of Medicine.

Additional information may be found at the following link:

- [Article: Racial Disparities in Medical Student Membership in the Alpha Omega Alpha Honor Society](#)
-

8. Black, Native American, and Latinx (URM) students have access to designated physical spaces, as well as support staff, including administrators, physician mentors, mental health providers, and peer counselors.

- A. The above metric is fully met
- B. There are some resources specifically designated to support URM students**
- C. There are no designated resources for URM students

The Office for Diversity, Inclusion, and Community Engagement (DICE), led by the Chief Diversity Officer, coordinates support for URM students. This office supports URM student groups, sponsors a mentorship program (iMUST) for URM students and trainees, and hosts socials for URM students. There are, however, no designated physical spaces or mental health providers for URM students.

Additional information may be found at the following link:

- [Yale Office of Diversity, Inclusion, and Community Engagement \(DICE\)](#)
 - [DICE: Inclusion](#)
-

9. There is no hospital/campus police force, or police are used as a last resort after the failure of alternative safety structures such as peer walking escorts, restorative justice councils, and mediation. If police or security officers exist, publicly-available data should demonstrate that they have not disproportionately stopped, arrested, or otherwise interacted with people of color.

- A. The above metric is fully met
- B. There are some programs designed to reduce reliance on police
- C. There is a campus police force, and no evidence that they have sought to address racism in policing**

Yale has a campus police force, and an officer patrols the medical center 24 hours a day. There is a clear process for reporting complaints about the conduct of Yale Police Department Officers. There is no evidence, however, that there have been efforts to address racist policing or pursue alternative safety structures.

Additional information may be found at the following links:

- [Yale Security](#)
 - [Yale Police Department](#)
-

10. Expectations for students' level of independence and supervision are clearly documented and are consistent across training sites (for example, students are not disproportionately given the opportunity to "practice" while rotating in VA or public hospitals or while volunteering in free clinics).

- A. The above metric is fully met
- B. Policies exist to ensure that all patients receive equally well-supervised care, but are inconsistently enforced (*clear policies exist at YSM, but are somewhat different in Yale New Haven Hospital and in the HAVEN Free Clinic*)**
- C. Students are routinely given more independence when caring for marginalized patients

There are clear policies on the supervision of medical students at Yale New Haven Hospital during required clinical rotations. The HAVEN Free Clinic policies and procedures clearly describe the expectations for supervision of pre-clinical students and describe a role for clinical students that is similar to the role they would have in a clerkship setting, e.g. during their training in Yale New Haven Hospital. However, preclinical students do not typically engage directly in clinical care in the hospital setting, but are allowed to do so within the HAVEN Free Clinic.

Additional information may be found at the following links:

- [Guidelines for Performance of Invasive Procedures by Medical Students](#)
 - [Guidelines for Student Supervision and Safety of Required Clerkships](#)
 - [Haven Free Clinic](#)
-

11. At the primary teaching hospital(s), patients of color are represented in all services (including specialist services) and practices at their rate in the local population. Patients of color are not segregated in resident or student clinics.

- A. The above metric is fully met
- B. There are some efforts to promote equal access to care (e.g. Medicaid patients seen in faculty clinics)
- C. Patient care is highly segregated or this information is not publicly available**

There is no publicly available information on racial segregation of care at Yale facilities. However, although Yale New Haven Hospital is by far Connecticut's largest hospital, and New Haven one of the state's poorest cities, Yale New Haven Hospital ranks 8th in the state in uncompensated care as a share of patient revenue and 5th in the share of discharged patients who lack health insurance. Approximately 28% of patients discharged from Yale New Haven Hospital in 2016 had Medicaid insurance. Given that people of color are overrepresented among patients receiving uncompensated care (including under-reimbursed Medicaid care) and among patients who lack health insurance, this raises concern that Yale New Haven Hospital is failing to adequately serve patients of color.

Additional information may be found at the following links:

- [Uncompensated Care Analysis 2014-2016](#)
- [Article: New Haven Divided by Growing Income Disparity](#)
- <https://www.politico.com/story/2017/12/31/Yale-New-haven-hospital-community-trust-261660>
- [Connecticut State Indicator: Medicaid Coverage Rates for the Nonelderly by Race/Ethnicity](#)
- [Connecticut State Indicator: Uninsured Rates for the Nonelderly by Race/Ethnicity](#)
- [\[zip file\] Health Care Information System \(HCIS\) Data File for 2010](#)

12. The primary teaching hospital has demonstrated a commitment to immigrant patients including multilingual signs stating that patients are welcome regardless of immigration status, and a policy of referring immigration authorities to hospital attorneys prior to any cooperation by hospital staff.

- A. The above metric is fully met
- B. The hospital has some symbolic commitment to immigrant patients (e.g. signs), but no policies explicitly protecting undocumented patients

C. The hospital has no public or policy commitment to immigrant patients

Yale New Haven Hospital has no public policies or statements affirming their support for immigrant patients.

13. All medical school staff and staff at the primary teaching hospital are paid a living wage as defined by local advocacy organizations. All full-time staff have comprehensive health insurance that is accepted at the health system where they work.

- A. The above metric is fully met
- B. N/A

C. Some staff earn less than a living wage and/or do not have access to comprehensive health insurance or this information is not publicly available

There is not publicly-available information on whether all Yale School of Medicine and Yale New Haven Hospital employees are paid at least the New Haven living wage (\$13.05/hour for a single adult).

Additional information may be found at the following link:

- [Living Wage: New Haven](#)
-

14. IRB approval process requires researchers involved in any research that uses race to precisely define race and how it is being used in the research project. Projects based on race-based genetics or any other biological notions of race are not approved. All student research projects are evaluated with regards to responsible treatment of race by a qualified faculty member.

- A. The above metric is fully met
- B. IRB process requires researchers to explain their use of race
- C. IRB process has no requirements regarding the treatment of race or this information is not publicly available**

The Yale IRB policy on the Recruitment, Appointment, Terms and Evaluation of Members and Chairs states, “The IRB will maintain diversity of membership, including race, gender, and sensitivity to community attitudes in order to fulfill its obligations to review the breadth of research that is conducted by investigators

representing Yale University.” There are no specific policies protecting research subjects of color. There is no required review of how researchers use “race” in their research, and there is no routine review of student projects for their treatment of race.

Additional information may be found at the following links:

- [Yale University Human Research Protection Program](#)
- [IRES IRB](#)



Appendix C

2019 Responses by Institution

Appendix C: 2019 Responses by Institution

Out of 17 institutions that were evaluated by student groups for RJRC 2019, 13 institutions acknowledged student-collected report cards whereas the remaining 4 did not respond. At 8 institutions, leadership provided significant feedback and additional evidence for consideration. Below are responses received. Full responses and associated documents from those institutions can be found [via this link](#).

Frank H. Netter School of Medicine at Quinnipiac University

*Institutional Response from School of Medicine, Director of Finance
(In Full)*

Thank you for sending us this information. Here are a couple of comments that were made: “I don’t understand how a grade can be given to URM Grade Disparity; we’re pass/not pass the first two years and students of color are doing well with residency match. It might also be mentioned that not having AOA is a good thing, since it’s been argued that it’s biased against students of color.”

George Washington University

*Institutional response from the Office of Diversity and Inclusion
(In Full)*

The Office of Diversity and Inclusion was grateful for the opportunity to work in conjunction with our student members of the social justice group to prepare the Race Report Card for the White Coats for Black Lives Initiative. It was an opportunity to think carefully about areas where we have an opportunity to improve our institutional mission of diversity, inclusion and equity. We look forward to the opportunity to continue this collaboration and have high expectations for moving forward together.

Harvard Medical School

*Institutional Response from Associate Dean, Chief Communications Officer
[View Full Response](#)*

Please find attached our response to the 2019 Racial Justice Report Card for Harvard Medical School. We would be happy to answer any questions you may have after reviewing our response.

Icahn School of Medicine at Mount Sinai

Institutional Response from President for Academic Affairs and Chief Diversity and Inclusion
[View Full Response](#)

The Icahn School of Medicine continues to support and endorse the contributions that White Coats for Black Lives has made in calling attention to the issues of bias, racism, inclusion, and equity in medical education and the practice of medicine. It is a moral and social imperative to identify benchmarks and hold institutions accountable for their effort and measure success utilizing validated metrics. By taking the initiative to set standards and assess institutions' performance, you are helping to bring sunshine onto these issues and in so doing, to set the stage for significant and sustainable improvements. These are goals that we all share.

We believe that we can work together to make your analysis even more comprehensive and robust. In the responses below, we have attempted to provide facts and data that are more specific and accurate than the "anecdotal evidence" cited in several of the items in this report card. In cases where the report card contains factual errors, we would appreciate your making corrections before publicly releasing it. And to the extent that the students who supplied information for this report card may have been uninformed or unclear about some of our policies and programs, we are grateful for the opportunity to provide clarification, as well as for the feedback that we need to do a better job of informing the school at large about these policies and programs.

Thank you for considering this material. We would welcome the opportunity to collaborate further with you to address these very important issues.

Johns Hopkins University School of Medicine

Institutional response from the Office of Diversity and Inclusion
[View Full Response](#)

Thank you for sharing the 2019 RJRC report card with us and inviting us to comment. We are pleased to share our response with you and appreciate your commitment to include our response in the final report's appendix. Please feel free to reach out to us if you have any questions.

Johns Hopkins' commitment to social justice is ingrained in its charter from its inception. The institution was established in 1867 as the first American research university, with funds bequeathed by a Quaker merchant, Mr. Johns Hopkins, who sought to create a university-based health center that would provide care to all people "regardless of sex, age, color or ability to pay." Mr. Hopkins set a standard for

providing care without regard to race or ability to pay, which was rare in the 19th-century world.

Headquartered in the heart of Baltimore's Middle East community with its social, economic and health statistics among the worst in the city - Johns Hopkins has grown to recognize its intricate bond with its surrounding community and its residents. The socioeconomic and social struggles of the community became painfully obvious in the spring of 2015 leading to intensification of Johns Hopkins' community engagement culminating in the HopkinsLocal initiative. This initiative, which was born out of race dialogues and town hall meetings across the Johns Hopkins institutions, signifies a commitment to leverage Johns Hopkins' economic power through the following initiatives. Expanding participation of local and minority-owned businesses in construction opportunities; hiring more city residents, with a focus on neighborhoods in need of job opportunities; and enhancing economic growth, employment, and investment in Baltimore through the institution's purchasing activities. This is the milieu in which the Johns Hopkins School of Medicine is situated.

Below we address inaccuracies, missing or incomplete information in the 2019 Racial Justice Report Card. We wish for this response to be included in the final 2019 report.

Sidney Kimmel Medical College at Thomas Jefferson University

No Institutional Response

Tulane University School of Medicine

No Institutional Response

University of California Berkeley- University of California San Francisco Joint Medical Program

*Institutional Response from Head of Admissions, JMP
(In Full)*

Thank you for doing this essential anti-racism work, and sharing it with us. We have discussed the findings about our program among top JMP leadership. We will carefully consider all possible ways in which the JMP must be improved to better meet the needs of students, staff, faculty, and patients of color, and to work more effectively towards racial justice and against racism, for the benefit of everyone.

University of California San Francisco

*No Institutional Response**

*Of note, students completing the Racial Justice Report Card at UCSF noted that they did not expect a response, as they had already been working with medical school leadership support to incorporate evidence and feedback from the Office of the Dean and other administrators prior to the request for an official institutional response.

University of Colorado School of Medicine

Institutional Response from Senior Associate Dean for Education, Associate Dean for Diversity and Inclusion

Thank you for your hard work at putting this together. We are excited to be participating in this project and look forward to ways to help us grow. I am sure we will have some increased input as our students had a short turnaround time for collecting some of the data and we may be able to supplement it more fully.*

**no follow-up response provided.*

University of Miami Miller School of Medicine

No Institutional Response

University of Michigan School of Medicine

Institutional Response from Dean of University of Michigan Medical School

[View Full Response](#)

Perelman School of Medicine at the University of Pennsylvania

Institutional Response from Dean of Perelman School of Medicine and Vice Dean of Office of Inclusion & Diversity

[View Full Response](#)

The recent Racial Justice Report Card distributed by White Coats for Black Lives is meant to prompt discussion of the role academic medical centers can and should play to establish racial justice in medicine. This memo highlights initiatives the University

of Pennsylvania is taking to address concerns the Report Card raises but is not intended to represent the full scope of our efforts.

We have an ongoing process of analyzing where we are and where we need to be as an integral part of our strategic planning process. There is a [Commitment to Diversity Statement](#) on the Office of Inclusion (OID)Website.

University of Pittsburgh School of Medicine

Institutional Response from Vice Dean of School of Medicine

[View Full Response](#)

Thank you for the opportunity to review your report concerning the University of Pittsburgh School of Medicine. We also appreciate the chance to provide comments to the report since the issues White Coats for Black Lives raises are profoundly important to us.

I am attaching a file that includes our comments for your review.

Also, please include me in future communications if you will. I work closely with the people you already include and am often the one who coordinates our efforts.

University of Rochester School of Medicine

No Institutional Response

Washington University in St. Louis School of Medicine

Institutional Response from Associate Vice Chancellor and Associate Dean Diversity, Equity and Inclusion

[View Full Response](#)

Yale School of Medicine

Institutional Response from Deputy Dean for Diversity and Inclusion, Chief Diversity Office (In Full)

Thank you for reaching out to Yale School of Medicine regarding the WC4BL Racial Justice Report Card. We will not be responding to the 2019 report card, as we do not

feel that we have adequate time to conduct the necessary research to correct the accuracy of statements represented in the document.

The school's Committee of Diversity, Inclusion and Social Justice has decided, however, to partner with individuals at the Yale School of Medicine and Yale New Haven Health System in addressing various aspects of the report card in the upcoming academic year.



Appendix D

Glossary

Appendix D: Glossary

The following terms are used in the Racial Justice Report Card itself or in the explanation of some schools' performance.

Anti-Black Racism: [The Movement for Black Lives](#) defines anti-black racism as “term used to specifically describe the unique discrimination, violence and harms imposed on and impacting Black people specifically.” (For example, the belief that Black people do not experience pain or do not experience pain as severely as white people).

Anti-Racism: The practice of publicly and personally supporting policies and actions intentionally designed to dismantle racism.

Capitalism: According to the [Movement for Black Lives](#), capitalism is “an economic system in which products are produced and distributed for profit using privately owned capital goods and wage labor.” They also acknowledge that “many feminists assert that a critique of capitalism is essential for understanding the full nature of inequality, as global economic restructuring based on capitalism reflects a particular ideology that celebrates individual wealth and accumulation at the lowest cost to the investor, with little regard for the societal costs and exploitation.”

Diversity: A justice-oriented state of inclusivity that actively values and celebrates people of all social identities, backgrounds, and experiences. With regards to racial inclusivity, this means actively dismantling whiteness while simultaneously empowering people of color.

Intersectionality: A concept/methodology based on the interconnection of social identities which can simultaneously affect one's experience. This is especially important to consider when thinking about and addressing intersecting oppressions. All anti-racist conversations and actions should take intersectionality into account, addressing not only race, but ability, class, gender identity, sexuality, etc.

Race: A social, political, cultural, and historical construct that artificially divides people into groups based on characteristics such as phenotype, ancestry, national origin, etc. in order to facilitate and justify exploitation.

Racism: The systematic subordination of racialized groups with little social, political, or economic power by racial groups who have more power (i.e. white people). This subordination can occur on behalf of individuals, systems, policies/laws, belief systems, and more.

Race-based Genetics: The study of heredity that relies on a [largely debunked](#), biologically-based definition of race.

Structural Violence: Violence built into a societal institution, law/policy, or guiding belief system that subjugates people of a certain social identity and prevents people of that population from accessing the resources they need to achieve social, physical, and mental well-being

Underrepresented minority (URM): For the purposes of this checklist, we are defining underrepresented minorities in racial and ethnic terms only and specifically Black, Latinx, and Native American students. We recognize that other racial and/or ethnic groups may be considered URMs and it is up to the school to be up to date with which populations are currently included in this definition. Further research and improved data collection are warranted to identify specific sub-groups who are also likely under-represented in medicine i.e. Cambodians, Filipinxs, etc.

Whiteness: A system of beliefs predicated on the normalizing of white supremacy through physical and psychological violence and the subjugation of other racial groups. Common manifestations of whiteness include (neo)colonialism, imperialism, capitalism, revisionist history, meritocracy, etc. As a dominant ideology in the United States, whiteness lays claim to a certain invisibility, usually by asserting itself through systemic and structural means.

Anti-Racism Training: This training can cover many topics, but should lay a foundation for guiding principles of both racism and anti-racism. In order to fully

understand anti-racism as a practice, participants must have a base understanding of what racism is and how it operates. This means discussing the intentional creation of race as a hierarchical system (first through religious justifications and then “scientific” ones), the link between racism and capitalism in the United States, and white domination. With this foundation, participants can then learn about anti-racism as a practice that intentionally dismantles racism and white domination, elevates the voices of marginalized individuals, and fights for the well-being of all individuals, regardless of social identity.



Appendix E

Medicaid Representation at
Affiliate Hospitals

Appendix E: Medicaid Representation at Affiliate Hospitals

Medicaid prevalence among discharged patients, adults in the state, and adults in the city/township, 2017

Hospital	Location	Percent of discharged patients with Medicaid insurance (2017)	Percent of adults ages 19-64 in the state with Medicaid insurance (2017)	Percent of adults ages 19-64 in the city/township with Medicaid insurance (2017)
UC San Francisco				
Zuckerberg San Francisco General Hospital	San Francisco, CA	Data unavailable[i]	21	14
UCSF Medical Center	San Francisco, CA	15[ii]	21	14
University of Colorado				
Denver Health Medical Center	Denver, CO	65	15	16
University of Colorado Hospital	Aurora, CO	26	15	17
National Jewish Health	Denver, CO	43	15	26
Frank H Netter School of Medicine at Quinnipiac University				
St Francis Hospital & Medical Center	Hartford, CT	22	17	17
St Vincent's Medical Center	Bridgeport, CT	21	17	28
Yale University School of Medicine				

Waterbury Hospital	Waterbury, CT	28	17	33
Bridgeport Hospital	Bridgeport, CT	32	17	28
Saint Mary's Hospital	Waterbury, CT	21	17	33
Greenwich Hospital Association	Greenwich, CT	6	17	11
Yale-New Haven Hospital	New Haven, CT	31	17	27
Griffin Hospital	Derby, CT	18	17	20
Danbury Hospital	Danbury, CT	19	17	13
Nowalk Hospital Association	Norwalk, CT	19	17	21
Sidney Kimmel Medical College of Thomas Jefferson University				
Main Line Hospital Bryn Mawr Campus	Bryn Mawr, PA	1	16	5
Thomas Jefferson University Hospital	Philadelphia, PA	3	16	23
Riddle Memorial Hospital	Media, PA	1	16	8
George Washington University School of Medicine & Health Sciences				
George Washington University Hospital	Washington, DC	10	--	21
The Johns Hopkins University School of Medicine				

Sibley Memorial Hospital	Washington, DC	1	--	21
The Johns Hopkins Hospital	Baltimore, MD	29	14	25
Suburban Hospital	Bethesda, MD	6	14	3
Johns Hopkins Bayview Medical Center	Baltimore, MD	31 ⁱⁱ	14	25
Howard County General Hospital	Columbia, MD	4	14	10
Miller School of Medicine at the University of Miami				
UHealth Tower	Miami, FL	Data unavailable	11	14
Jackson Memorial Hospital	Miami, FL	18	11	14
Tulane University School of Medicine				
University Medical Center of New Orleans	New Orleans, LA	10	21	20
Tulane Medical Center	New Orleans, LA	0.2	21	20
Harvard Medical School				
Mount Auburn Hospital	Cambridge, MA	13	22	10
Cambridge Health Alliance	Cambridge, MA	19	22	10
Massachusetts General Hospital	Boston, MA	21	22	24

Massachusetts Eye and Ear Infirmary	Boston, MA	3.5	22	24
Beth Israel Deaconess Medical Center	Boston, MA	6.6	22	24
Brigham and Women's Hospital	Boston, MA	9.1	22	24
University of Michigan Medical School				
University of Michigan Health System	Ann Arbor, MI	4	19	7
St Joseph Mercy Chelsea	Chelsea, MI	2	19	2
Washington University School of Medicine in St. Louis				
Barnes-Jewish Hospital	Saint Louis, MO	10	9	15
Barnes-Jewish West County Hospital	Creve Coeur, MO	2	9	1
Perelman School of Medicine at the University of Pennsylvania				
Penn Medicine Princeton Medical Center	Plainsboro, NJ	3	13	1
Hospital of the University of Pennsylvania	Philadelphia, PA	2	16	23
Chester County, Hospital	West Chester, PA	4	16	7
Penn Presbyterian Medical Center	Philadelphia, PA	3	16	23

Pennsylvania Hospital	Philadelphia, PA	3	16	23
Icahn School of Medicine at Mount Sinai				
Mount Sinai Hospital	New York, NY	5	23	26
Mount Sinai West	New York, NY	7	23	26
Mount Sinai Beth Israel	New York, NY	8	23	26
University of Rochester School of Medicine and Dentistry				
FF Thompson Hospital	Canandaigua, NY	1	23	--
Jones Memorial Hospital	Wellsville, NY	2	23	--
Rochester General Hospital	Rochester, NY	3	23	35
St James Mercy Hospital	Hornell, NY	3	23	--
Highland Hospital	Rochester, NY	8	23	35
Nicholas H Noyes Memorial Hospital	Dansville, NY	5	23	--
Strong Memorial Hospital	Rochester, NY	4	23	35
University of Pittsburgh School of Medicine				
UPMC Chautauqua WCA	Jamestown, NY	4	23	--

UPMC McKeesport	McKeesport, PA	3	16	31
UPMC Jameson	New Castle, PA	2	16	17
UPMC Mercy	Pittsburgh, PA	4	16	13
UPMC Hamot	Erie, PA	3	16	17
UPMC Altoona	Altoona, PA	2	16	17
UPMC Northwest	Seneca, PA	1	16	9
UPMC St. Margaret	Pittsburgh, PA	1	16	13
UPMC Passavant	Pittsburgh, PA	1	16	13
Magee Women's Hospital of UPMC Health	Pittsburgh, PA	2	16	13
UPMC Bedford Memorial	Everett, PA	1	16	23
UPMC Presbyterian Shadyside	Pittsburgh, PA	2	16	13
UPMC Horizon	Greenville, PA	1	16	--
UPMC East	Monroeville, PA	2	16	8
UPMC Susquehanna Muncy	Muncy, PA	2	16	--
UPMC Cole	Coudersport, PA	1	16	23
UPMC Susquehanna Soldiers & Sailors	Wellsboro, PA	20	16	--

All data are drawn from the Center for Medicare & Medicaid Services (CMS) Healthcare Cost Reporting Information Center (HCRIS), the American Community Survey (2013–2017), and from the Henry J Kaiser Family Foundation. All data are from 2017, unless otherwise noted. Children’s hospitals have been excluded from this table. More information is available at:

- <https://www.cms.gov/Research-Statistics-Data-and-Systems/Downloadable-Public-Use-Files/Cost-Reports/>
- https://factfinder.census.gov/faces/nav/jsf/pages/guided_search.xhtml
- <https://www.kff.org/other/state-indicator/adults-19-64/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>.

[i] Zuckerberg Hospital has a formal policy of not accepting private insurance. More information on this practice can be found at

<https://www.vox.com/policy-and-politics/2019/1/7/18137967/er-bills-zuckerberg-san-francisco-general-hospital> and at

<https://www.vox.com/health-care/2019/1/24/18195686/vox-zuckerberg-hospital-emergency-room-bill>

[ii] 2017 data unavailable; reflects 2016 data



Appendix F

2018 Metrics

Appendix F: 2018 Metrics

URM Representation

Medical school faculty and students are at least 13% Black, 1% Native American, and 17% Latinx (corresponding to the share of these groups in the U.S. population).

Anti-Racism Training

All faculty and students participate in mandatory workshops, courses, or trainings about the history and ongoing presence of racism in medicine, intersectional oppression, and anti-racism strategies.

URM Recognition

The physical space of the medical school acknowledges the contributions of alumni and other physicians of color (through plaques, statues, portraits, and building names) and does not celebrate racist or white supremacist individuals.

URM Recruitment

The medical school takes proactive measures to recruit and retain students of color, prioritizing undocumented students and students from the local community. Students of color who participate in recruitment are compensated for their time.

URM Leadership

Community advocates and students who are underrepresented in medicine (Black, Native American, or Latinx) are incorporated in the planning and leadership of sessions on community health and health disparities, and are compensated for their time.

Anti-Racist Curriculum

The curriculum incorporates information about the history of racism in various medical fields and explicitly addresses the fact that race is a social construct, not a biological one. Lecturers avoid describing race (rather than *racism*) as a risk factor for disease, cause of health disparities, or basis for diagnostic reasoning.

Discrimination Reporting

The medical school has a system for collecting student and faculty reports of racism and other forms of oppression, and a clear plan for follow-up when problems are reported.

URM Grade Disparity

There are no racial disparities in medical students' grades or honors, including AOA election.

URM Support/Resources

Black, Native American, and Latinx (URM) students have access to designated physical spaces, as well as support staff, including administrators, physician mentors, mental health providers, and peer counselors.

Campus Policing

There is no hospital/campus police force, or police are used as a last resort after the failure of alternative safety structures such as peer walking escorts, restorative justice councils, and mediation. If police or security officers exist, publicly-available data should demonstrate that they have not disproportionately stopped, arrested, or otherwise interacted with people of color.

Marginalized Patient Protection

Expectations for students' level of independence and supervision are clearly documented and are consistent across training sites (for example, students are not

disproportionately given the opportunity to "practice" while rotating in VA or public hospitals or while volunteering in free clinics).

Equal Access for All Patients

At the primary teaching hospital, patients of color are represented in all services (including specialist services) and practices at their rate in the local population. Patients of color are not segregated in resident or student clinics.

Immigrant Patient Protection

The primary teaching hospital has demonstrated a commitment to immigrant patients including multilingual signs stating that patients are welcome regardless of immigration status, and a policy of referring immigration authorities to hospital attorneys prior to any cooperation by hospital staff.

Staff Compensation & Insurance

All medical school staff and staff at the primary teaching hospital are paid a living wage as defined by local advocacy organizations. All full-time staff have comprehensive health insurance that is accepted at the health system where they work.

Anti-Racist IRB Policies

IRB approval process requires researchers involved in any research that uses race to precisely define race and how it is being used in the research project. Projects based on race-based genetics or any other biological notions of race are not approved. All student research projects are evaluated with regards to responsible treatment of race by a qualified faculty member.