Diversity, Equity, and Inclusion

Diversity, Equity, and Inclusion in the Brown Journal of Hospital Medicine

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To the Readers of the Brown Journal of Hospital Medicine,

We are pleased to contribute to the first issue of the Brown Journal of Hospital Medicine (BJHM). For decades, Brown University has been a leader in anti-racism training. In 1976, the Warren Alpert Medical School created what is now known as the Office of Diversity and Multicultural Affairs (ODMA). The ODMA has helped students, residents, fellows, and faculty develop anti-racism expertise; it has produced national leaders in the field of diversity, equity, and inclusion (DEI) across several disciplines. BJHM plans to continue this tradition and bring a critical DEI lens to the works published. To fully appreciate the urgency of antiracist work in medicine, we must first understand the history of racism in the communities in which we live and serve. In the first United States census in 1790, the State of Rhode Island (RI) reported 948 slaves among the 68,825 total population.[1] Since the colonization of RI, the city of Providence and its surroundings have been the home to Indigenous and immigrant people. As a port city, Providence's trade boom made RI one of the wealthiest states by the late 1800s. Along with the trading of goods came the trading of enslaved Black people. White and Black people have long co-inhabited Providence but have been segregated. Many Black inhabitants lived in Snowtown, a segregated neighborhood where the capitol building now sits. Snowtown was also the location of industrial waste disposal.[2] Archaeological excavation around Snowtown, revealed artifacts that reflect a racially and ethnically diverse community, but one that was pushed to the margins of the affluent city.[2] In more recent history, we have witnessed the redirection of the major highway that runs through Providence, perpetuating the division of predominantly wealthier, white neighborhoods from the rest of the city.[3] We have learned that housing factors (among other social determinants of health) have strong associations with poor coronavirus disease 2019 (COVID-19) outcomes among racial and ethnic minority groups; the same people we serve in our hospital system.[4]

In 2020 during the height of the COVID-19 pandemic, fellows in training of the Pulmonary, Critical Care and Sleep Medicine (PCCSM) division of Brown asked for specific training in how to discuss and act against racism and its effects on our patients. This request authentically prompted the creation of Justice Equity Diversity Inclusion (JEDI); a curriculum designed to begin the process of educating the faculty and fellows at Brown about racism and the very real consequences racism has for our patients and colleagues.

JEDI content was resourced and curated from presentations by Black and Indigenous People of Color and White allies who are local and national experts. The foundation of this comprehensive and longitudinal series is factual, evidence-based, and allows participants to engage in active learning through discussion and self-reflection, following andragogical principles. The impact of this program lies in the real-time, interactive component of the content that trained facilitators oversee. JEDI facilitators were recruited from current Brown faculty who have expertise in DEI work across several departments. Our facilitators also treat patients from underserved populations, such as LGBTQ+ individuals (Open Door Health), un- and underinsured patients (RI Free Clinic) and incarcerated people (Department of Corrections). In the past year, we have delivered a total of 41 hours of anti-racism content and continuing medical education credit to over 150 faculty members and fellows. Participants in the first iteration of the JEDI curriculum in the PCCSM division endorsed improved understanding and comfort in discussing race and racism.

Combatting centuries of racism is daunting, but we must succeed. As physicians caring for hospitalized patients, we are in a unique position to positively affect patient experience and mitigate ways in which racism affects patient outcomes. We embrace this role, providing care to a large patient population, and interfacing with all medical disciplines. We can and should serve as role models for our learners and our hospital systems of anti-racist caregiving.

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CONFLICTS OF INTEREST

The authors report no conflict of interest

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