

Correspondence

Response: Re: Evaluating the Uptake of Antiracism Training, Policies, and Practices in Departments of Family Medicine

To the Editor: In their letter to the editor, Hogans-Mathews et al¹ provide important considerations that expand the scope of the conversation related to our article “Evaluating the Uptake of Antiracism Training, Policies, and Practices in Departments of Family Medicine.”² In their response, Hogans-Mathews et al highlight advancing the aims of systems of care to include equity as a core outcome. They describe ways to build toward a sustainable foundation of balanced representation among those underrepresented in medicine (URiM) with partnered allyship from non-URiM colleagues. Hogans-Mathews et al illustrate the opportunity to leverage the privilege that exists within our unbalanced systems, through the sponsorship of meaningful antiracist efforts and taking responsibility for the burden of racist structures that perpetuate privilege and drive inequity and injustice.

Hogans-Mathews et al describe the impact of improved URiM representation in recruitment efforts on workforce diversity. Our team wants to continue the conversation about how the recent Supreme Court of the United States (SCOTUS) decision to end affirmative action in college admissions (*Students for Fair Admissions, Inc. v. President and Fellows of Harvard College*) affects our ability to balance URiM representation. This landmark SCOTUS decision holds that using race as a basis for purposive recruitment (in college admissions) violates the Equal Protection Clause of the Fourteenth Amendment. In the US, racism has been the single most influential driver of oppression and inequity. Antiracist initiatives work to dismantle structures that perpetuate systemic racism that feed interpersonal and internalized racist experiences.^{3,4} While correcting inequities requires a broader perspective than race alone, the SCOTUS decision creates additional challenges for balanced workforce representation as its influence runs downstream to graduate medical education. It logically follows that reducing the diversity of undergraduate admissions will negatively impact the racial and ethnic diversity of future medical school classes applying for residencies. Our history in this space has a repeated and enduring legacy of promulgating barriers to success and lessening opportunities for potential workforce applicants. It sustains environments of inequity fraught with microaggressions experienced by minoritized health care professionals.

We support the efforts to advance understanding and use of holistic review processes to recruit URiM applicants through processes that seek to understand, access, value, and better account for the lived experience of structural oppression.⁵ Coupled with recruitment, ongoing antiracist efforts need to focus on retaining and advancing the

impact of URiM colleagues through academic reparations to correct historic underrepresentation through bidirectional mentorship and coaching; and elevation and sponsorship via the positions and resources of privilege.^{6,7} Antiracist initiatives to address this challenge may include advocating for: removal of inequitable incentive structures; adequate funding streams; and internal admissions processes that adhere to best practices for holistic admissions.

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