We Demand Action at the Yale School of Medicine.

Introduction

The recent, publicly documented murders of multiple Black people by the police have laid bare the urgent and mortal threat posed by institutionalized racism and white supremacy to Black lives. Administrators at Yale School of Medicine (YSM) and Yale University responded to these events by sending us numerous emails expressing their shock, anger, and fear, and identified these incidents as "reminders of a Yale gone-by." This characterization is objectively untrue: institutionalized racism at Yale is alive and well, and the current administration is complicit in maintaining it.

Ten years ago, Black and brown students and faculty wrote an extensive report[1] demanding immediate curricular reform and creation of a multidisciplinary research center addressing structural determinants of health inequity and injustice. That report, like so many before it, was buried and ignored. Five years later, a group of students called NextYSM stood up at a town hall very similar to this one and delivered a set of demands[2] to Dean Alpern that outlined concrete steps to address systemic racism at YSM. Another detailed report in 2018[3] formally outlined very similar priorities. It is now 2020. After 10 years of endless meetings and committees, considerable effort from students, faculty, and the Office of Diversity, Inclusion, Community Engagement, and Equity (DICE), little has changed. Our curriculum remains racist. Our faculty is overwhelmingly white. A private police force employed by this University is empowered to terrorize Black and brown students and to use deadly force against the citizens of New Haven, yet is accountable to neither group. And, of course, Yale commands the resources of a small country in a city which struggles to pay for primary education.

Today, we again demand action. We demand a YSM that is anti-racist, a YSM that actively dismantles its own complicity in systemic and structural violence against Black people. We acknowledge that racism does not act within a vacuum, but rather is enmeshed with other systems of oppression that must be dismantled together. Although many of our concerns extend beyond the School of Medicine—to Yale University or to Yale-New Haven Health system (YNHHS)—these bureaucratic entanglements are no excuse for inaction. We expect that our Deans will actively work to ensure fulfillment of these demands across these artificial

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[1] Cultural Competency Goals Committee Report. Cindy Crusto (Co-Chair), Forrester Lee (Co-Chair), et al. August 2012. https://drive.google.com/file/d/1Fg5_4ipKnAye6QmxeXl3J-jc4PpBzFUg/view?usp=sharing

[2] Demands for Inclusion and Diversity at Yale School of Medicine. NextYSM (signed by >250 students, faculty, and staff). November 2015. https://goo.gl/zbhJmu

[3] Yale School of Medicine, EPCC Subcommittee on Diversity, Inclusion, and Social Justice in Medicine. Marcella Nunez-Smith (Chair), Doug Shensen (Associate Chair), et al., March 2018. https://drive.google.com/file/d/1k0Xx4YeqJdRVHjSMJ0SejfXHYUgVgkQL/view

boundaries, just as they did for the response to COVID-19. The actions we demand are not radical. They are the bare minimum essential steps toward rectifying the inequities and harm perpetuated by this institution. They are not negotiable.

We have 9 core demands, each with a detailed list of actionable items. All unmet items from the original 2015 NextYSM demands are included in these significantly expanded demands.

Sign the demands: ysmdemands.org/sign

Link to this document: ysmdemands.org

1. We demand increased support for the wellbeing of underrepresented students in medicine.

This will require expanded funding and personnel for the DICE office to support a wide variety of initiatives, a more accessible advising system, expanded financial aid support, and mental health professionals for underrepresented students.

1. **Expand and restructure the DICE office to accomplish the following functions**. DICE must receive an adequate budget and must hire an appropriate number of associate deans, directors, and administrative staff to support these functions.
    a. This is to include the following specific positions, each with appropriate support staff:
        i. **Associate Dean of student diversity and inclusion:** This dean will have experience in this field and a background in social psychology, organizational and behavioral psychology, or sociology (or equivalent) or will hire a director with these qualifications.
        ii. **Associate Dean of faculty diversity, development, and retention:** This dean will likely require multiple directors to address this high-need area, including oversight of hiring practices, promotions processes, junior faculty support, compensation issues, mentoring/sponsorship, and climate.
        iii. **Communications director** who will perform the following functions:
            1. Amplify the work and advance the careers of underrepresented students and faculty.
            2. Advertise and promote events on campus related to DISJ topics.
            3. Create guidelines for emails and communications from administration and assist with implementing accountability structures for messages conveyed to students in violation of the guidelines.
        iv. **URM guidance counselor:** This staff member will serve a support role specifically for URM students and will themselves be Black, Latinx, and/or Indigenous. They will provide formal and informal counseling related to career, wellness, the personal experiences of URM students, and emotional support. They will meet with students individually and as a group and will be available for pre-scheduled appointments and on a drop-in basis through open office hours. This role will be similar to that of typical high school guidance counselors, but adapted for URM medical and graduate students, and will formalize much of the informal support

currently provided by DICE staff and other URM faculty and staff. This role is fundamentally different from the mental health clinicians discussed in Demand 1.3; both are required.

b. The following additional functions will be met, supported by appropriate staffing and funding, as determined by DICE:

   i. **Anti-oppression training:** This role will be fulfilled by person(s) with appropriate expertise. They will be responsible for implementation of anti-oppression training for faculty, staff, and trainees, as discussed in detail in Demand 3.5 as well as Demands 2.4 and 2.6.

   ii. **Admissions:** The admissions role will be either an associate dean or a director and will be housed in DICE, not the Office of Admissions. They will have full access to all admissions data, information, and applications and will serve on the executive admissions committee. They will have authority to grant interviews to any candidates without additional approval. They will oversee implementation of demands related to admissions under Demand 4.2.

   iii. **Student wellness:** This is to complement, not replace, the wellness work done by the Office of Student Affairs and should focus on the specific needs of students represented by DICE (including BIPOC, LGBTQ+, first-generation college graduates, low-income, disabled).

   iv. **Physical environment:** This staff member will ensure completion of the demands related to physical space under Demand 3.6. They will develop and implement further plans to improve the physical environment for underrepresented students, including disabled students.

   v. **Research:** This staff member will work with the Office of Student Research to implement demands related to student research under Demand 5.1, and work on additional initiatives to support research of underrepresented students and student research on DISJ topics. They will be a conduit between DICE and the Health Justice and Social Innovation Center (HJSIC) in Demand 5.2, ensuring that research performed by the Center adheres to the values of anti-oppression, debiologization of race and gender, and intersectionality. They will additionally oversee the demands related to IRB and human subjects research policies in Demand 5.3. They will facilitate collaboration between and support of investigators working on DISJ topics.

   vi. **Community engagement**: This staff member will work to support and advocate on behalf of marginalized populations in the New Haven community. They will work to increase engagement with, accountability to, and responsiveness to New Haven residents by Yale. We recommend building on the years of experience and many relationships already

developed by existing DICE staff, allowing them to expand their efforts with additional funding and administrative support.

c. The Office for Women in Medicine should be housed within the DICE office. Throughout the University, initiatives and offices to support underrepresented identities (such as URM, women, LGBTQ+) should be co-housed whenever possible to support the multiple intersecting identities held by members of our community.

2. **Provide financial and programmatic resources** via broadened Yale Health insurance, emergency funds, an expanded Peer Advocate program, and increased financial aid.

    a. **Include dental and comprehensive optometry services** as part of the Basic Yale Health plan.

    b. **Provide additional emergency and miscellaneous funds** to support the needs and professional development of first-generation, low-income, undocumented, and international students.

        i. Expand and reform the current “hardship account” in the Office of Student Affairs.

            1. Provide ongoing, budgeted funding to this account from the Dean’s Office.

            2. Establish equitable guidelines for accessing these funds, including both grants and no-interest loans.

            3. Authorize three points of access to these funds so students can request them through the avenue of their choosing: Office of Student Affairs, DICE Office, Ombudsman

        ii. Establish additional funding to support student travel to and participation in conferences, workshops, and other educational or career-development activities. These funds should be managed by DICE, cover expenses unmet by other funding sources, and prioritize low-income and underrepresented students.

    c. **Expand the Peer Advocate program** to include a dedicated Minority Peer Advocate for each medical school class to act as a resource for minority students and to relay issues and complaints to the administration.

    d. **Improve financial aid services to better serve underrepresented students.**

        i. Increase transparency of the policies and practices of the Office of Financial Aid. This includes, but is not limited to, information on

determination of scholarship allocation and calculation of parental contribution.[4]

ii. Hire financial aid consultants who are trained to deal specifically with the financial aid application processes of international and undocumented students.

iii. Decrease the unit loan to $0. Inadequate financial aid is repeatedly cited as a reason for diverse students declining to matriculate at Yale.

iv. Decrease the interest rate on any institutional loans that will be available to students needing additional funding after the unit loan is decreased to $0.

v. Increase the number of scholarships for low-income and URM students.

1. Provide guaranteed full scholarships to students accepted to YSM who graduated from a New Haven public high school. This program should be similar to the JHU Baltimore Scholars Program, but adapted to YSM.

vi. Availability of support for low-income, undocumented, and other underrepresented groups must be clearly advertised and directly communicated through recruitment efforts to reduce perceived access barriers that prevent underrepresented students from applying.

3. **Hire mental health professionals dedicated to the health and well being of minority and underrepresented students.**

a. Hire mental health care professionals located on the medical and nursing campuses who are themselves people of color and/or queer and who are trained specifically to work with underrepresented individuals in health care professions.

b. Provide more BIPOC and queer mental health professionals through Yale Health and Magellan.

i. Ensure students can be matched with a therapist of color or queer therapist upon request.

ii. Ensure there are adequate providers equipped to work with students who need to discuss gender identity.

c. Take steps to normalize seeking mental health care and reduce barriers for students to access mental health services. For example, consider assigning students to a counselor upon matriculation.

4. **Remove language from technical standards that is discriminatory against potential applicants with disabilities,** especially Deaf and hard of hearing people,

[4] Harvard Medical School is an example of more transparent financial aid policies: https://meded.hms.harvard.edu/package-determinations

people with visual impairments, people with other physical disabilities, and people with psychological disabilities.[5,6]

5. **Enable underrepresented trainees, faculty, and staff to readily access support.**
    a. **Create a navigable, centralized, online platform that clearly outlines all available resources, offices, committees, and initiatives for underrepresented members of the Yale community.** This must be maintained to remain current and accurate. It should be organized for ease of use and according to identity (e.g. LGBTQ+, disabled, Black, low-income, women) and position (e.g. medical student, prospective graduate student, postdoctoral fellow, YLS faculty).
    b. Create **opt-in** affinity lists of trainees, faculty, and staff according to identity (e.g. Black, URM, disabled, Muslim) that is shared **only** with list servs specific for each identity. This is inspired by "Outlists" for LGBTQ+ students and faculty and is intended to help foster community, enable mentoring, and provide additional, more accessible support to underrepresented members of the Yale community.

[5] "Non-Academic Considerations (Technical Standards). Yale School of Medicine. https://medicine.yale.edu/education/admissions/nonacademicconsiderations/

[6] See University of California San Francisco technical standards for example of disability-inclusive language: https://meded.ucsf.edu/policies-procedures/technical-standards

2. We demand curricular reform that is anti-oppressive and anti-racist.

Implicit bias training is ineffective and inadequate; racism and oppression are drivers of disease and are ubiquitous in healthcare, and nothing short of a comprehensive, anti-oppressive curriculum does justice to students or our patients.

An **anti-oppressive curriculum is meant not only to make students aware of inequity but to teach them to actively resist systems of oppression**. We have great confidence in the Health Equity thread leader, Dr. Beverly Sheares, to enact such a curriculum; however, we want to ensure she has the resources and the clear mandate to do so. To emphasize the scope of the task before her, we briefly outline our vision for an anti-oppressive curriculum.

Two core parts of such a curriculum are **structural competency** and **anti-racist pedagogy**.[7] Structural competency is the ability to recognize and articulate how structural forces—laws, policies, companies, economies, the built environment—affect health, and to imagine and observe structural interventions.[8] Anti-racist pedagogy is a method whereby students learn to critically reflect on oppressive power relationships; by examining issues from multiple perspectives and confronting—often emotionally—their own biases, students can work to overcome them.[9] We highlight anti-racism here but this methodology can be applied to resist other systems of oppression.

Transforming our current curriculum into an anti-oppressive curriculum will require both addition and subtraction. First, a large number of ahistorical and non-scientific ideas need to be removed. Race is a social construct, not a biological one.[10] Nevertheless, decades of research have eagerly sought to tie differences in racial outcome to genetics—often in the face of compelling evidence otherwise. The idea of biological race is embedded so deeply in the medical literature and in the thinking of many clinicians that it almost always passes without

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[7] Wear, D., Zarconi, J., Aultman, J. M., Chyatte, M. R., & Kumagai, A. K. (2017). Remembering Freddie Gray: Medical Education for Social Justice. Academic Medicine, 92(3), 312–317. https://doi.org/10.1097/ACM.0000000000001355

[8] Metzl, J. M., & Hansen, H. (2014). Structural competency: Theorizing a new medical engagement with stigma and inequality. *Social Science and Medicine*, *103*, 126–133. https://doi.org/10.1016/j.socscimed.2013.06.032

[9] Wagner, A. E. (2005). Unsettling the academy: Working through the challenges of anti-racist pedagogy. *Race Ethnicity and Education*, *8*(3), 261–275. https://doi.org/10.1080/13613320500174333

Hassouneh, D. (2006). Anti-racist pedagogy: Challenges faced by faculty of color in predominantly white schools of nursing. *Journal of Nursing Education*, *45*(7), 255–262. https://doi.org/10.3928/01484834-20060701-04

[10] Roberts, D. E. (2011). Fatal Invention: How Science, Politics, and Big Business Re-create Race in the Twenty-first Century. New Press.

comment.[1112] In this sense, a massive effort will be needed to “debiologize” race in our curriculum. The use of race in diagnostic testing (e.g., estimated Glomerular Filtration Rate), treatment algorithms (e.g. hypertension guidelines), and risk assessment (e.g. pooled cohort equations for ASCVD risk) must be critically evaluated.

Likewise, sex and gender must be carefully disentangled; the prevalence, risk factors, and presenting symptoms differ in complex ways with both sex (due to biological differences) and gender (due to cultural and structural factors). Teachings which characterize male anatomy, disease presentation, or behaviors as “typical” or “default” must be revised.

Finally, there are numerous instances where frank bias, inappropriate and non-inclusive comments, cultural appropriation, or historical inaccuracy persist in the curriculum—often despite annual complaints from students about the same problematic issues.

Many things must also be added—too much to list here, but here is a partial list:

- Teach clinical presentations of diseases across diverse patient populations.
    - Show skin pathologies on all skin types, show the ‘red reflex’ in Black and brown patients, etc.
    - Use precise language when talking about sex and gender. Avoid narrow illness scripts that cast the clinical presentation of disease in men or males as typical, while making women or females seem atypical. When discussing clinical differences in sex or gender, whenever possible attribute those differences to the mechanism from which they are understood to arise: disparate anatomy, endocrine differences, social factors, or others. If the mechanism is not known, simply state as much. Recognize that biological sex is distinct from social gender, and that neither are binary categories.
- Provide historical context in places where the medical literature is deeply entwined with ancestry—for example, the increased prevalence of genetic diseases among Ashkenazi Jewish people.
- Discuss the roles of underrepresented physicians, scientists, and activists—traditionally excluded in accounts of the history of medicine and public health. For example:
    - The Black Panther Party’s health clinics and sickle cell testing
    - Young Lords health clinics and testing for lead poisoning, etc.

  This is important to provide alternative frameworks for understanding the roles and structures of health care and to challenge the notion that only white men were historically responsible for important advancements in medicine.

[11] Tsai, J., Ucik, L., Baldwin, N., Hasslinger, C., & George, P. (2016). Race matters? Examining and rethinking race portrayal in preclinical medical education. *Academic Medicine*, *91*(7), 916–920. https://doi.org/10.1097/ACM.0000000000001232

[12] Vyas, D. A., Eisenstein, L. G., & Jones, D. S. (2020). Hidden in Plain Sight — Reconsidering the Use of Race Correction in Clinical Algorithms. *New England Journal of Medicine*, NEJMms2004740. https://doi.org/10.1056/NEJMms2004740

- Teach students to provide trauma-informed care throughout their education via the Integrated Longitudinal Clinical Experience (ILCE), Clinical Skills, and clerkships.
- Incorporate intersectionality into existing topics relevant to health justice—for example, consider providing sponsoring intersectional reproductive justice sessions (facilitated by women of color) into the "Across the Lifespan" course and OBGYN Clerkship.[13]

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1. **Institute and fully support an anti-oppressive Health Equity thread and Community Learning Practicum as recommended by the 2018 report to EPCC.**
    a. These courses must include a curricular development committee of students and faculty of marginalized identities, with consultation from faculty from the program in Ethnicity, Race, and Migration, African American Studies, and Women and Gender Studies.
    b. Provide the Health Equity thread leader with full-time administrative support to ensure the thorough implementation of the present demand. Provide additional funding to the Office of Education to support this effort.
    c. Create and fund a post-doctoral position to promote scholarship of anti-oppressive curricular reform and assist with implementation of the new thread.
2. **Reform the existing preclinical, clerkship, and elective curriculum with the goal to eliminate non-scientific and ahistorical teachings that perpetuate systemic racism and bias.**
    a. Remove race as a biological category in all instructional materials. Where racial health inequities are discussed, present these inequities as a function of systemic and structural racism rather than racialized genetics or personal choice (such as "lifestyle choices", "nonadherence", or "noncompliance"). Provide historical context when race is conflated with genetics in the medical literature (e.g. documented increased prevalence of genetic diseases among certain racial groups). Special care must be taken that patient vignettes do not perpetuate racial stereotypes.
    b. Provide for such mandatory training as necessary to ensure knowledge about these topics among educational leadership, including directors of integrated courses, director of clerkships, master course directors, thread leaders, and clerkship directors.
    c. Reform the Public Health and Clinical Epidemiology (PHCE) thread and the Professional and Ethical Responsibility (PER) course to include more diverse faculty leaders and highlight issues of structural inequality.

[13] https://www.sistersong.net/rj-training-and-leadership-development-programs

i. Diversify leaders of this thread and course.

ii. Work with Health Equity thread staff to ensure structural race issues are integral to discussions where relevant (e.g. incarceration, health law session, and civil rights in health care).

iii. Ensure PHCE and PER faculty are trained in issues of race, gender, LGBTQ+, and eurocentrism.

iv. Expand History of Medicine thread and synergize content with history lectures in PER and Responsible Conduct of Research.

3. **Ensure simulated clinical encounters and standardized patients reflect the diversity of our patient population and that issues of race, gender, and ability are handled appropriately.**

    a. **Employ standardized patients for the physical exam curriculum.** Willingness and ability to participate in peer physical examination training varies considerably with gender, religion, and other factors.[14] Moreover, assumptions about gender roles by students and preceptors complicate the ability of students to learn the physical exam equitably.[15] Students do not typically agree to participate in peer physical examination under the conditions required for informed consent.[16]

    b. **Always employ standardized patients when simulating clinical encounters involving patients from marginalized or vulnerable groups.** Never require students to role-play as patients with disabilities, victims of intimate partner violence, etc.

4. **Extend anti-oppression training to graduate medical education**, in recognition of the crucial role that housestaff play in training medical students.

    a. **Provide anti-oppression training within all GME programs as part of didactic sessions**, in line with the training provided to medical students and other members of the Yale community in Demand 3.5.

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[14] Chang, E. H., & Power, D. V. (2000). Are medical students comfortable with practicing physical examination on each other? *Academic Medicine*, *75*(4), 384–389. https://doi.org/10.1097/00001888-200004000-00020

Burggraf, M., Kristin, J., Wegner, A., Beck, S., Herbstreit, S., Dudda, M., Jäger, M., & Kauther, M. D. (2018). Willingness of medical students to be examined in a physical examination course. *BMC Medical Education*, *18*(1), 1–8. https://doi.org/10.1186/s12909-018-1353-5

[15] Vnuk, A. K., Wearn, A., & Rees, C. E. (2017). The influence of students' gender on equity in Peer Physical Examination: a qualitative study. *Advances in Health Sciences Education*, *22*(3), 653–665. https://doi.org/10.1007/s10459-016-9699-0

[16] Delany, C., & Frawley, H. (2011). We need a new model for obtaining students' consent to conduct peer physical examinations. *Academic Medicine*, *86*(5), 539. https://doi.org/10.1097/ACM.0b013e318212eb2c

b. **Provide training to housestaff on inclusive teaching and evaluation** of medical students.

c. **Ensure that this training does not create additional burden for housestaff** by **integrating it into existing GME didactic time or by creating additional protected time for this work**. Forcing housestaff to complete trainings on their days off or expecting them to make time in addition to their usual clinical duties is not acceptable.

5. **Create and provide for advanced studies in health equity for medical students.**

    a. Promote the student-run US Health Justice Course to a formal elective appearing on student transcripts, provide funding for the course, and provide administrative support commensurate with other electives.

    b. Create a Certificate in Health Equity, following recommendations of the 2018 EPCC DISJ Subcommittee Report.

6. **Design and implement a relevant curriculum for graduate students in the Combined Program in Biological and Biomedical Sciences (BBS)** that includes anti-oppression training and education on the roles of social factors such as race and gender in biomedical research.

    a. Provide anti-oppression training to all BBS students.

    b. Provide a mandatory first-year course that promotes a historically and scientifically accurate understanding of race, gender, and disability. This course will debiologize race, deconflate sex and gender, and deconstruct ableist frameworks of health and disease. Students will be equipped to design and perform biomedical research that does not perpetuate or justify systemic racism, ableism, sexism, transphobia, and bias.

3. We demand the creation and maintenance of a genuinely inclusive environment at the Yale School of Medicine for students, faculty, and staff who are underrepresented in medicine.

Institutional culture change requires changes to systems (rules, procedures, leadership structures) as well as individual behaviors. A process for addressing unacceptable behavior—through replacement of punitive measures with restorative justice and education whenever possible—is essential if people of all identities are to be welcomed and included.

Systems and culture in the institutional environment

An inclusive institutional environment is not rooted solely in individual behavior, but also in systems (rules, procedures, leadership structures) **and culture** (values, beliefs, behavioral norms).[17] Interventions that purely focus on individual behaviors (such as implicit bias trainings or punitive measures against individual behavioral episodes) are ineffective at changing the composition and culture of an organization.[18] This is because institutional context (systems and culture) can be so powerful as to override any individual's personal inclinations.[19] Further, and even if individual actions are changed, without change to systems, those systems will re-create the same problematic culture.[20] The bulk of our demands are therefore intended to address structural and cultural factors. We call attention to several specific systems to show how they perpetuate a non-inclusive culture:

- **Faculty tenure and promotion processes:** promotion and tenure committees reward certain types of academic products (namely publications and grants), while the burden of other types of institutional labor (mentorship, committee service, diversity and inclusion efforts) falls disproportionately on faculty from groups who are already underrepresented in medicine—BIPOC and women in particular. While leadership claims that this work is valued in the promotion process, it is clear that this is not the case—both from numerous conversations with faculty and from the demographic makeup of faculty at each level of the academic ladder. Despite increased scientific innovation in those from underrepresented groups, they are less likely to achieve recognition and measures of

[17] Golom, F. (2018). Reframing the Dominant Diversity Discourse: Alternate Conversations for Creating Whole System Change. *Metropolitan Universities*, *29*(1). https://doi.org/10.18060/22172

[18] Dobbin, F., & Kalev, A. (2016). Why diversity programs fail. *Harvard Business Review*, 94(July-August). https://hbr.org/2016/07/why-diversity-programs-fail

Kalev, A., Dobbin, F., & Kelly, E. (2006). Best Practices or Best Guesses? Assessing the Efficacy of Corporate Affirmative Action and Diversity Policies. *American Sociological Review*, *71*(4), 589–617. https://doi.org/10.1177/000312240607100404

[19] Golom, *Ibid.*

[20] Burke, W. W. (2017). *Organization Change: Theory and Practice* (5th ed.). Sage Publications. https://us.sagepub.com/en-us/nam/organization-change/book244771

career success than those from majority groups.[21] Moreover, the opacity of the promotion process prevents this process from being studied. Ultimately, this discrepancy in valuation prevents these faculty from achieving higher academic rank (associated with increased compensation, job security, and standing in the academic community) and causes more of them to leave academic medicine. The effect is an explicit signal that certain types of faculty (and the labor they provide) is not of value to the institution.

- **Faculty compensation structure:** Most faculty are assigned a salary based on department, academic rank, and leadership/administrative responsibilities. The Dean's Office provides a certain amount of support for that salary (typically 50% support for junior faculty and 30% support for tenured faculty)[22] then faculty must undertake revenue-generating activities to fund the remainder of that salary—including obtaining competitive external funding and performing clinical activities. Mentorship (with limited exceptions), teaching, and advocacy are typically not such funded activities; neither is service on relevant committees, task forces, etc. Dean Alpern has assured us that faculty are "compensated for teaching," in the sense that if a faculty member spends 20% of their time teaching, then the cost of that faculty member's teaching is 20% of that faculty member's salary—presumably coming from the percent support guaranteed by the Dean's Office.

  This model has several flaws. First, faculty are explicitly rewarded for increasing their revenue-generating activity; for example, grant funding allows a faculty member to recruit research trainees, increasing their research output; clinical collections or salary support for administrative duties can offset money that would otherwise support faculty salary, having the same effect. The same is not true for teaching, which is typically not compensated at all. Second, as above, activities such as teaching and mentorship are valued significantly less in promotion and tenure committees than revenue-generating activities. Third, this model fails to acknowledge that certain uncompensated activities fall more heavily on particular faculty members, as discussed above. Perhaps most importantly, this model ignores the fact there are major disparities in grant funding success rates by race and ethnicity[23]—quite likely due to a constellation of structural and cultural factors that affect the peer review process and funding agencies—so treating assuming these outcomes are indicative of merit will likely recapitulate inequities.

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[21] Hofstra, B., Kulkarni, V. V., Galvez, S. M. N., He, B., Jurafsky, D., & McFarland, D. A. (2020). The Diversity–Innovation Paradox in Science. *Proceedings of the National Academy of Sciences*, 117(17), 9284-9291. https://doi.org/10.1073/pnas.1915378117

[22] Dean Alpern, CDISJ Meeting 2019-12-17

[23] Ginther, D. K., Haak, L. L., Schaffer, W. T., & Kington, R. (2012). Are race, ethnicity, and medical school affiliation associated with NIH R01 type 1 award probability for physician investigators? Academic Medicine, 87(11), 1516–1524. https://doi.org/10.1097/ACM.0b013e31826d726b

- **Departmental funds flow:** Presently, most of the roughly $1 billion of clinical revenue[24] at YSM is distributed to departments; ~10% of this amount is collected by the Dean's Office to underwrite indirect costs of research, fund the Office of Education, and build reserves (among other items). Department chairs use their revenue "cross-subsidize" faculty who are engaged in teaching or research. This model impairs the ability of both the departments and the Dean's Office to direct funding towards institutional priorities. It creates strong incentives for departments to pursue revenue-generating activities; departments which perform procedures collect disproportionately more clinical revenue, and thus are better funded. This also creates institutional inefficiencies—the Department of Neurosurgery can staff more rooms per clinician than the Section of Rheumatology; the latter is doubly-punished, as its clinical collections are dependent on outpatient visits (rather than procedures), but it has less money to run its clinical practice efficiently. Given that procedural specialties tend to be less diverse, these differences in burden (and compensation) also break along racial and gender lines. Again, this signals the valuation of certain types of labor over others.

Responses to individual behavior

In addition to changes to the structures and systems of YSM, we will need to articulate how we expect individuals to contribute to an inclusive community:

- We endorse **anti-oppression training** (described in more detail below), the goal of which is to develop skills to resist the systems and culture contributing to oppression in our own institution. This includes teaching individuals to examine their own beliefs, prejudices, and biases, as well as the beliefs, values, and norms they inherit from the institution's culture.
- To handle **individual instances of bias and harassment**, we advocate a process rooted in **education and restorative justice**.[25] Restorative justice seeks to repair harm caused by negative behavior, in a manner that is empowering to the person who suffered that harm. Often this is done by helping the two parties meet and agree on a way to repair the harm—but of course this may not always be possible or desirable, in which case alternative methods are necessary. Regardless, the person who committed the negative behavior should take responsibility for the harm and commit to change. This process can be transformative and lead to lasting change in behavior.
- Respect for the YSM community can be demonstrated by **meaningfully holding accountable the people who commit acts of misconduct, including sexual harassment and assault, mistreatment, and bullying**. Those who have shown

[24] Including both revenue from ~$700m collected by Yale Medicine from patients, insurance companies, CMS, etc. and ~$345m in payments from Yale-New Haven Hospital to YSM. Dean Alpern, CDISJ Meeting 2019-12-17

[25] Acosta, D., & Karp, D. R. (2018). Restorative justice as the rx for mistreatment in academic medicine: Applications to consider for learners, faculty, and staff. *Academic Medicine*, *93*(3), 354–356. https://doi.org/10.1097/ACM.0000000000002037

through their actions they do not value the YSM community may no longer find themselves to be a part of it. There is a pervasive view at YSM that those who commit gross acts of misconduct, in violation of the intentional community we have created, face no consequences—or are even commended.[26] Even if this view is inaccurate, it contributes to widespread fear of reporting misconduct: students[27] and faculty[28] fear retribution, do not feel confidentiality is assured, and they have little reason to believe their complaints will be addressed. We can and must rescind the damaging message that misconduct is not taken seriously, and thereby make it easier for students and faculty to report misconduct without fear of retribution. We can instead create a system in which we are all valued.

Crucially, these **processes for dealing with individual behavior need to be equipped to identify patterns**—either within a single person or across the institution—in order to inform the development of better policies and other institutional responses.

Comments on the Creation of a Title VI Office

Title VI of the Civil Rights Act of 1964 protects against discrimination on the basis of race or national origin in programs or institutions receiving federal funds.[29] In May of 2018, following a racist incident, Black graduate students and their allies wrote an open letter (An Open Letter to

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[26] See e.g. the recent case of Michael Simons; after objections from the family of Robert W Berliner, for whom Simons' endowed chair was named, Simons was re-assigned to the Waldemar Von Zedtwitz endowed chair; President Salovey wrote "Mike […] endowed chairs are awarded to those whose scholarship has brought distinction to the university, and I am delighted to convey our pleasure in your accomplishments." Dr. Simons's appointment to the Von Zedwitz Chair was not reversed until significant public outcry ensued.

Cho, S., Peryer, M. (October 22, 2018). "Stripped of endowed chair, Simons files lawsuit against Yale." Yale Daily News. https://yaledailynews.com/blog/2018/10/22/stripped-of-endowed-chair-simons-files-lawsuit-against-yale/

http://civilinquiry.jud.ct.gov/DocumentInquiry/DocumentInquiry.aspx?DocumentNo=15422279

[27] Medical students have the opportunity to report instances of sexual harassment/assault, mistreatment/abuse, and discrimination by faculty on their course evaluation forms; students are assured these complaints will be handled anonymously and that their identity will not be revealed to the subject of their complaint. Complaints are forwarded to the course director and if necessary the department chair, who document a response to the Educational Policy and Curriculum Committee (EPCC), who review these responses twice per year. Despite assurances of confidentiality, almost invariably there are several complaints where the student documents the misconduct but refuses to name the person responsible—typically citing concerns that their complaint will not be handled confidentially.

[28] Peryer, M. (October 23, 2018). "Alpern feedback incomplete, committee argues." Yale Daily News. https://yaledailynews.com/blog/2018/10/23/alpern-reappointment-feedback-incomplete-committee-argues/

Rogers, S., and Siegel, R. (December 3, 2014). "Alpern comes under fire at Med School town hall." Yale Daily News. https://yaledailynews.com/blog/2014/12/03/at-town-hall-med-school-faculty-criticize-administration/

[29] https://www.justice.gov/crt/fcs/TitleVI

the Yale Administration from Black Graduate Students and Allies)[30] recommending the establishment of a Title VI office at Yale, among several other important changes. Similar to the better-known Title IX office, a Title VI office would investigate and respond to race-based discrimination. Nominally, the Office for Equal Opportunity Programs was at that time responsible for such actions. President Salovey's response created a Student Advisory Group on Diversity, Equity, and Inclusion, and otherwise focused on additional training on available University resources and implicit bias, as well as a forthcoming review by external experts. Before this report arrived, the University ruled out the creation of a separate Title VI office, to the frustration of many students.[31]

That report,[32] when it arrived, identified several key problems with the University's Title VI enforcement structure: it remained unclear to students where to go to raise Title VI concerns; University communications and responses to racist incidents were inadequate; the Office for Equal Opportunity Programs lacked capabilities for tracking the development of proceedings; and additional proactive training was needed for students, faculty, and staff. In President Salovey's response to the report,[33] he agreed to clarify leadership structures, add staff to the Office for Equal Opportunity Programs, and rename that office, which is now called the Office of Institutional Equity and Access (OIEA).

However, despite all of this action, it is not apparent to us how much has changed. It is unclear whether more staff have been added to OIEA. Several problems identified throughout this process apparently remain unaddressed—the OIEA remains opaque and difficult to find, although a new, separate website[34] was created to direct students either to the OIEA or the Title IX Office. The only method listed to file a formal complaint with the OIEA (which does not mention Title VI on its website) is to contact the Senior Director, Valerie Stanley.[35] There is no formal complaint resolution process described. It remains unclear how many instances of race-based discrimination and harassment have occurred, because there is evidently no public reporting process (short of student complaints reaching the popular press). And, of course, there remain major problems with the way the University communicates responses to major

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[30] Siyonbola, Lolade; Williams, Alexia; Williams, Teona; Hall, Amanda J.; Brown, Charles D. II; McMillon-Brown, Lyndsey; Kothor, Marius; Barrera, Pablo N.; Lewis, Demar F. IV; Jean-Louis, Reneson; Okafor, Ifeanyi; Dromgoole, Ambre. (May 26, 2018) "An Open Letter to the Yale Administration from Black Graduate Students and Allies." http://www.conversationx.com/2018/05/26/an-open-letter-to-the-yale-administration-from-black-graduate-students-and-allies/

[31] https://yaledailynews.com/blog/2018/10/12/150140/

[32] Reese, Benjamin D. "Findings and Recommendations on Yale University's Institutional Responses and Resources on Racial Discrimination and Harassment." February 25, 2019. https://belong.yale.edu/sites/default/files/files/Recommendations.pdf

[33] https://news.yale.edu/2019/04/09/actions-address-discrimination-harassment-create-more-inclusive-yale

[34] https://student-dhr.yale.edu/

[35] https://oiea.yale.edu/complaint-procedures

crises.[36] The President's Committee on Diversity, Inclusion, and Belonging continues its work,[37] although students are relegated to a separate Advisory Group[38] and report "frustration" that this group "was not being taken seriously."[39] Overall, the impression of this process is frustratingly familiar to many students: students demand change in the form of simple, clearly articulated reforms; they are met with multiple committees, reports, revisions to names of offices and titles, and very little sense that much has changed. This response is so well recognized it has a commonly used name: "the Yale 'no.'"

Finally, the University's reforms are inadequate for a very simple reason: the massive disparity in resources for Title IX compared to Title VI is itself inequitable, unjust, and unacceptable. Today, we re-focus on and amplify the moral clarity in the message of our allies over two years ago—Create a Title VI Office.

1. **Create a Racial Discrimination and Harassment Office (Title VI) at the University level**, with resources and staffing comparable to the Title IX office.
    a. We endorse and echo the 2018 demands presented in An Open Letter to the Yale Administration from Black Graduate Students and Allies.
    b. The Title VI and Title IX offices should be co-housed in order to handle complaints that cross multiple identities. The function of these offices can be distributed among schools, to promote a localized response as previously recommended;[40] at YSM, they should be part of DICE.
    c. **LGBTQ+ people are included in Title IX protections**.[41] Yale Title IX offices must expand LGBTQ+ specific programming and ensure all members of the Yale community understand this interpretation of Title IX coverage through advertising and education.

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[36] President Salovey's response to the killing of George Floyd (https://president.yale.edu/speeches-writings/statements/memory-george-floyd) was detached and academic, pointing to emotions of individuals ("I knew that many members of our community feel fear in their daily lives because of the injustices they have experienced and witnessed, and I thought of how fear so reliably leads to anxiety, depression, health deterioration, and anger, and also to aggression and even violence") but never referencing systems of oppression. He ultimately invoked civil rights activist Pauli Murray and suggested vaguely that "we are capable, all of us, of creating the America we must insist belongs to us all." Other messages were worse. Perhaps most gallingly, one message suggested that these images and other "historical images of slavery" are "reminders of a Yale gone-by." If only it were so.

[37] https://belong.yale.edu/update-work-presidents-committee-diversity-inclusion-and-belonging

[38] https://secretary.yale.edu/student-life/student-advisory-group-diversity-equity-and-inclusion

[39] Reese, *Ibid*, p. 11.

[40] Reese, *Ibid*, p. 3–15.

[41] https://www2.ed.gov/about/offices/list/ocr/letters/colleague-201010.pdf

2. **Create a universal hospital- and school-wide system for reporting and responding to bias, within an educational and restorative justice framework whenever possible.** There is a broad spectrum of behavior that constitutes bias, discrimination, and mistreatment—ranging from ill-informed statements, to microagressions, to frank harassment or assault. The goal of such a universal bias response system should be to provide a single point of entry for reporting, responding to, and tracking such behavior—recognizing that responses will need to be diverse and situational.
    a. **Create an online bias reporting portal** that allows trainees (students, residents, clinical fellows, postdoctoral fellows), staff, and faculty to report identity-based discrimination by faculty and peers.
    b. **Hire an independent Bias and Discrimination Officer to monitor and respond to reports of bias in real time.** This Officer should report jointly to the Chief Diversity Officer and to the Dean. Establish a clear series of policies for the response to bias incidents, such as that outlined below:
        i. The Bias and Discrimination Officer will first establish whether it is likely that a specific institutional policy or law was violated, and, if necessary, refer the complaint to the appropriate office (e.g. Title IX, Title VI, Office of Education, YNHH Medical Staff Office, YNHH Graduate Medical Education Office, etc.), and mandate appropriate follow-up.
        ii. In all other cases, the goal should be a process of restorative justice and education that is empowering to the person who submitted the complaint. The process should seek to repair harm by educating the respondent, who should be encouraged to take responsibility for their actions—in a public setting whenever possible.
        iii. If the respondent to a complaint is consistently unwilling to engage in a process of restorative justice, or if evidence arises that the respondent has sought retribution against the complainant, this will be considered a serious breach of community citizenship, and will be referred directly to the Dean. Likewise, patterns of repeated behavior will be noted and will, at the discretion of the Bias and Discrimination Officer, be escalated to disciplinary action.
    c. **Develop institutional policies informed by individual bias-related incidents to foster a more inclusive organizational culture.** The Bias and Discrimination Officer should contribute an annual report documenting themes or patterns in bias incidents, and work with the Chief Diversity Officer to suggest structural interventions to address these patterns.
    d. **This system must seamlessly span the hospital and the medical school.** While these are nominally separate organizations, their functions are deeply intertwined and many personnel are shared. To facilitate this role, we recommend the Bias and Discrimination Officer carry a joint appointment to the

Medical School and to YNHH—much as YSM Department Chairs also serve as Clinical Chiefs at YNHH.

3. **Reform course evaluations and and programming surveys to evaluate identity-based discrimination in the classroom and on the wards.**
    a. Incidents of bias and mistreatment reported on course evaluation forms should receive attention both from the Office of Education and from the universal bias-response process described above.
        i. Complaints will receive appropriate action following consultation between the relevant course director, the Bias and Discrimination Officer, the Health Equity thread leader, and other leadership within the Office of Education as appropriate.
            1. Responses to individual incidents will be conducted within a restorative justice framework.
            2. Complaints from previous years will be reviewed to establish patterns and address ongoing unresolved problems.
            3. Serious issues, repeated complaints, or a refusal to engage with a restorative process will result in removal from teaching and educational roles and additional appropriate disciplinary action as necessary.
        ii. Publish the anonymized and summarized comments from course evaluations about bias and mistreatment, along with the institutional action ultimately taken in response.
    b. Publish the results of medical student exit surveys, especially questions on the learning environment, harassment, and discrimination.
4. **Conduct regular, comprehensive evaluation of medical school leadership.** Positions including Deputy Deans, Department chairs, and Directors of Centers and Programs who report to the Dean should be evaluated regularly. These reviews must be a comprehensive “360 degree” evaluation including protected and confidential input from staff, students, and other trainees (residents, clinical fellows, postdoctoral fellows) who work regularly with these faculty in any capacity.
    a. Any faculty member who has engaged in identity-based discrimination, harassment, or mistreatment, or who has abused their power by mistreating trainees, staff, or faculty of lower rank, will be barred from leadership positions.
    b. Leadership positions will carry a limit of two 5-year terms.

5. **Implement mandatory anti-oppression training for Yale faculty, staff, affiliates, and trainees.** The goal of this training[42] is an ongoing process of institutional and personal reckoning with systems of oppression to create an inclusive environment at Yale; all faculty and staff "need not only the ability to recognize prejudice and discrimination but also the tools to speak up against it when they witness it."[43] This type of training is also a prerequisite to delivering a truly anti-oppressive curriculum to trainees.[44]

   The type of training needed is outside of most well-established faculty development programs, so experimentation and creativity will be required. We recommend the expertise of professional anti-oppression training organizations[45] be employed, in order to ultimately develop an evidence-based program tailored to health professionals and to the circumstances at Yale. **Based on the best available evidence,[46] such training should have at least the following features:**

   a. It should be ongoing (e.g. annually or more frequent).

   b. It should be conversation-based and ideally in-person (online modules are not sufficient).

   c. It should not focus exclusively on personally-mediated racism (i.e. prejudice and discrimination) or internalized racism (e.g. implicit biases or stereotypes), but also

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[42] How is anti-oppression training for faculty, staff, and affiliates different from the comprehensive anti-oppression curriculum for students and trainees (described in Demand 2)? The curriculum for trainees is meant as a fundamental part of their studies to become physicians and scientists; it must therefore be comprehensive and integrated throughout their training. But many of the same principles should apply. The curriculum for trainees is a superset of the training for faculty and staff.

[43] Acosta, D., & Ackerman-Barger, K. (2017). Breaking the Silence: Time to Talk about Race and Racism. Academic Medicine, 92(3), 285–288. https://doi.org/10.1097/ACM.0000000000001416

[44] Acosta, *Ibid.*

[45] For instance, Undoing Racism: The People's Institute for Survival and Beyond, which leads workshops in New Haven under the Elm City-UROC (Undoing Racism Organizing Collective); the Anti-Oppression Resource and Training Alliance: AORTA; or The Catalyst Project. Of course, developing and providing training for an organization as large and complex as YSM is a massive task and any organization or professionals involved in this training would need to be appropriately compensated.

[46] Paluck, E. L., & Green, D. P. (2009). Prejudice Reduction: What Works? A Review and Assessment of Research and Practice. *Annual Review of Psychology*, 60(1), 339–367. https://doi.org/10.1146/annurev.psych.60.110707.163607

Dobbin, *Ibid*.

Kalev, *Ibid.*

Bezrukova, K., Spell, C. S., Perry, J. L., & Jehn, K. A. (2016). A meta-analytical integration of over 40 years of research on diversity training evaluation. *Psychological Bulletin*, *142*(11), 1227–1274. https://doi.org/10.1037/bul0000067

institutionalized racism—social norms, rules, and structures that perpetuate inequities.[47]

d. It should be updated regularly, based on the particular structural factors and individual behaviors identified at Yale.

In addition, we recommend that:

e. Where possible, anti-oppression training be certified as CME, in order to reduce the burden of participation.

f. The training should be overseen by the designated training officer in DICE, with additional staff or consultant support as needed.

g. The training officer should work with the HJSIC to rigorously assess the effectiveness of the training program and to document and publish the results.

We specifically oppose isolated unconscious bias training (also known as implicit bias training) for several reasons:

h. Implicit bias training focuses on individual bias, rather than systemic or institutional factors. This focus "emphasizes agency (eg, individual choice) over structure (eg, institutional, organisational, and political systems), ignoring the latter's role in framing not only the beliefs and actions of individuals but also the rules, regulations, laws, and culture that govern social institutions."[48] This has the effect of "depoliticizing" systemic racism—that is, encouraging a focus on individual rather than systemic change.

i. Available evidence from large meta-analyses suggests that implicit bias training has a weak effect on implicit measures of bias and a trivial effect on explicit bias or behavior.[49] Perhaps relatedly, there is considerable controversy about the ability of implicit association tests (IATs) to predict racial and ethnic discrimination.[50] This finding is consistent with broader studies of diversity programs and prejudice reduction strategies, which have revealed that ongoing,

[47] Jones, C. P. (2000). Levels of racism: a theoretic framework and a gardener's tale. *American Journal of Public Health*, *90*(8), 1212–1215. https://doi.org/10.2105/AJPH.90.8.1212

[48] Pritlove, C., Juando-Prats, C., Ala-leppilampi, K., & Parsons, J. A. (2019). The good, the bad, and the ugly of implicit bias. *The Lancet*, *393*(10171), 502–504. https://doi.org/10.1016/S0140-6736(18)32267-0

[49] Forscher, P. S., Lai, C. K., Axt, J. R., Ebersole, C. R., Herman, M., Devine, P. G., & Nosek, B. A. (2019). A meta-analysis of procedures to change implicit measures. *Journal of Personality and Social Psychology*, *117*(3), 522–559. https://doi.org/10.1037/pspa0000160

[50] Oswald, F. L., Mitchell, G., Blanton, H., Jaccard, J., & Tetlock, P. E. (2015). Using the IAT to predict ethnic and racial discrimination: Small effect sizes of unknown societal significance. Journal of Personality and Social Psychology, 108(4), 562–571. https://doi.org/10.1037/pspa0000023

integrated, multifaceted approaches are necessary[51]—all features which isolated implicit bias training programs lack.

j. By definition, implicit bias training does not address explicit biases and is therefore unlikely to be effective for those already aware of their biases or who lack motivation to change.

To be clear, we do not deny the existence of unconscious bias nor object to the use of implicit association testing as a part of an integrated, anti-oppression training program.

6. **Make the physical space of YSM more welcoming to and reflective of the contributions of underrepresented groups, including women and people of color.**
    a. Name public spaces to reflect the values, rather than merely the history, of YSM.
        i. Name Café Med after a distinguished YSM alumna woman of color.
        ii. Prohibit namesakes who were slaveholders, slave traders, or proponents of slavery.
        iii. Assess and publicly report the history of all namesakes at YSM.
        iv. Name and rename public spaces to promote and celebrate diversity, inclusion, equity, and social justice.
    b. Commission portraits of twenty or more notable underrepresented YSM alumni, staff, or faculty.
        i. The subjects of all of these portraits will be women, transgender, gender nonbinary/nonconforming, and/or people of color. A minimum of 50% will be women of color.
        ii. These portraits will be hung in Sterling Hall of Medicine, the medical library, and other prominent places throughout the medical school.
7. **Ensure the School and University calendar is inclusive.**
    a. Ensure no mandatory coursework, meetings of key committees, etc. occur on major religious holidays, even if those holidays are not recognized as University holidays.
    b. Make Juneteenth a paid University holiday.
    c. Make Election Day a paid University holiday.
8. **Finance a monetary reward for the Robert Rock and Tehreem Rehman Medical Student Activism Award.**

[51] Paluck, *Ibid.*

Bezrukova, *Ibid.*

9. **Evaluate the accessibility of the medical school for disabled people and implement a plan for improvement.**
10. **Prohibit all-male and all-white panels and committees.**
11. **We endorse the 2016 Gender and Sexual Misconduct Proposal.**[52] For any overlapping items between the 2016 report and these demands, these demands will supersede the 2016 proposal.

4. We demand increased diversity among the faculty and student body.

Beyond recruitment, Yale must develop and retain a diverse faculty; this includes compensating faculty and students for the vast, racialized equity labor that currently falls overwhelmingly to those who identify as Black, Indigenous, or people of color. This burden is especially heavy on women of color.

The YSM faculty fails to reflect the diversity of our nation, or even the physician workforce—a shocking 2.5% of YSM ladder faculty are Black or African American, compared to ~6% of physicians and ≥12% of the general population. 3% of ladder faculty are Hispanic or Latinx, compared to 5.5% of physicians and >15% of the US population.[53] ~41% of ladder faculty are women, but only ~22% of tenured faculty are women.[54] The same is likely true for other domains (e.g. sexual orientation, gender identity), although data are lacking.

[52] Flynn, C. A., & Singh, A. (2016). (rep.). *Gender and Sexual Misconduct Proposal*. New Haven, CT: Yale School of Medicine. https://docs.google.com/document/d/1zSnoa1Mz46DhVdnXBIL9kJcdyyI6jEPzTGOlUwcB37w/edit

[53] Yale University Office of Institutional Research. "W106 University Faculty by Race/Ethnicity and Gender, 2011-2019." https://oir.yale.edu/sites/default/files/w106_fac_racegen_hc_2019.pdf

DataUSA: Physicians and Surgeons. https://datausa.io/profile/soc/291060/#demographics

American Association of Medical Colleges. (2019). "Diversity in Medicine: Facts and Figures 2019." https://www.aamc.org/data-reports/workforce/report/diversity-medicine-facts-and-figures-2019

[54] 777 women of 1891 ladder faculty are women, and 53 of 239 tenured faculty are women. See Office of Yale Office of Institutional Research, "W056 Ladder Faculty by Gender," https://oir.yale.edu/sites/default/files/w056_fac_u_tenterm_gen_2019_0.pdf . Unsurprisingly, the pattern is even worse for named professorships (17% women) and Sterling professorships (11% women). See Yale Women's Faculty Forum. "Women and Men Faculty – Yale University: A View of 2016-2017" https://wff.yale.edu/sites/default/files/files/The%20View%20of%202016-2017%2C%20v26%2C%202_28_18.pdf p. 33-34

Faculty diversity is both an inherent good and a prerequisite to a diverse and inclusive community at YSM. Diverse groups make better decisions,[55] so it stands to reason a more diverse faculty and leadership would yield a better-run school; diversity in science[56] and technology[57] produces better outcomes; a diverse healthcare workforce provides better care,[58] sometimes strikingly so.[59] Diverse faculty are essential to providing sufficient formal and informal mentorship to a diverse student body.[60] Additionally, faculty diversity affects our ability to recruit a diverse student body—admitted students who decline to matriculate have cited the lack of visibility of diverse faculty as a key reason for declining admission offers. Faculty diversity is one prerequisite (but not sufficient alone) to promote an inclusive learning environment. Scholarly diversity ensures there are experts available to teach on topics such as health equity and social determinants of health, the science of diversity, and medical humanities.

A comprehensive effort is needed to diversify the faculty at YSM. In addition to centralized reforms and supervision[61] of the hiring process throughout the school, perhaps more important are steps to promote and retain diverse faculty. We outline several strategies below.

For students, two major challenges are admitting/matriculating diverse students and broadening the "pipeline" of students applying to health professional and graduate school. To this end we propose several steps to reduce bias and increase equity in the admissions process, but we also emphasize support for "pipeline programs" that aim to expose prospective

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[55] Phillips, Katherine W, Sun Young Kim-Jun, and So-Hyeon Shim. (2010). "The Value of Diversity in Organizations: a Social Psychological Perspective." In *Social Psychology and Organizations*, 253–71. London, United Kingdom: Routledge

[56] Campbell, Lesley G, Siya Mehtani, Mary E Dozier, and Janice Rinehart. (2013). "Gender-Heterogeneous Working Groups Produce Higher Quality Science." *PloS One* 8 (10): e79147. https://doi.org/10.1371/journal.pone.0079147

[57] Barker, Lecia, Cynthia Mancha, and Catherine Ashcraft. 2014. "What Is the Impact of Gender Diversity on Technology Business Performance? Research Summary." *National Center for Women and Information Technology*. https://www.ncwit.org/sites/default/files/resources/impactgenderdiversitytechbusinessperformance_print.pdf

[58] Gomez, L E, and Patrick Bernet. (2019). "Diversity Improves Performance and Outcomes." *Journal of the National Medical Association* 111 (4). United States: 383–92. https://www.ncbi.nlm.nih.gov/pubmed/30765101

LaVeist, Thomas A, and Geraldine Pierre. (2014). "Integrating the 3Ds—Social Determinants, Health Disparities, and Health-Care Workforce Diversity." *Public Health Reports* 129 (1_suppl2). SAGE PublicationsSage CA: Los Angeles, CA: 9–14. https://doi.org/10.1177/00333549141291S204

[59] Alsan, Marcella, Owen Garrick, and Grant C Graziani (2018). "Does Diversity Matter for Health? Experimental Evidence From Oakland." *National Bureau of Economic Research Working Paper Series*. Vol. 24787. http://www.nber.org/papers/w24787.pdf

[60] Brown-Nagin, Tomiko. (2016). "The Mentoring Gap." *Harvard Law Review Forum* 129 (May): 303–12. https://harvardlawreview.org/2016/05/the-mentoring-gap/

[61] Although Dean Latimore holds an *ex officio* position on all YSM search committees, it is clearly impractical for him to supervise each of the hundreds of faculty hiring decisions each year.

underrepresented students to health professions and to support their eventual application and matriculation.

Finally, for both students and faculty, we draw attention to the vast, uncompensated labor of advancing diversity, equity, and inclusion at this institution. "Racialized equity labor"[62] describes the phenomenon whereby underrepresented students and faculty push the institution for diversity, equity, and inclusion (changes essential to their survival in an institution built specifically to exclude them); are tapped to implement initiatives (for which they are not compensated—financially or by career advancement); and ultimately often have their efforts co-opted—claimed by the institution as its own, but often diluted or changed from the original vision. This process is exhausting, and it is a significant structural barrier to the retention, career advancement, and wellness of BIPOC faculty and trainees—particularly women of color. We therefore call on YSM to recognize and compensate this labor, in a variety of ways.

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1. **Diversify the clinical faculty and housestaff.** Create a joint initiative between Yale School of Medicine and Yale-New Haven Hospital to recruit and retain faculty and housestaff who are URM, LGBTQ+, disabled, female, or otherwise underrepresented.
    a. **Create a visiting rotation clerkship program for students of color** supported by funding from both the school and hospital.
    b. **Devote special attention to <u>retention</u> and <u>promotion</u> of junior faculty who have these identities, with initiatives dedicated to faculty underrepresented in medicine**—for example, increased internal grant funding, junior-senior faculty mentoring programs, "K clubs" to support initial funding applications, facilitated pairing of junior and senior faculty on joint grant applications, increased opportunities for advancement (such as through leadership term limits), improved tenure and promotion processes, and alternative models of compensation for institutional labor (see Demand 4.5, below).
    c. Identify reasons for failure to retain faculty.
        i. Conduct and document exit interviews with faculty from underrepresented groups, administered by or in collaboration with the DICE office.
        ii. Interview current junior faculty members from underrepresented groups to determine their needs, then develop and implement a support improvement plan. This will be done by or in collaboration with the DICE office.
2. **Diversify the student body of health professional schools and BBS.** Any points specific to the medical school will be understood to apply to the analogous parties,

[62] Lerma, V., Hamilton, L. T., & Nielsen, K. (2020). Racialized Equity Labor, University Appropriation and Student Resistance. *Social Problems*. https://doi.org/10.1093/socpro/spz011

processes, and components of the other health professional schools and BBS and must be similarly addressed.

a. **Increase funding and programming for recruitment of underrepresented students.**

    i. **DICE and Admissions will develop and implement a plan to improve URM recruitment**, including expanded on-campus recruitment events at historically Black colleges and universities (HBCUs), Hispanic-serving institutions (HSIs), tribal colleges and universities (TCUs), and Gallaudet University (the only Deaf university in the US). They will consult with and include, as appropriate, current URM students.

        1. This plan must include special attention to recruitment of the following groups: 1) American Indian, Alaska Native, Native Hawaiian, and Pacific Islander students 2) Black students, with specific attention paid to the recruitment of Black students who are the descendants of enslaved people in the US.
        2. The YSM application will specifically exclude non-Black students from selecting “Black or African American” under the race/ethnicity section. Non-Black students who are residents or citizens of an African country may include this information under a “nationality” section. YSM will encourage AMCAS to adopt this change as well.

    ii. **Admissions will develop a program offering preliminary application screening and feedback for underrepresented students** who plan to apply in future cycles. This program will include online or in-person practice interviews with formative feedback.

    iii. **Admissions will pay for interview costs for all low-income students.** This policy will be clearly communicated both on the admissions website and in the interview offer email.

    iv. DICE, SNMA/LMSA, YFLI, and OutPatient will be treated as full partners of Admissions and MSC in planning Second Look.

    v. **The summary demographic statistics of current students, admitted classes, and the applicant pool will be made available** to current and admitted students of the medical school, MSTP, PA program, nursing school, and BBS (both the overall BBS statistics and those for each individual program). This will help prospective students make informed choices when selecting a school rather than relying on rumor, word-of-mouth, or the nonrepresentative sample of students at Second Look.

    vi. **DICE will have real-time, unmitigated access to all admissions data, both individual and summary.** This is necessary to equip DICE to

recruit underrepresented candidates. They will be treated as full partners to the Office of Admissions in the admissions process.

b. Implement structural changes to admissions policies and processes to reduce access barriers to underrepresented students.

i. Increase transparency and alter the makeup of the admissions committee.

1. Admissions will make publicly available the demographic statistics of the admissions committee. This will include the entire committee and subsets, such as the executive committee, students, and faculty.
2. Admissions will provide a list of all members of the admissions committee and the executive committee, and will respond with appropriate action to concerns about individual members.
3. DICE and Admissions will develop and implement a plan to include more URM students and faculty on the admissions committee, including the executive committee.
4. The executive admissions committee will include DICE members and underrepresented student members (from CDISJ, SNMA/LMSA, OutPatient, or YFLI).

ii. The following admissions processes for all health professional schools and BBS programs will be evaluated by DICE or an appropriate outside contractor (selected by DICE). A plan to improve these processes for underrepresented groups will be developed and implemented.

1. Overall admissions process and pipeline.
2. Process for ranking candidates.
3. Special focus will be paid to interviewing and admitting a larger proportion of URM students.
4. Current admissions policies related to disability status and plan to implement anti-ableist admissions policies.

c. Expand pipeline programs and opportunities for students from underrepresented groups.

i. Formally assess current pipeline programs for efficacy, engagement of target groups, and deficiencies.

ii. Create additional pipeline programs extending from elementary school through post-baccalaureate that serve BIPOC, undocumented, and low income students, with spaces reserved for students from New Haven.

1. We would like to highlight the Yale BioMed Amgen Scholars Program as a model for other pipeline programs. It has been successful, with many of its graduates matriculating in highly competitive PhD and MD/PhD programs (including at Yale). It additionally contains extensive opportunities for community building, multiple levels of mentoring, unique educational programming, and career development workshops. Both the undergraduate scholars and the medical/graduate student leaders are paid, and there is significant administrative support and faculty participation. Graduates of the program have received continued support from program leadership, including assistance with on-campus housing, obtaining additional research opportunities, applying to graduate/medical school, identifying mentors, and gap year employment.
2. The former SMDEP (now Summer Health Professions Education Program) pipeline program was eliminated after the external funding source withdrew support. This critical program continues to run at other schools with internal funding. It has not been replaced at Yale. This program, or an equivalent, must be reestablished at YSM.
3. Develop and implement a plan to recruit more underrepresented New Haven students to pipeline programs, such as direct recruitment from the Sci.CORPS and Evolutions programs at Yale Peabody Museum of Natural History.

iii. Provide increased financial and administrative support for existing programs.

1. HPREP will receive significant administrative support and student leaders will be paid; both will be on par with the Yale BioMed Amgen Scholars Program.
2. Additional administrative support will be provided for YSEP and the SNMA/LMSA community health fair.
3. DICE will assess remaining programs and identify areas that require increased financial or administrative support.
4. Include student involvement in pipeline programs as an option for fulfillment of the Experiential Learning Practicum.

iv. Create research and clinical shadowing opportunities for students who don't have the necessary connections in medicine/academia to access them.

1. These will be in addition to summer programs and will accommodate nontraditional students who cannot participate in summer programs.
2. These opportunities, whenever possible, should be paid.
    a. This should include part-time, flexible schedule, paid clinical research opportunities that would provide both clinical exposure and research experience.

3. **Support faculty engaged in health disparities research, minority student mentorship, teaching, and institutional diversity and inclusion labor, through tenure and promotion track reform and appropriate compensation.**
    a. **Reform promotion and tenure track policies to account for and reward:**
        i. Time spent in teaching and student mentorship.
        ii. Nontraditional scholarly pursuits such as health advocacy and activism work.
        iii. Institutional labor for diversity and inclusion, including but not limited to serving on standing and ad hoc committees, drafting reports, building curricula, and engaging in searches for relevant faculty.
        iv. Community development, organization, and local health disparities research.
    b. **Conduct a comprehensive, scholarly review of the tenure and promotion process**, including a quantitative review of promotions and a qualitative review of promotion and tenure committee meetings to discover ways in which this process explicitly or implicitly affects certain candidates over others. A report of the findings will be made publicly available and published in the academic literature.
    c. **In addition, commit dedicated salary support for certain specific activities:**
        i. Compensate faculty who commit above average time toward student development, such as roles on thesis committees and as thesis advisors, and toward institutional progress, such as committees and QA/QI projects.
        ii. Compensate BIPOC and underrepresented faculty for their institutional labor on diversity, inclusion, and equity.

4. **Compensate institutional student labor with particular attention to the disproportionate burden of labor by BIPOC and underrepresented students.**
    a. **YSM should follow the examples of the Office of Graduate Student Development and Diversity (OGSDD) and BBS in employing student fellows through structured programs** (OGSDD Fellows and YBDIC) to compensate

student labor towards diversity, equity, and inclusion. Examples of currently uncompensated institutional student labor include:

i. Community services that are required to fulfill critical gaps in institutional or governmental services, including HAVEN Free Clinic, SNMA/LMSA Community Health Fair, HPREP, and YSEP.

ii. Medical school-specific labor, including Second Look Weekend, Admissions Committee, and Introduction to the Profession (iPro) leaders (who are currently minimally compensated).

iii. Teaching, including the US Health Justice course.

iv. Diversity and equity work, including CDISJ and the Dean's Advisory Council on LGBTQI+ Affairs.

5. **Develop and implement multiple equitable compensation mechanisms for both student and faculty institutional labor**, recognizing the diverse needs of members of our community and prioritizing personal choice in compensation method.

    a. **Provide traditional compensation via monetary payments.** Successful examples of this at Yale include:

        i. Paying student leaders of the Yale BioMed Amgen Scholars Program and the student curriculum reviewers for the sex and gender project led by Dr. Njeri Thande.

        ii. Paying student fellows for numerous types of work at GSAS (including fellows of the Poorvu Center for Teaching and Learning, Office of Career Strategy, Graduate Student Life) and the University (fellows of the Office of Cooperative Research).

        iii. Paying the Health Equity thread leader.

    b. **Explore alternative compensation models** such as the Academic Biomedical Career Customization program at Stanford University School of Medicine, which resulted in an average of 1.3 more grant awards and $1.1 million in additional funding per participant compared to non-participant controls.[63]

        i. Home support services such as housecleaning, laundry, meal delivery, errand outsourcing, car service, child care, pet care, and transportation.

        ii. Work support services including grant-writing assistance, manuscript editing, speech coaching, lab or office management services, website design, graphics design for presentations or manuscripts, office

[63] Fassiotto, M., Simard, C., Sandborg, C., Valantine, H., & Raymond, J. (2018). An Integrated Career Coaching and Time-Banking System Promoting Flexibility, Wellness, and Success: A Pilot Program at Stanford University School of Medicine. *Academic Medicine*, *93*(6), 881–887. https://doi.org/10.1097/ACM.0000000000002121

organizing, medical scribing services, private tutors, administrative support, and laboratory technician support.[64]

[64] Sporadic laboratory technician support could be provided by creating a centralized pool of laboratory technicians paid by the university who can be “contracted out” to individual labs for discrete amounts of time either for free (as compensation for institutional labor) or paid for by the lab (similar to paying for core services). This would not only alleviate the significant costs to career advancement of identity-based institutional labor, but would provide increased support for all faculty. The cost of hiring a full-time lab technician to support research activities is often too expensive, especially for junior faculty. Additionally, labs often need technician support on a sporadic rather than permanent basis. The ability to access lab technician services on an as-needed basis would significantly enhance research productivity and wellness for both trainees and faculty.

5. We demand expanded financial support and recognition for Community-Based Participatory Research (CBPR), Participatory Action Research (PAR), health disparities research, and anti-oppression scholarship as well as implementation of anti-racist practices in research across the medical school.

Through a multidisciplinary research center, Yale will guide national policy and develop gold standard institutional practices to invest in diversity, respond to sexual harassment and assault, promote anti-oppressive education, and exist without police. Yale will guard against racist and oppressive research through it's Institutional Review Boards (IRBs).

It is abundantly clear that racism, sexual misconduct, police violence, and other forms of oppression are health issues. However, few interventions proposed to address diversity, equity, and inclusion are well supported by evidence. We have tried to highlight the best available evidence here, but it is clear that there are vast gaps in society's understanding of how to address bias, sexual misconduct, and race-based discrimination; of how we should make our communities more diverse and inclusive; and of how our society should look with a dramatically reduced or eliminated police force. We should approach these pervasive societal problems as we do other problems in medicine—with rigorous academic research. **We propose Yale create a multi-disciplinary research center, which we are calling the Health Justice and Social Innovation Center (HJSIC), as a way to use its considerable strengths to become the national leader on these issues.** Of course, these strengths extend outside the medical school, and such a center should draw upon expertise from the Faculty of Arts and Sciences, the Nursing School, the Law School, and the School of Management in addition to recruiting new talent.

Beyond and including work within the HJSIC, Yale should cultivate a new generation of researchers who will develop and apply cutting edge methods to these challenging problems. The Office of Student Research (OSR) is a natural avenue for such efforts towards medical students, but similar efforts must be made to support BBS and other graduate students. Finally, Yale must ensure its ongoing research programs do not contribute to a long history of violence and oppression in medical research[65]—whether by unjustly utilizing and exploiting Black and brown bodies, by wrongfully excluding certain groups from access to clinical trials, or by perpetuating ahistorical and unscientific ideas such as biologized race or gender.

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1. **Create opportunities within the OSR for student research involving CBPR, PAR, health disparities research, and anti-oppression scholarship.**

[65] Washington, H. (2007). *Medical Apartheid: The Dark History of Medical Experimentation on Black Americans from Colonial Times to the Present*. New York: Doubleday.

a. The OSR will expose students to the theory and practice of CPBR/PAR and establish long-term collaborations with local community-based organizations for students to partner with for CBPR/PAR research.
    i. This should be established in collaboration with the Experiential Learning Practicum director.
    ii. Create mentorship, advertising, and training opportunities for CPBR/PAR and qualitative research.
    iii. Ensure that all education about and involvement with CBPR/PAR emphasizes the importance of community partnership/leadership, not community exploitation.
b. Dedicate endowed fellowships for students to conduct health equity research, CBPR/PAR, or anti-oppression research during their 5th year.
c. Create and fund an award for senior thesis projects on issues of domestic health equity.

2. **Create and fund an endowed multidisciplinary research center, which we are calling the Health Justice and Social Innovation Center (HJSIC).** We would like to highlight two prior proposals that informed and inspired the HJSIC and were both ignored by Yale: a Multicultural and Equitable Care Resource Center and a center for research on sexual misconduct.
    a. This research center will receive substantial funding and institutional support, allowing it to conduct rigorous interdisciplinary research, foster national and international leaders, and develop global expertise on anti-oppression scholarship and addressing structural determinants of health injustice and inequity.
    b. This research center will recruit internal and external faculty from diverse fields including anthropology, race and ethnicity studies, gender studies, sociology, psychology, public health, medicine, history, environmental science, and law.
        i. The center will be directed by Dr. Helena Hansen or someone equally qualified.
    c. Research will be conducted on the topics of health justice, inclusion, equity, and anti-oppression, including, but not limited to:
        i. Community accountability protocols and structures that are anti-carceral, anti-oppressive, and anti-violent (e.g. transformative and restorative justice practices).
        ii. Preventing and responding to sexual misconduct.
        iii. Effective anti-oppression, anti-racism, and bystander intervention trainings.

iv. Strategies for effective recruitment, retention, and development of BIPOC and underrepresented students and faculty.

v. Strategies for improving inclusion and well-being of BIPOC and underrepresented students and faculty.

vi. Equitable admissions policies and practices that increase the proportion of URM and underrepresented students.

d. The center will involve and be accountable to marginalized residents of New Haven and community leaders.

3. Implement anti-racist and anti-ableist Instituitonal Review Board and Human Subjects Research Committee policies.

a. This will, at minimum, adhere to the criteria outlined in the White Coats for Black Lives Racial Justice Report Card[66].

i. Include people of color among listed “vulnerable populations,” thereby requiring additional scrutiny of research involving people of color.

ii. 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.

iii. Reject any proposed study that will explicitly or tacitly reinforce biological definitions of race.

b. Include non-Yale, New Haven community members as members of the aforementioned boards and committees.

[66] White Coats for Black Lives Racial Justice Report Card (2019).

6. We demand that Yale School of Medicine, Yale New Haven Health System, and Yale University end all ties with and practices involving police forces.

In the United States, police historically enforced the enslavement, segregation, and terrorism of Black and brown people. Decades of reform have resulted only in the increased incarceration of these folks and diversion of community and mental health resources to carceral spaces. The Yale Police Department must be abolished and YSM must commit to fighting police violence and mass incarceration as a public health crisis.

We support the growing movement to abolish police[67] and other elements of the broader carceral system,[68] which commits systematic violence against Black and brown people. Furthermore, we object specifically to the Yale Police Department (YPD) on additional grounds—they are redundant, unnecessary, and unaccountable to the broader community. New Haven already has a public police department; Yale has an extensive security force. In solidarity with the broader police abolition movement and to further the goals of true community safety and wellbeing, we demand that Yale devote resources of the YPD to community accountability protocols and structures (i.e., transformative and restorative justice practices) —including to studying the efficacy and consequences of those alternatives.

Beyond the Yale Police, we denounce the ways in which our healthcare system participates in police-like violence and implore our hospitals and clinics to think and act more broadly to reduce violence within our walls. We argue for the disarmament of uniformed hospital security and the banning of guns in all healthcare settings, where a staggering percentage of the time they cause unintentional or otherwise avoidable injury and death,[69] as highlighted by several recent, horrifying deaths.[70] We demand that all healthcare workers, staff, and trainees be given the

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[67] Kaba, Mariame. “Yes, We Mean Literally Abolish the Police.” The New York Times. June 12, 2020. https://www.nytimes.com/2020/06/12/opinion/sunday/floyd-abolish-defund-police.html

[68] Underground Scholars Initiative. “Language Guide for Communicating About Those Involved In The Carceral System.” March 26, 2019. https://undergroundscholars.berkeley.edu/news/2019/3/6/language-guide-for-communicating-about-those-involved-in-the-carceral-system

[69] Hankin, C. S., Bronstone, A., & Koran, L. M. (2011). Agitation in the inpatient psychiatric setting: A review of clinical presentation, burden, and treatment. *Journal of Psychiatric Practice*, *17*(3), 170–185. https://doi.org/10.1097/01.pra.0000398410.21374.7d

Janofsky, J. S., Alampay, M., Bonnie, R., & Buchanan, A. (2018). (rep.). *Position Statement on Weapons Use in Hospitals and Patient Safety*. American Psychiatric Association. https://drive.google.com/file/d/1mvj2WQwH4Y5xkyxIIrAwRcuugUaFtLTl/view?usp=sharing

[70] Rosenthal, E. (2016, February 12). “When the Hospital Fires the Bullet.” The New York Times. https://www.nytimes.com/2016/02/14/us/hospital-guns-mental-health.html

McAdams, A. (2020, June 18). “Family of Munster Community Hospital patient shot, killed by security guard questions official narrative of incident.” ABC 7 Chicago.

tools to calm and de-escalate, so that restraint and violence is truly a last resort. This is a fundamental matter of safety for both patients and staff.

1. **YSM should publicly declare that law enforcement violence is a public health crisis and convene an institutional working group to use the expertise of YSPH and YSM to address it as such.**
    a. Endorse the American Public Health Association's Policy 201811 (Addressing Law Enforcement Violence as a Public Health Issue).
    b. Provide grant funding through YCCI, the HJSIC, and/or other institutional entities to support research on health consequences of law enforcement violence and interventions reducing reliance on law enforcement.
    c. Partner with the New Haven mayor's office and New Haven community-based organizations to focus study on policy interventions to reduce police violence.
    d. Participate in state and national lobbying for specific reforms and policies through commitment of institutional financial resources and YSM faculty expertise.
2. **Abolish the Yale Police Department (YPD).**
    a. **Dismantle YPD and commit the entire YPD budget into a New Haven fund for community accountability protocols and structures** (i.e., transformative and restorative justice practices).
        i. We endorse the petition and proposal to Defund and Dismantle the YPD, authored by the Black Students for Disarmament at Yale (BSDY) and the Yale Undergraduate Prison Project.
        ii. Yale must publish current YPD and Yale Security budgets.[71]
        iii. Engage New Haven community-based organizations in assessing the best uses for the funds as community accountability protocols and structures (i.e., transformative and restorative justice practices). These organizations should be approved by BSDY and the community review board described in Demand 9.2.e.
        iv. Alternatives to policing will not include functional equivalents that reproduce violence. For example, rebranding armed police as "security" would not be an acceptable outcome. Nor would replacing them with other systems that are based upon violence, incarceration, and destruction of families and communities of color such as involuntary

https://abc7chicago.com/family-of-munster-hospital-patient-killed-by-security-guard-questions-official-narrative/6254796/

[71] YPD and Yale Security budgets are not currently publicly available; the only available record of YPD's annual budget was through mention in a 2008 lawsuit that reported it as $10.3 million at that time.

Shoaib, Meera. (June 13, 2020). "Students call to defund, dismantle YPD." Yale Daily News. https://yaledailynews.com/blog/2020/06/13/students-call-to-defund-dismantle-ypd/

inpatient psychiatric admissions, involuntary inpatient substance use treatment, and existing child welfare systems.[72]

b. Irrespective of whether Yale University complies with this demand, YSM should immediately and publicly establish as its position that YPD should be abolished.

3. **Eliminate guns, law enforcement personnel, and violent restraint from all clinical settings at YSM and YNHHS.**

    a. Ban all guns from all clinical settings at YSM and YNHHS. Prohibit police from entering any patient examination room. Hospital staff, not police escorts, will provide support for treating violent or potentially violent patients.

        i. We support and endorse the Open Letter to DMHAS petitioning to disarm police at the Connecticut Mental Health Center (CMHC).

    b. Train all hospital staff on de-escalation techniques[73], such that the use of force or restraints by unarmed YNHH Protective Services or Yale Security is truly a last resort. Under no circumstances should police be responsible for supervising a patient during an exam.

    c. Adopt a policy to limit the use of restraints throughout the hospital, but particularly in the emergency department and on the labor and delivery floor.

    d. Provide appropriate support staff and facilities to conduct interviews in a confidential, dignified, and HIPAA-compliant manner, consistent with needs for staff security.

        i. Emergency Department (ED) staff routinely conduct patient interviews in public waiting areas due to concerns about provider safety in private exam rooms. These concerns are simultaneously valid—as hospital staff (especially women) are frequently subjected to violence[74]—and harmful to

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[72] Roberts, Dorothy E. (June 16, 2020). “Abolishing Policing Also Means Abolishing Family Regulation." The Chronicle of Social Change. https://chronicleofsocialchange.org/child-welfare-2/abolishing-policing-also-means-abolishing-family-regulation/44480

Roberts, Dorothy E. (2012) "Prison, Foster Care, and the Systemic Punishment of Black Mothers." UCLA L. Rev. 1474 https://www.uclalawreview.org/pdf/59-6-2.pdf

[73] Du, M., Wang, X., Yin, S., Shu, W., Hao, R., Zhao, S., Rao, H., Yeung, W.-L., Jayaram, M. B., & Xia, J. (2017). De-escalation techniques for psychosis-induced aggression or agitation. *The Cochrane Database of Systematic Reviews*, *4*, CD009922. https://doi.org/10.1002/14651858.CD009922.pub2

Spencer, S., Johnson, P., & Smith, I. C. (2018). De-escalation techniques for managing non-psychosis induced aggression in adults. *The Cochrane Database of Systematic Reviews*, *7*, CD012034. https://doi.org/10.1002/14651858.CD012034.pub2

[74] Phillips, J. P. (2016). Workplace violence against health care workers in the United States. *New England Journal of Medicine*, 374(17), 1661–1669. https://doi.org/10.1056/NEJMra1501998

patients, as they are subjective and driven by bias. For instance, YSM students anecdotally report that white female staff are often reluctant to provide private interviews to Black male patients. This problem is readily addressed by providing support staff to the ED and other appropriate clinical areas who can accompany providers during private patient encounters upon request. This support staff will not consist of security guards, will be appropriately trained, and should provide support to both patients and staff to prevent violence against both patients and staff.

4. **Educate students about, and work to protect students from, the effects of racist policing.**
    a. **Overhaul the training students receive about the roles of YPD, Yale security, and YNHH Protective services**. The session during iPro has historically painted New Haven as dangerous and separate from Yale/YSM, establishing a harmful precedent at the beginning of medical school.[75] Instead, this and similar sessions should involve input from the DICE Office and the Health Equity thread, as well as a presentation from a qualified faculty member on the history of race and policing in New Haven and the US more broadly. This training should include effective alternative options to calling police in situations commonly encountered by students.
    b. **Train medical students alongside other hospital personnel in de-escalation** techniques, alternatives to restraints, and safe ways (for both parties) to respond to and care for agitated (including violent) patients.
    c. **Provide appropriate consequences for students and faculty who racially weaponize the police**,[76] through the school-wide bias and accountability system described above.

Wong, A. H., Ruppel, H., Crispino, L. J., Rosenberg, A., Iennaco, J. D., & Vaca, F. E. (2018). Deriving a Framework for a Systems Approach to Agitated Patient Care in the Emergency Department. *Joint Commission Journal on Quality and Patient Safety*, 44(5), 279–292. https://doi.org/10.1016/j.jcjq.2017.11.011

[75] Minor, J. (2015, July 6). It's Not Just the Confederate Flag: The Example of New Haven. *HuffPost*. https://www.huffpost.com/entry/its-not-just-the-confeder_b_7719112

[76] Caron, Christina. (May 9, 2018). "A Black Yale Student Was Napping, and a White Student called the Police." The New York Times. https://www.nytimes.com/2018/05/09/nyregion/yale-black-student-nap.html

O'Daly, Britton. (May 10, 2018). "Yale responds after black student reported for napping in common room." Yale Daily News. https://yaledailynews.com/blog/2018/05/10/yale-responds-after-black-student-reported-for-napping-in-common-room/

d. **Provide a single avenue for students to report racist and adverse experiences with police and security staff**, regardless of jurisdiction.[77]

e. **Open meetings of the MSC Security Committee to the entire YSM student body and solicit open submission of agenda items, questions, and concerns**. If students do not submit agenda items, these meetings should not be canceled; instead, representatives from the involved security/police organizations should present recent security incidents and concerns to students. Representatives from YSM and the relevant security/police organizations will provide updates at each meeting on progress toward meeting the relevant portions of these demands (Demand 6) until they have been fulfilled.[78]

[77] Students in the vicinity of the medical school campus may be subject to policing from YPD, Yale Security, YNHH Protective Services, and even New Haven Police Department. It may be unclear (to students) which of these bodies has jurisdiction over a particular building or situation and which organization should be held accountable in the event of harassment or biased policing.

[78] The MSC Security Committee nominally meets quarterly with representatives from YPD, Yale Security, and others; however, this meeting is often canceled if the (typically first-year) MSC president does not send an agenda.

7. We demand Yale School of Medicine and Yale New Haven Health System prioritize the protection of marginalized patients in clinical care.

Yale Medicine and YNHHS must expand services and protect the rights of marginalized patient populations including: patients who are Black, Indigenous, or people of color; patients without formal immigration status; patients who are lesbian, gay, bisexual, transgender, and queer (LGBTQ+); patients who are intersex or with differences of sexual development (DSD); and patients who are uninsured and underinsured.

1. **YSM and YNHHS should make care of the most marginalized patients its top clinical priority, providing them with expanded resources and protection.**
    a. **Provide free or appropriately reduced-price medications and essential medical devices to YNHHS patients receiving free care and discounted care**, respectively.[79]
    b. **Ensure that the New Haven Primary Care Consortium site at Sargent Drive remains accessible to members of the community** it serves and does not disconnect patients from care. In particular, ensure that no patients receiving YNHH Free Care are denied primary care services due to inability to pay.
    c. **Ensure students and residents are not learning medicine by "practicing" primarily on the most vulnerable patients.** Create an explicit statement of students' scope of practice and guarantee that the practice of medicine by students is always supervised by a qualified faculty member.
    d. **Protect immigrant and undocumented patients by, as a matter of policy, not cooperating with Immigration and Customs Enforcement (ICE)** and not permitting ICE on hospital property. Ensure patients are aware of this policy through public posting, staff education, and advertising.
    e. Create an explicit policy and public statement that prohibits YNHHS from refusing care to transgender patients or on the basis of gender identity.
    f. Create a task force to study and address Black maternal mortality in the greater New Haven community, Bridgeport area, and regions containing all YNHHS and YaleMedicine clinical sites.
2. **Protect the health and wellbeing of graduate medical trainees throughout YNHHS.**

[79] Currently, patients of the HAVEN Free Clinic have access to a limited list of free medications and medical devices provided through an in-house pharmacy. Patients who are inappropriate for student management at HAVEN due to medical complexity lose these services when referred to the Primary Care Center or an FQHC. Patients should not have to choose between necessary medications and an appropriate provider.

a. **Accept and implement the Resident and Fellow Bill of Rights** in any graduate medical program sponsored by YNHHS or supervised by YSM faculty.

b. **Undertake a comprehensive assessment of policies for recruitment and hiring of disabled residents and fellows**. Develop and implement a plan to adopt anti-ableist policies and support disabled trainees.

3. **Support the health of LGBTQ+ patients.**

    a. **Insist on a workforce competent in the care of LGBTQ+ patients.** Develop a program for all faculty and staff to acquire familiarity with sex, gender, and sexuality, and their social and clinical implications. Work with patients to determine best practices.

    b. **Create an interdisciplinary LGBTQ+ clinic** including key services like primary care, mental health, reproductive health, endocrinology, reconstructive surgery, infectious disease, geriatrics, and social services. This clinic should serve as a medical home for patients and provide comprehensive, coordinated services including outpatient management preceding and following gender affirming surgery.

    c. **Develop the capacity to perform gender-affirming genital reconstruction** for both transfeminine and transmasculine people, a critical service that is currently difficult to access in the state of Connecticut, over the next two years.

4. **Systematically examine and work to address ways in which clinical care provided at YSM, YNHHS, and elsewhere upholds systemic racism and white supremacy.**

    a. **Document and publish the racial demographics, socioeconomic statuses, and payer statuses of patients seen** in each outpatient clinic and inpatient ward—including specialty services—within YaleMedicine and YNHHS. Develop a plan to address disparities in patient access uncovered by this process.

    b. **Each department should develop an interactive, ongoing educational program to openly discuss ways their field has contributed to systemic racism and oppression**. This program should be developed in consultation with experts in the History of Medicine and DICE and should involve all members of the department. While these programs should seek to inform practitioners with historical context, they must not be purely historical but also uncover and address ongoing systemic oppression.

    c. **Critically examine the use of race in routine clinical practice across YNHHS**—including, but not limited to: laboratory testing, treatment algorithms, and risk assessment calculators. The University of Washington acted as an

example of such immediate action by eliminating the use of race in the calculation of estimated glomerular filtration rate.[80]

5. **Tie increases in compensation for YNHH and YNHHS Senior Management to proportional increases in salaries of healthcare workers and support staff.**[81]

[80] "UW Medicine to exclude race from calculation of eGFR (measure of kidney function)." Department of Medicine, University of Washington. May 29, 2020. https://medicine.uw.edu/news/uw-medicine-exclude-race-calculation-egfr-measure-kidney-function

[81] From 2005 to 2015, a study of 22 large non-profit academic medical centers reported a 93% increase in CEO compensation compared to a 3% increase for registered nurses.

Du, J. Y., Rascoe, A. S., & Marcus, R. E. (2018). The Growing Executive-Physician Wage Gap in Major US Nonprofit Hospitals and Burden of Nonclinical Workers on the US Healthcare System. *Clinical Orthopaedics and Related Research*, *476*(10), 1910–1919. https://doi.org/10.1097/CORR.0000000000000394

8. We demand Yale School of Medicine, Yale New Haven Health System, and Yale University use their financial and political capital to directly benefit people from oppressed groups, and that they make financial reparations to Black and Indigenous communities and to the people of New Haven.

Yale must increase the amount of money it invests in the New Haven community, including increased voluntary payments to the city. It must divest from perpetrators of structural violence such as private prisons, and change its unethical investment policies that personally enrich the members of the board of trustees while robbing the people of this city of basic necessities. Yale must reckon with its historical and ongoing legacy of profiting from slavery and colonization and pay reparations to the communities that it has exploited and continues to exploit.

Yale's Endowment

Yale's endowment management strategy—known as the Yale Model, or simply the Endowment Model—is famous and influential. One notable feature of this model is its reliance on active portfolio management—purchasing assets at the discretion of fund managers—as opposed to "passive" management, for instance in funds that track the total stock market. The majority of the Yale endowment's portfolio consists of "non-traditional" assets—hedge funds, private equity, foreign equity, venture capital, real estate, etc.—as opposed to domestic stocks and bonds. Yale's investment office argues that this strategy is responsible for outstanding returns. However, active management incurs large fees to support the fund managers; such an approach is discouraged by many experts for most investors, because the fees can exceed gains.[82] The endowment is managed in relative secrecy, so the exact cost of these fees is not publicly known, but the fees are estimated to be between $500 million and $1 billion per year.

We object to this secretive, costly investment strategy on several grounds.

- **We question the claim of outsized returns, which are impossible to meaningfully verify with available data.** Yale reports the absolute returns on its investments on an annual basis and compares those returns with a benchmark, such as an index fund which tracks the performance of the stock market. Over a certain time window, Yale's actively managed endowment outperforms a benchmark composed of index funds. However, several analysts have argued that it does so by assuming considerably greater risk.[83] This risk cannot be known precisely, because Yale only reports returns

[82] https://www.berkshirehathaway.com/letters/2016ltr.pdf

[83] Mladina, P., & Coyle, J. (2010). Yale's Endowment Returns: Manager Skill or Risk Exposure? *The Journal of Wealth Management*, *13*(1), 43–50. https://doi.org/10.3905/JWM.2010.13.1.043

Roberts, D. (2017). Can Simple Asset Allocation Strategies Outperform the Ivy League Endowments? *The Journal of Wealth Management*, *20*(2), 9–15. https://doi.org/10.3905/jwm.2017.20.2.009

annually—smoothing over much volatility in its portfolio's performance—so risk must be estimated by constructing model portfolios that perform similarly to Yale's. Several analysts have constructed passive management strategies which match or out-perform Yale's expensive, actively-managed portfolio by simply assuming greater risk.[84] For instance, by borrowing money ("leveraging"), one can increase returns at the cost of greater risk. **The point is not that Yale's returns are not impressive, but that their massive spending on active management may not be justified—and that the value of Yale's costly active management is impossible to publicly evaluate because costs and risks are hidden.[85]**

Furthermore, Yale's Investments Office confidently asserts that Yale's endowment success will continue long into the future, but the degree of risk assumed and the reliance on illiquid assets calls this into question. For instance, in one study, the only asset class where Yale's active managers outperformed the market was in private equity;[86] however, the returns from private equity are highly variable compared to the stock market, meaning past performance does not guarantee future performance.[87] There is some evidence this is now the case—as of 2018, Yale's endowment over a 10-year time period no longer outperforms even a simple, non-leveraged, passive investing strategy.[88] It remains to be seen what impact the recession following the COVID-19 pandemic will have on the value of Yale's endowment.

- **Given this lack of transparency, we question the ethics of massive spending on investment management** by a non-profit organization (Yale)—personally enriching

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Fragkiskos, A., Ryan, S., & Markov, M. (2018). Alpha and Performance Efficiency of Ivy League Endowments: Evidence from Dynamic Exposures. *SSRN Electronic Journal*. https://doi.org/10.2139/ssrn.3098198

[84] Fragkiskos, *Ibid*. Roberts, *Ibid.* Mladina, *Ibid.*

[85] Investing "risk" can be quantified retrospectively by looking at volatility (estimated by variance) in the value of an asset over time. Yale provides summary estimates of the "risk" for various asset classes in its annual report (which exceed the returns for many asset classes), but these annual summary estimates are not sufficient to comprehensively evaluate the risk of the portfolio.

[86] Mladina, *Ibid.*

[87] Kaplan, S.N., and B.A. Sensoy. "Private Equity Performance: A Survey." Fisher College of Business Working Paper No. 2015-03-10, 2014.

[88] Markov Processes International. (2018). Uncovering The Hidden Risks Of The Endowment Model. https://www.markovprocesses.com/blog/endowments/uncovering-the-hidden-risks-of-the-endowment-model/

Markov Processes International. (2018). Measuring The Ivy 2018: A Good Year For Returns, But Is Efficiency Becoming An Issue? https://www.markovprocesses.com/blog/measuring-the-ivy-2018-a-good-year-for-returns-but-is-efficiency-becoming-an-issue/

owners of hedge funds, private equity funds, and venture capital funds who hoard obscene wealth (and who are incidentally overwhelmingly white and male)[89].

- **The lack of transparency facilitates investment in causes which are contrary to Yale's mission.** As we discuss below, Yale has refused to divest itself of several high-profile classes of businesses—including private prisons, fossil fuel companies, and firearm manufacturers. It is impossible to know what other causes are supported by Yale's endowment, because its holdings are not published.
- **The lack of transparency and the disposition of the endowment towards private investment raises questions about the relationship between Yale investments and the personal finances of the Board of Trustees**—many of whom have leading roles in financial services companies. Although information about these potential conflicts of interests is sparse, there have been concerning reports of exactly this type of self-dealing in the past.[90]

Yale's wealth, New Haven, and a legacy of slavery and colonialism

This massive, costly, and opaque operation to grow Yale's wealth stands in stark contrast to Yale's financial relationship with respect to the City of New Haven. Yale owns a large amount of valuable property in the city (which would otherwise be taxed) and provides many services (e.g. housing, dining, transportation) which might otherwise be provided by businesses (and therefore taxed). As meager consolation for the >$140 billion in tax revenue per year that the city would receive if Yale and YNHHS were taxable entities, the University and hospital make voluntary payments of ~$15 million per year, as well as maintain a portfolio of taxable properties in the city.

Finally, all of this must be considered in the context of this institution's broader history. Yale has historically profited from, and continues to profit from, a legacy of slavery and colonialism. Elihu

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[89] Prequin. (2017). Preqin Special Report: Women in Alternative Assets (Issue October). https://docs.preqin.com/reports/Preqin-Special-Report-Women-in-Alternative-Assets-October-2017.pdf

Fairview Capital. (2016). "The Value of Ethnic and Gender Diversity in Private Equity and Venture Capital." http://fairviewcapital.com/wp-content/uploads/attachments/Fairview_Capital_The_Value_of_Ethnic_and_Gender_Diversity_in_Private_Equity_and_Venture_Capital.pdf

[90] In 2012 the Chicago Tribune reported that "investments with trustee-related firms are not prohibited" at Yale and a 2003 Yale Daily News article reported examples of self-dealing by the Yale Corporation.

Schneider-Mayerson, M. (September 10, 2003). "Surprise, it's the Yale Corporation's five-finger discount." Yale Daily News. https://yaledailynews.com/blog/2003/09/10/surprise-its-the-yale-corporations-five-finger-discount/

Pressman, A., Herbst-Bayliss, S. (May 31, 2012). "Dartmouth, Brown lead Ivies in investing with trustees." Chicago Tribune. https://www.chicagotribune.com/news/ct-xpm-2012-05-31-sns-rt-us-dartmouth-endowment-surveybre84u1ai-20120531-story.html

Yale, the institution's namesake, was a slave trader. University buildings sit atop land taken by force from Algonquian-speaking nations.

This is profoundly unjust and contrary to the stated values and mission of the University. We propose the following changes.

1. **Alter University endowment investment policies and strategies to increase transparency, mitigate harm, and benefit the New Haven community.**
    a. Publish annually the full costs of active management of the endowment, including management and performance fees paid for investment management.
    b. Publish policies (if any) on self-dealing investments and institutional insider trading.[91] If these policies do not exist, they must be developed and enacted with oversight from a completely independent committee that includes students from CDISJ or recommended by CDISJ and New Haven residents unaffiliated with Yale.
    c. Publish annual financial conflict of interest statements for all employees of the Yale Investments Office, members of the Investment Committee, members of the Advisory Committee on Investor Responsibility (ACIR), and the members of the Board of Trustees.
    d. Include one or more New Haven residents unaffiliated with Yale on the Investment Committee and the ACIR.
    e. Develop and implement a plan to divert a significant portion of the payments for active management of endowment investments (estimated[92] to be hundreds of millions of dollars annually) to the city of New Haven as voluntary payments in lieu of taxes.
        i. This plan may include conversion to passive management for a portion or the entirety of endowment investments, which would potentially provide equal or greater net returns on investment at significantly lower cost compared to current high-risk active management strategies.[93] Full

[91] We are unable to find information on such a policy in the Yale Ethical Investing Policy or in any other publicly available documents. See notes about previous reports of self-dealing.

[92] Fleisher, V. (August 25, 2015). "Private Equity Fees Paid by Universities Deserve Examination." The New York Times. https://www.nytimes.com/2015/08/26/business/dealbook/private-equity-fees-paid-by-universities-deserve-examination.html

Fleisher, V. (August 19, 2015). "Stop Universities From Hoarding Money." The New York Times. https://www.nytimes.com/2015/08/19/opinion/ stop-universities-from-hoarding-money.html

[93] Markov Processes International. (2018). "Measuring The Ivy 2018…," *Ibid*.

transparency of management costs (Demand 8.1.a) will permit rigorous scholarly analysis to help formulate this plan.

f. Fully divest from perpetrators of structural and state violence.

   i. Private prisons[94] and companies exploiting prison labor.

   ii. Puerto Rican debt.[95]

   iii. Defense and military contractors, weapons manufacturers[96], police department suppliers, and manufacturers of drugs or devices used for capital punishment.

Segal, J. (2018, April 16). Yale's Risk-Adjusted Returns Not So 'Superior,' Firm Argues. *Institutional Investor*.

https://www.institutionalinvestor.com/article/b17szlhnw5fh4f/yale%E2%80%99s-risk-adjusted-returns-not-so-%E2%80%98superior,%E2%80%99-firm-argues

Segal, J. (2018b, November 29). Not One Ivy League Endowment Beat a Simple U.S. 60-40 Portfolio Over Ten Years. *Institutional Investor.* https://www.institutionalinvestor.com/article/b1c1c4tq2bjm3c/Not-One-Ivy-League-Endowment-Beat-a-Simple-U-S-60-40-Portfolio-Over-Ten-Years

Markov Processes International Inc. (2020, February). Measuring The Ivy 2019: Decoding The Performance Gap. https://www.markovprocesses.com/blog/measuring-the-ivy-2019-decoding-the-performance-gap/

Segal, J. (2019, October 14). Ivy League Endowments Fail to Beat a Simple U.S. 60-40 Portfolio — Again. *Institutional Investor.* https://www.institutionalinvestor.com/article/b1hlc1hjfsbwfq/Ivy-League-Endowments-Fail-to-Beat-a-Simple-U-S-60-40-Portfolio-Again

Ennis, R. (2020). Endowment Performance and the Demise of the Multi-Asset-Class Model. https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3614875

Roberts (2017), *Ibid.*

Dahiya, S., & Yermack, D. (2018). Investment Returns and Distribution Policies of Non-Profit Endowment Funds (No. w25323). National Bureau of Economic Research. https://www.nber.org/papers/w25323.pdf

[94] We reject Yale's assertion that divestment from private prisons "is not warranted under the University's ethical investing guidelines" and insist that any guidelines supporting investment in private prisons are inherently unethical.

[95] The Yale ACIR determined that "divestment from Puerto Rican debt is not warranted when an investor is abiding by the applicable legal framework in a process in which the debtor's interests are appropriately represented." This response is unacceptable and fails to account for the direct cause of this debt crisis, the historical and ongoing exploitation that Puerto Rico has suffered as a US colony.

Dayen, D. (February 20, 2018). "Yale University Under the Spotlight for its Investment in Puerto Rican Debt." The Intercept. https://theintercept.com/2018/02/20/yale-puerto-rico-debt/

[96] Yale's policy that it "will not invest in any retail outlets that market and sell assault weapons to the general public" does not decrease the production of weapons and does not fulfill our demand.

iv. Fossil fuels.[97]

2. **Develop and implement plans to use Yale's significant financial and political capital to benefit, and pay restitution for exploiting, oppressed communities**.

    a. Increase the amount of voluntary payments made by YNHH and Yale University to New Haven in lieu of taxes.[98] We echo the Yale: Respect New Haven coalition letter to Peter Salovey and Marna Borgstrom.

        i. This amount should increase yearly with inflation.

        ii. Payments by Yale University should increase proportionally to growth of the endowment.

        iii. Payments by YNHH should increase proportionally to annual profits.

        iv. Pay a fixed percentage of all University donations to the City of New Haven (we recommend 5%).

    b. Create a University-wide committee to develop and implement a plan for reparations.

        i. These reparations will be direct financial payments to specific individuals or groups of people, as determined by the committee. They are intended as restitution for harm inflicted by Yale upon marginalized people.

[97] Yale's policy of "investments with large greenhouse gas footprints are disadvantaged relative to investments with small greenhouse gas footprints" is woefully inadequate and does not fulfil the demand of complete divestment from fossil fuels. http://investments.yale.edu/2020-update-on-climate-change

[98] Yale University and YNHH will contribute a reported $13 million and $2.8 million, respectively, in voluntary payments to the city of New Haven for fiscal year 2020-2021, in addition to roughly $5 million in taxes on taxable property (such as retail). The city estimated Yale would pay $144 million annually if not tax exempt.

O'Leary, M. (May 27, 2020). "New coalition wants Yale University and the hospital to give more to New Haven." New Haven Register. https://www.nhregister.com/news/article/New-coalition-wants-Yale-University-and-the-15295135.php

Breen, T. (May 26, 2020). "Rally Demands Yale, YNHH Pay 'Fair Share.'" New Haven Independent. https://www.newhavenindependent.org/index.php/archives/entry/coalition_protest/

"Economic Growth and Fiscal Impact." Yale Office of New Haven Affairs. https://onha.yale.edu/economic-growth-and-fiscal-impact

ii. This committee will consider, at minimum, reparations for Yale's profits from slavery and colonialism[99] as well as the University's current colonization of Indigenous land[100].

iii. This committee must contain students, faculty, staff, members of non-Yale New Haven community organizations, members of Algonquian-speaking nations whose land is currently occupied; the committee should include representatives from the Afro-American Cultural Center, the Native American Cultural Center, the Department of African American Studies, the Yale Group for the Study of Native American, and the Yale Center for the Study of Race, Indigeneity, and Transnational Migration. Outside scholars and experts must be hired and serve on the committee.

iv. The members of this committee must be approved by the Afro-American Cultural Center, the Native American Cultural Center, and the Community Review Board described in Demand 9.2.e.

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[99] Doctor, G. (2017, February 15). The Indian history of the racist, slave-trading Yale University founder. Scroll.In. https://scroll.in/magazine/829298/the-indian-history-of-the-racist-slave-trading-yale-university-founder

Dugdale, A., Fueser, J. J., & Celso de Castro Alves, J. (2001). *Yale, Slavery and Abolition.* The Amistad Committee, Inc. http://www.yaleslavery.org/YSA.pdf

Smith, S., & Ellis, K. (2017, September). *Shackled Legacy.* American Public Media. https://www.apmreports.org/episode/2017/09/04/shackled-legacy

Goyal, Y. (2017, February 17). The Ivy League's dark history shows it is not easy to reject charity that involves dirty money. *Quartz India.* https://qz.com/india/913438/yale-university-the-ivy-leagues-dark-history-shows-it-is-not-easy-to-reject-charity-that-involves-dirty-money/

Remnick, N. (2015, September 11). Yale Grapples With Ties to Slavery in Debate Over a College's Name. *The New York Times.* https://www.nytimes.com/2015/09/12/nyregion/yale-in-debate-over-calhoun-college-grapples-with-ties-to-slavery.html

Zernike, K. (2001, August 13). Slave Traders In Yale's Past Fuel Debate On Restitution. *The New York Times.* https://www.nytimes.com/2001/08/13/nyregion/slave-traders-in-yale-s-past-fuel-debate-on-restitution.html

[100] Yale University Office of the Secretary and Vice President for University Life. *Land Acknowledgment Statements* [Press release]. https://secretary.yale.edu/services-resources/land-acknowledgment-statements

Katz, D., & Trusty, L. (2017, August 21). Native Yale Students Pushing For Quinnipiac Recognition. *Wshu Public Radio*. https://www.wshu.org/post/native-yale-students-pushing-quinnipiac-recognition

v. The members of this committee will receive the necessary funds to thoroughly study this issue and will be appropriately compensated for their work.

c. **Mitigate Yale's contribution to rent inflation, gentrification, high property taxes, and homelessness in and surrounding New Haven.**

i. Develop and implement a plan to invest in affordable housing, legal housing assistance, and related community benefits.

ii. Involve local residents in all decisions related to new construction and require a gentrification mitigation plan.

d. **Combat disenfranchisement of BIPOC voters by financially and institutionally supporting efforts to register voters** and request mail-in ballots for citizens in New Haven.

i. Make registering voters and requesting mail-in ballots in the New Haven community a required service activity during iPro, for the pre-clerkship students, or as a clinical elective.

ii. Include universal screening for voter registration, in-clinic assistance with voter registration, and voter education (including dates, locations, information about voting by mail) at all outpatient visits, with emphasis on primary care visits. Provide appropriate materials, training, and support staff to clinics to implement this effectively.

iii. Exert institutional pressure on state and local authorities to increase the number of polling places in the city, including in Yale-owned facilities, to promote more easily accessible and safer voting for all who choose to vote in person.

e. Establish, as an ongoing principle, that community members will be compensated for labor provided to Yale.

9. We demand full institutional accountability, transparency, and follow-through with these demands.

The goals of diversity, equity, and inclusion should be enshrined in the YSM Mission Statement. The administration must publish a strategic plan with quantitative goals, benchmarks, and a timeline for implementing these demands, including annual reporting and re-assessment of progress.

These demands outline our vision for an inclusive, equitable YSM. Achieving this vision will require substantial institutional investment. The first step is a formal commitment to these principles in the School's Mission Statement. Second, and in parallel, is a detailed strategic plan, including measurable goals and a timeline for implementation. Without such a plan, work will continue to be ad hoc, efforts duplicated, labor wasted, and overall progress halting. Managing the complex task of implementing these goals must not fall to students. However, meaningful student participation in all aspects of this work will be essential. Most significantly, selection of major institutional leaders should always involve students as full participants in the process. To this end, we applaud Dean Brown's commitment to include multiple students in the committee to identify the next Deputy Dean for Education. We look forward to a similar commitment in the future.

1. **Cement the goals of these demands—a commitment to diversity, true inclusivity, and anti-oppressive teaching and scholarship—into a revised mission statement for the Yale School of Medicine.**[101] Mission statements matter—they affect how students and employees relate to the organization, recognize the interests of stakeholders, and affect resource allocation.[102] More importantly, the public process of developing such a mission statement educates members of the organization and facilitates strategic planning. Medical school mission statements are associated with graduates' specialty choices—one concrete example of how mission statements are related to outcomes.[103]
2. **Create an institutional strategic plan, originating from the Dean's Office and DICE, to meet these demands.**
    a. This plan must include quantitative goals, benchmarks, and a timeline for implementation.

[101] Mullan, Fitzhugh, Candice Chen, Stephen Petterson, Gretchen Kolsky, and Michael Spagnola. 2010. "The Social Mission of Medical Education: Ranking the Schools." Annals of Internal Medicine 152 (12): 804–11. https://doi.org/10.7326/0003-4819-152-12-201006150-00009

[102] Lewkonia, Ray M. 2001. "The Missions of Medical Schools: the Pursuit of Health in the Service of Society." *BMC Medical Education* 1 (1). https://doi.org/10.1186/1472-6920-1-4

[103] Morley, Christopher P, Emily M Mader, Timothy Smilnak, Andrew Bazemore, Stephen Petterson, Jose E Rodriguez, and Kendall M Campbell. 2015. "The Social Mission in Medical School Mission Statements: Associations with Graduate Outcomes." *Family Medicine* 47 (6): 427–34

b. This plan must be revisited at least annually and revised as necessary with future developments.

c. This plan should be presented to the Committee for Diversity, Inclusion, and Social Justice.

d. A dedicated staff member, with training in organizational psychology, should be hired to supervise the implementation of the strategic plan in real time. This person should report to both the Dean and the Chief Diversity Officer.

e. **Convene a Community Review Board (CRB) to advise the School of Medicine, consisting of key New Haven leaders and stakeholders**, to ensure longitudinal community engagement and prioritization of community needs. Members of the CRB will not be determined by members of the Yale community.

3. **Issue an annual report, beginning Fall 2020, documenting progress towards the strategic plan.** This report should contain, at the minimum:

    a. Accounting of hiring, tenure, and promotion of underrepresented faculty within each department.

        i. Demographics of those holding leadership positions, endowed professorships, and other prestigious positions.

        ii. Analysis of faculty and staff compensation by gender and race.

    b. Departmental budget allocations.

    c. Measures of student diversity in the medical school classes and among all trainees in each department.

4. **Guarantee student participation in crucial tasks of school governance, including a student representative with full voting rights on each of the following committees:**

    a. Executive admissions committee for medical students.

    b. Admissions committee for each BBS graduate program.

    c. Faculty search committees for department chairs.

    d. Search committees for the dean, all deputy dean positions, and all student-facing associate dean positions (including those within the Office of Education).

    e. Search committees for leadership positions with high significance to students, such as directing the Office of Student Research or the Teaching and Learning Center.

5. **Provide guaranteed protection for those engaged in advocacy, activism, or the reporting of bias or harassment.**

    a. Provide whistleblower protections and protections against retaliation for trainees, staff, and faculty engaged in anti-racist and social justice work.

b. Allow any trainee to request intervention from the DICE Office on their behalf if the trainee reasonably believes that a formal evaluation is or will be adversely affected in retaliation for reporting bias or harassment

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Conclusion

These are our demands. We expect a written response from the Office of the Dean expressing intent to fulfill these demands by Wednesday, July 1st, sent to the entire School of Medicine. Upon intent to fulfill, we expect a written plan to implement these demands be delivered to the Committee for Diversity, Inclusion, and Social Justice (CDISJ), the ongoing and active inclusion of students in all aspects of implementation, as well as transparent updates to the entire medical school on the status of these demands on, at minimum, a bi-monthly basis.

In its mission statement, YSM claims that it will educate us to become leaders who will “advance the practice of medicine” and “alleviate suffering caused by illness and disease.” But much of the illness and disease that plagues our society, both domestically and globally, is directly linked to European colonization, chattel slavery, and cisheteropatriarchal oppression. The medical community has done significant harm in perpetuating these violent systems, both through inaction and willful participation. If YSM truly stands by its mission, it needs to create the intellectual, social, and institutional environment to foster diverse leadership and strong communities to meet the complex challenges facing both the field of medicine and humanity as a whole.