really meant so much to see that other people recognize it too.”

We see all women in our department as Sheroes, and their contributions deserve to be celebrated. But how do we acknowledge the value of these individuals on a regular, deliberate basis? We believe that doing so represents critical support for women physicians on their career paths, and academic medical centers should commit to such outward recognition along with changing structural factors. As networking organizations like PWIM create virtual and in-person programming, we aim to be deliberate about building community, encouraging sponsorship to promote women’s academic advancement, and driving substantial change to encourage women’s success.

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**Medical Students Confront Racism and Systemic Oppression Amidst a Global Pandemic**

**To the Editor:** The year 2020 will be marked in our history textbooks with an asterisk. It will represent the year the United States witnessed an unprecedented global pandemic alongside a racial revolution. Although the murder of George Floyd in Minneapolis on May 25, 20201 ignited the brewing discontent much of the public felt toward the justice system in the United States, the national quarantine imposed by the COVID-19 pandemic made it possible for so many Americans to take part in this racial awakening. Everyone was indoors, collectively witnessing the public killing of a Black man who cried out helplessly for his mother for 8 minutes and 46 seconds.1 The events that took place on May 25th shifted the paradigm of the COVID-19 pandemic, and the medical community shifted along with it. In particular, medical students across the country began drafting “call to action” documents urging their institutions to readdress their medical curriculum and the ways in which the medical community has failed marginalized patient populations.

At Oakland University William Beaumont School of Medicine, we, alongside other medical students, composed a call to action document in an effort to highlight opportunities to improve our curriculum and condemn the manifestations of structural and systemic racism in the United States. We recognize we cannot adequately live up to the oath we took upon entering the medical community and the standard we have held ourselves to without acknowledging racism as a public health crisis. In our call to action, we outline 8 core action items for our institution to work on implementing, including curriculum reform, more robust support for minority medical students enrolled at our institution, and the implementation of antiracism workshops. As medical students who will one day serve an ever-diversifying patient population, we emphasize that our course material must reflect contemporary race issues and increased efforts need to be made to ensure that minority populations are represented in our medical school curriculum.

Since publishing our call to action document, our institution’s administration has been receptive to implementing the proposed action items, and we have witnessed an overall increase in discussions at our institution surrounding inequality. We hope this initiative demonstrates the importance of activism in medicine and the role of doctors and medical students to affect change. We encourage other students to take this initiative at their own institutions and are hopeful for the future of medicine.

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**Reference**


**Social Justice and COVID-19: A Rallying Cry for Medical Schools to Prioritize Criminal Justice Health**

**To the Editor:** Although the COVID-19 pandemic has highlighted and further reinforced preexisting health disparities in the U.S. general population, the severity and acuity of this health crisis has been particularly alarming in the criminal justice system. COVID-19 has disproportionately impacted people housed in U.S. jails and prisons. With our national focus on correcting social injustice, now more than ever should criminal justice health be reflected in medical education curricula. There are 2.3 million people behind bars in the United States, the majority of whom are incarcerated for low-level offenses. As a result, these individuals are at increased risk of COVID-19 and other infectious diseases. In a recent article in JAMA Network Open, Melikian et al. noted that without intervention, COVID-19 is projected to be the leading cause of death for incarcerated individuals (n=303,000) in 2020.2 This is concerning, as incarcerated individuals are at heightened risk of developing complications from COVID-19.

In an effort to address this critical issue, clinical medical schools have published articles on improving medical education curricula to address health disparities,1,3 yet the physical, mental, and emotional health of incarcerated individuals is not discussed.2,4 In 2020, the AAMC created PWIM to focus on increasing diversity and inclusion in medical education and promote the health of marginalized populations.5 This statement expresses a call to action for medical schools to prioritize the health of incarcerated individuals.6

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**Reference**


States, with an overrepresentation of the most economically disadvantaged Americans and racial minorities. As every physician takes an oath to “do no harm,” medical schools should prepare physicians to understand the health needs of all, including those of the incarcerated. Failure to take action will only widen disparities among this population, which unevenly consists of people of color with serious health care needs.

Promoting correctional health care is a key component of improving population health. The indelible link between correctional medicine and public health has been dramatically highlighted by the spread of SARS-CoV-2. This topic should not be relegated to optional learning. Rather, understanding how to care for all our patients in the context of criminal justice and systemic racism is essential learning. We must be prepared to care for every patient holistically. Teaching criminal justice health in medical schools is a widely neglected area and a missed opportunity for engagement with public health.

All academic institutions have a responsibility to address the crisis of mass incarceration in the United States. Because of the profound connection between criminal justice and public health, medical schools in particular should lead educational efforts—the development of sound public policy, the implementation of meaningful research, and the delivery of quality health care to the populations impacted by the criminal justice system. The necessity and urgency of this issue was thrown into stark relief by the COVID-19 pandemic and serves as a call to action to the medical education community.

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Reference

Ensuring Equitable Access to Remote Learning During the COVID-19 Pandemic

To the Editor: The rapid shift to online learning imposed by the COVID-19 pandemic created uncharted territory for medical educators. Little evidence exists to guide remote learning in medical education. To inform best teaching practices at Harvard Medical School, we conducted an anonymous survey of our medical students, who transitioned to remote learning in March 2020, to assess their needs and preferences for online learning. The survey request was emailed 4 weeks after the transition to all current students. The response rate was 39% (255/654).

Responding students highly valued small-group learning (82% rated breakout groups “effective or very effective”) but preferred reducing required synchronous online instruction (86% of students preferred less than 4 hours per day, with 3–4 hours optimal). We were concerned to learn that many students were regularly struggling with basic remote learning necessities, including an adequate Internet connection (20% “often/always,” 40% “sometimes”) and a quiet space to attend class and study (18% “often/always,” 35% “sometimes”). Only 39% reported “rarely/never” having either of these issues.

Before our analysis of our data, many faculty expected all students to attend synchronous sessions and participate in discussions with their microphones and video cameras turned on. Informal discussions with faculty indicated that lack of such participation was perceived negatively, without the understanding that a significant number of students were unable to participate effectively.

Following our needs assessment, programs were launched to assist students in meeting basic requirements to assure their full participation in remote learning. For example, the medical school raised a student emergency fund to provide funds to students with financial need to help with expenses related to broadband Internet access. Our future analysis of our survey data will further explore the relationship between lack of an accessible and predictable learning environment and attitudes toward remote learning by including qualitative analysis of students’ open-ended comments.

Medical schools must seek to uncover disparities in student access to remote learning and pursue ways to close the gap to enable all students to reach their potential during this time of distance learning. Students with difficulty accessing the Internet or a quiet learning environment may also be vulnerable to other stressors. Faculty must be mindful that individual learning environments may vary greatly and strive to support every student as challenges arise. It is important that faculty approach students with a mindset that assumes students are doing the best they can with the resources they have. From a programmatic point of view, it is critical that our decisions are not only based on preferences and consensus but also on a careful assessment of the needs of the most vulnerable students.

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