Promoting Culture Change Within Organizations

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Women physicians add value to health care organizations yet continue to lag behind men in career growth and leadership roles, in large part because of factors related to organizational culture. Promotion of culture change can facilitate equal access for both women and men to opportunities and resources. In this article, we identify and address the long-standing and urgently escalating need for culture change in medicine through the use of representative cases. Strategies are provided describing how to initiate and manage culture change. Examples of both process and outcome of such change include equal support for job positions, promotions, pay, and inclusion in decisions and discussions. The intersections of culture change and identified imperatives with respect to race, gender, and historically excluded and marginalized groups are specifically addressed. Finally, mechanisms of culture change are identified, as well as areas of opportunity to aid the long overdue evolution of medical culture toward one of inclusivity and equity.

PROMOTING CULTURE CHANGE WITHIN ORGANIZATIONS

Women physicians bring added value to health care organizations yet continue to lag behind men in career growth and leadership roles, in large part because of factors related to organizational culture.[1] Organizational culture is defined as the shared values, beliefs, or perceptions held by employees that drive interactions and functions within an organization or organizational unit. Shanefelt et al[2] described these "shared and fundamental beliefs, normative values, and related social practices of a group" as "so widely accepted that they are implicit and no longer scrutinized." Culture influences how physicians practice medicine, engage with colleagues, measure success, and even value their own contributions. Specific to medicine, culture change would facilitate equal access for both women and men to opportunities and resources, including equal support for job positions, promotions, pay, and inclusion in decisions and discussions.

The evolution of the Hippocratic Oath provides evidence about how

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the culture of medicine has already changed.[3] The culture of medicine revolves around this oath, which is taken on entering the field to "first do no harm." However, this commonly attributed phrase was not included in the original text of the oath, which speaks to the ever-changing culture of how physicians view themselves and the attitudes and belief about medical practice.[4] Revisions to the oath over time reflect changes in the world in which physicians practice. Indla and Radhika[5] point out that the essence of the original oath embodied beneficence, gratitude, confidentiality, and humility. However, many other aspects of the oath do not align with today's social norms. For example, the original oath was written explicitly for male physicians: "I will impart a knowledge of the art to my own sons," because women were not allowed to conduct the practice of medicine during the time the oath was originally written. In addition, patient autonomy and shared medical decision-making, now standard in medical practices and culture, were not emphasized.[5] The ever-changing interpretation and implementation of the Hippocratic Oath in medicine today exemplifies how the fundamental culture of medicine has already evolved and must continue to do so.[3] The need for further change is particularly evident in the realm of diversity, equity, and inclusion.

For years, medicine's white male–dominated culture has marginalized women and people who are Black, indigenous, and/or people of color (BIPOC), resulting in a physician workforce with a race and gender distribution that does not resemble the US population.[6–8] Lack of diversity and inclusion limits the profession's overall potential performance in health care quality. BIPOC physicians serve important roles in advancing innovative science and medicine, most often serving in underresourced communities, and their presence on medical teams is directly associated with improved health outcomes for marginalized communities.[9] In addition, physician-provider racial parity has been correlated with improved newborn outcomes and female health care providers have also been revealed to have generated improved patient outcomes.[2,10] However, physicians who are BIPOC face numerous barriers within medicine, such as inequitable opportunity for employment and advancement and having to navigate exclusionary and often hostile and racist environments. BIPOC women physicians must deal with a duality of barriers related to being a woman in medicine and a woman of color. All these challenges persist in a well-established and static culture that undervalues BIPOC women physicians and their role in achieving optimal health outcomes for all patients. If diversity in medicine is truly to be achieved, organizational culture change must be addressed.

In this article, we present several approaches for fostering inclusive and equitable culture change, followed by several representative cases. Strategies are provided within each case describing how to initiate, manage, and sustain culture change.

WAYS TO CHANGE CULTURE

Culture change can occur as the result of concerted, intentional effort and can also occur spontaneously, in unpredictable waves. The ever-changing field of medicine exemplifies how the fundamental culture of medicine has already and must continue to evolve. This is the nature of complex adaptive systems. Several mechanisms for culture change are described as follows.

SPONTANEOUS CHANGE

During rare times, positive culture change may occur spontaneously, and leaders may solidify such change by "riding the wave." If a contemporary cultural wave propagates in a desired direction, we can harness this energy and momentum for culture change within a profession or organization.[11] For example, medical culture responded strongly to the #MeToo movement, with widespread calls for gender equity and an end to discrimination and harassment in the workplace. The movement, initiated by Tarana Burke, gained national attention with the announcement of #MeToo by Hollywood actresses in 2019.[12] This campaign spurred a groundswell in health care, in which calls of #MeToo launched environmental changes in the medical profession (eg, removal of the honorary "walls of white men"). Negotiation and implementation of policies and structures to augment equal opportunity for women, and to promote environments free from discrimination and harassment, gained important priority and momentum from this movement. Organizations such as Times Up Healthcare were founded by health care professionals to facilitate these necessary changes in medicine.[13,14] However, meaningful, lasting, and effective culture change cannot be sustained by solely "riding the wave."

INTENTIONAL CHANGE

Overall, there is a paucity of tested and validated strategies for culture change within health care from an organization-wide perspective.[15] A systematic review

by Scott et al describes ways that culture change might be implemented within organizations.[11] The strategy begins with the important step of assessing and fully understanding current culture, climate, and their driving supports (implementing a "prescription" for culture change first requires a comprehensive "diagnosis," both quantitative and qualitative).[11] In 1946, Lewin described a model using repeating cycles of diagnosis, analysis, feedback, and action to implement change, cycles of change now familiar within quality improvement.[16] For example, surveys are conducted among medical trainees to identify experiences of disrespectful behaviors from faculty and staff. Then, analysis of results is communicated to institutional leaders, who then develop strategies and implement policies to target those behaviors. After follow-up evaluation of strategy effectiveness, the cycle begins again. Ideally, such continuous cycles lead to system-wide changes in culture, including this key practice of constant self-scrutiny and growth.

CONCRETE STRATEGIES

Short of organization-wide strategies, culture change often stems from locally targeted and specific approaches, which may or may not lead to large organizational shifts.[17] Such strategies are implemented on a smaller scale to address key identified areas (Table 1).

CHANGING COMPLEX ADAPTIVE SYSTEMS

The interactions and relationships between members of an organization determine culture more than characteristics or attributes of individual members.[17,18] The words that individuals choose imprint on others more than we recognize, especially among those who hold leadership titles and power.[19] Facial expressions, posture, and body language all convey meaning, and any or all can be misinterpreted easily and severely, affecting webbed relationships moment to moment, creating and altering culture with each interaction. In this way, culture is a self-organizing phenomenon, paradoxically impervious and susceptible to drifts and shifts, both engineered and organic, and is thus dependent on and resulting principally from relationships.[20] Therefore, individuals have a unique and important role in culture change regardless of title or position.

TABLE 1 Organizational Culture Improvement Interventions by Need and Organization Type

Intervention Type	Intervention and Strategy
Intervention by need, culture improvement need	
Workplace civility and staff engagement	Speaker presentations, active learning strategies, and leadership training
Teamwork	Coaching and team-building training
Effective leadership	Leadership development training, 360° feedback, executive coaching
Antibullying	Zero tolerance programs, conflict prevention and resolution training
Burnout	Wellness programs and resources
Intervention by organization type, organization type	
Health care organizations	Equal opportunity, human resources, and employee assistance programs
	Faculty development that focus on active learning, teamwork, giving and receiving feedback, leadership development, workplace equity, and wellness
	Standardized teamwork, communication, and patient safety training, such as TeamSTEPPs and communication courses based on crucial conversations
Professional societies	Clinical learning environment goals of the ACGME. The ACGME offers some free and some fee-based resources
	The AAMC, a free professional development toolkit (https://www.aamc.org/professional-development/affinity-groups/gwims/toolkit)
	Free mentorship programs, and fee-based or nominative leadership development programs. (eg, ACP, AAP, AAFP, AMA)
Other	Sheryl Sandberg's "Lean In" circles are free and can be set up with a local leader
	The field of physician coaching has blossomed in the past several years (many coaches have podcasts and Web sites or Facebook groups with free resources as well as fee-based coaching programs)
	Leadership-based book clubs can be set up locally to discuss and promote topics of interest and need to the organization

AAP, American Academy of Pediatrics; AAFP, American Academy of Family Physicians; AAMC, Association of American Medical Colleges; ACGME, Accreditation Council for Graduate Medical Education; ACP, American College of Physicians; AMA, American Medical Association.

MANAGING POLARITIES

Any complex system comprises divergent interests, priorities, and processes, along with their attendant advocates. Such opposing forces may be viewed as adversarial, but, in reality, they create a necessary, dynamic balance within a system. Rather

than 1-dimensional problems to be solved with singular solutions, complex challenges, such as diversity, equity, and inclusion, require myriad "right" answers, many of which are inextricably interdependent.

Barry Johnson provides a practical and visual method for defining and assessing polarities at work in our systems and how to maximize their respective advantages while minimizing pitfalls (Fig 1). [21,22,23]

We can apply the framework in the polarity management figure (used with permission from Barry Johnson and Polarity Partnerships, LLC) to diversity, equity, and inclusion initiatives. Such programs may be driven and executed by leadership (top-down, the left pole) and/or by rank-and-file staff and faculty (bottom-up, right pole). Each has its advantages and disadvantages. Top-down programs can succeed because they are more visible and well-funded (upper-left quadrant). However, they may suffer from uneven relevance and execution across a large organization (lower-left quadrant). Bottom-up initiatives, on the other hand, enjoy immediate buy-in from grassroots members (upper-right quadrant). However, they may be difficult to scale and generalize because of limited resources and support from leadership (lower-right quadrant). Both top-down and bottom-up strategies are needed to effectively create a more diverse, equitable, and inclusive culture. Harnessing the strengths of both poles (optimizing attention and actions in the upper quadrants) moves an organization toward the box at the top center. Here lives the polarity's greater purpose statement (GPS), the answer to the question, "Why should we attend to and manage this polarity?"

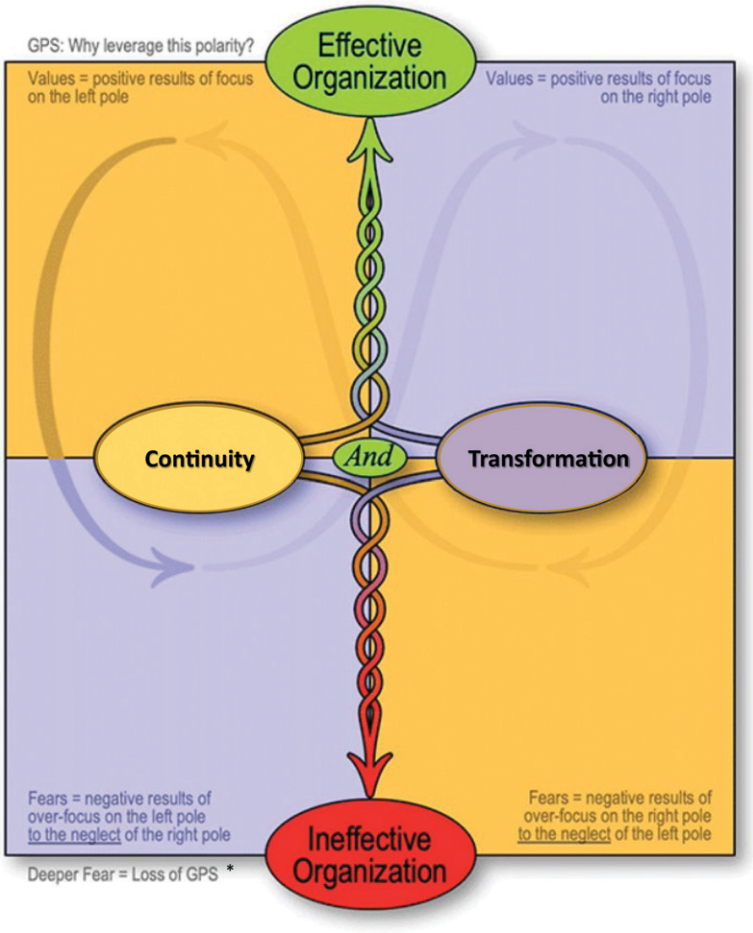

FIGURE 1

Pole 1 occupies the left 2 quadrants; pole 2, the right 2 quadrants. In this example of Diversity, Equity and Inclusion Initiatives, the two poles being considered might be Continuity vs. Transformation within an organization. The upper quadrants represent the benefits, or positive results, of focusing on each pole. However, with overfocus and imbalanced attention on one pole over the other, there are costs and negative results of overemphasis of one pole. When a system feels these effects, it tends to take action toward the other pole, thus bringing balance. However, as the costs of overfocusing there emerge, counterbalancing action toward the former pole takes place. In this way, systems live in an infinity loop. This figure reveals how polarities are relationships to be continuously managed rather than finite problems that can be definitively solved. The objective is to anticipate and observe early signs of overfocus and negative results and move quickly to rebalance the system in dynamic agility. Polarity Map is a registered trademark of Barry Johnson and Polarity Partnerships, LLC. Commercial use is encouraged with permission. GPS, greater purpose statement.

When leaders overexert power or influence, downsides of the top-down pole may emerge, such as workforce disengagement. The system moves from the upper-left to the lower-left quadrant. As warning signs appear, such as higher turnover, proponents of the bottom-up pole feel it most acutely. Resistance builds, and pressure increases to implement counterbalancing actions of grass roots engagement, moving the system up and to the right. When teams focus too much on this pole, pitfalls, such as departmental siloing and counterproductive redundancy, surface, the system moves to the lower-right quadrant, and countervailing forces then push

the system back up and to the left. This is the recurring, infinity-shaped path of polarity dynamics. The goal is to spend as little time and energy and as few resources as possible in the lower half of the grid.

Overfocus on 1 pole or the other usually occurs when people on either side lose sight of the inextricable and interdependent value of the opposite perspective. Effective culture change occurs when a system achieves optimal balance and mindful movement between the ideals of essential poles. This happens when leaders identify appropriate assessment metrics, mobilize collaborative relational tools, and execute effective actions, also in a recurring, self-scrutinizing manner. This model exemplifies the "Yes, and" mindset, converting the tension of polarities from anxious and divisive to cooperative and productive. Well-defined and managed polarities transform apparently oppositional relationships into ones that help a system thrive in synergy.

MANAGING TRANSITIONS

When leading change, the most effective agents anticipate and manage people's subjective experiences. William Bridges's work on managing transitions provides a helpful framework (Table 2).[24] His model first addresses perceptions of ending, loss, and grief. When people experience unwanted change, fear, denial, anger, resentment, and emotional hijack, this can cause resistance and stymie even the most well-intended change initiatives. It is difficult to give up the comfortable, if dysfunctional, status quo. Effective change initiatives provide space and time for people to process their feelings through transparent, multidirectional communication.

During the process of significant culture change, there will be a period of neutral zone or uncertainty. The middle space between what was and what will be can trigger low morale and productivity, anxiety, and skepticism. People know they cannot go back, but they do not yet know what they are moving toward. Bridges suggests that this is the time to engage team members in creating the new normal. There is opportunity here to maximize agency by delegating innovation tasks, leveraging individual and team strengths to pilot new projects and iterative cycles of learning, application, and analysis, as described above. Consistent feedback and amplifying small victories sustains momentum and buy-in in this phase of culture change. As the new beginning of a culture emerges, morale improves. Leaders can magnify this energy to nurture and sustain positive change. Bridges advocates continuous, open, and consistent communication, celebrating wins to date and likewise acknowledging potential pitfalls and creating plans to navigate them.

TABLE 2 Managing Transitions

Phase of Transition	What People Feel and Do	How Leaders Can Help
Ending, letting go	Grief, loss, sadness, anxiety, resentment, anger, disorientation	Identify who is losing what
	Deny, withdraw, disengage	Acknowledge losses openly and empathically
		Validate people's emotions and signs of grief
		Give information repeatedly: be transparent
		Treat the past with respect
Neutral Zone	All of the above, plus the following:	Normalize this phase, acknowledge the limbo feeling
	Desperation, excitement, possibility	Create temporary systems: huddles, task forces, etc
	Follow loudest contrarian	Minimize unimportant additional changes
	Look to leave organization	Facilitate creativity, experimentation, and innovation: leverage the undetermined to cocreate the better
New Beginning	All of the above, plus the following:	Convey purpose clearly and repeatedly
	Hope, connection, meaning	Paint the picture of meaningful vision
	Wax nostalgic, revert to previous ways of doing things	Share a clear plan
		Give team members each a part to play getting there

Remember that these phases do not necessarily occur in linear, sequential fashion. There will be people experiencing all phases around any given change at all times, and they may vacillate. It is when the majority of people have moved from one phase to the next that collective transition progression occurs.
Source: Bridges W, Bridges S. Managing Transitions: Making the Most of Change. 2017.

These 2 practices, managing polarities and transitions, in and of themselves could be seen as profound and transformational aspects of culture change and not just tools to change culture in other ways. To best serve our patients, our communities, and our profession at large, there may be no more complex work in the field of medicine than culture change. Even with dramatic leaps forward toward gender and racial equity, significant barriers to meaningful culture change persist and must be addressed.

CONCRETE PRACTICES FOR CULTURE CHANGE

Since the early 1900s, physicians have embraced morbidity and mortality (M&M) conferences as a powerful strategy for recognizing and illuminating missed opportunities and areas of need in patient care. This mindful, disciplined, and deliberate debriefing practice provides an important learning environment in which medicine can engage and grow from adverse events and mistakes. Conducting ongoing cultural M&M is one meaningful way of using a "Yes, and" paradigm in advancing culture. Yes, this mistake was made, and here are the changes we can implement around this point of harm to ensure the injury does not continue. We do this in a manner that seeks justice.

Considering the M&M as a model of assessing what is wrong and what can be or needs to be done, in the following case examples, we discuss significant needs and gaps in the current medical environment regarding gender and racial equity and justice. These case examples are aligned with tactical strategies and tied to concepts previously discussed (Table 1).

CASE 1

Dr H is a midcareer physician and faculty member at her current organization, which she has been at for >10 years. During this period, she has been 1 of only a few BIPOC physicians within her institution and the only Black physician within her department. Although she has achieved success in her career, she experiences isolation, microaggressions, and, at times, outright discriminatory and racist acts in her environment. On occasion, she has ventured to bring these topics up in faculty meetings and within discussions regarding need for "diversity" during trainee applicant sessions or other opportune times. However, most often she is the only one voicing concern about these issues and no meaningful changes have been made to address diversity, much less implementation of antiracist practices to foster diversity. Unfortunately, the issues faced by Dr H are not uncommon. Significant culture change is needed to ensure that the complex issues are fully addressed. Some strategies that can help to address the challenges faced by Dr H include regular, transparent organizational climate assessments with a commitment to action. Knowing the extent of the issues is often eye opening to organizational leaders and leads to a commitment to change. People experiencing challenges like Dr H does often feel unable to report because of concerns of retaliation; thus, creating safe reporting systems is another step needed while promoting culture change. Finally, developing recruitment and hiring practices that promote diversity will allow for Dr H to not be the only voice speaking up for needed change (see Table 2).

CASE 2

As the coronavirus disease 2019 (COVID-19) pandemic evolves, Dr C's organization gives supervisors guidance to liberalize telework and adds supervising children doing virtual school as a reason to approve telework. This comes with an implied message that everyone else is expected to continue to be at work in person. In an attempt to be sensitive to those with a heavy second-shift burden, Dr C rapidly implements telework for everyone with school-aged children. After a few weeks, she notices that the rest of her staff is working longer hours and on the weekends from home, often covering duties with short deadlines. A younger single employee approaches her about teleworking because of fear of being exposed to COVID-19 at work but also expresses fear about being in a "bubble of 1" all the time, with no one to call on for help if illness occurs. Dr C is also feeling as if she is just barely staying afloat because she has also taken on additional duties that would normally be done by the staff who are currently working off-site. Crises like the COVID-19 pandemic often unmask important issues that have previously been festering under the surface. It is critical to address differential treatment of employees, in this case related to parental status. If not addressed, the functioning of the team will continue to be impaired. Coaching and team-building trainings can assist. Additionally, there is an opportunity here to include fully embracing alternative work schedules for all (see Table 2).

CASE 3

Drs B and J are partners with 2 children. Dr B has a National Institutes of Health grant and is division director and associate professor in her department. Dr J is a surgeon in private practice. They were able to manage their schedules with child care with

help from babysitters and relatives. COVID-19 has placed new demands at their place of work and navigating challenges with telework and virtual home schooling. Dr B felt burned out and was having difficulty in navigating the current challenges. She considered changing her professional roles to better meet her family's needs. However, her National Institutes of Health grant made taking a leave complex, and she worried it may not be possible to take leave as a division director without giving up the role. Dr B should be encouraged to discuss time-flexible promotion and tenure processes and the need for intentional mentoring with her boss. Additionally, the organization would benefit from implementation of wellness programs and resources (see Table 3).

TABLE 3 Strategies to Improve Culture

Strategy	Benefit
Conduct comprehensive and connected onboarding	Onboarding is a critical opportunity to enculturate new hires. This is an opportunity to provide rules and initiate an effective mentorship or coaching relationship through that first, crucial year of employment.
Embrace alternative work schedules	Many women who choose to leave medicine cite the lack of flexibility, particularly when faced with dueling demands of child-rearing and caring for aging parents. Organizations should leverage part-time or flexible schedules for recruiting and retention and as part of physician reentry programs.
Conduct meaningful organizational assessments	Historically, when data are collected there is an overemphasis on quantitative data rather than qualitative data or focus group discussions. Qualitative insights from climate assessments, engagement surveys, and exit interviews can advance culture change in meaningful ways.
Create multiple leadership development pipelines	Mentorship and sponsorship programs like ELAM and other executive coaching modalities are extremely effective for mid- to late-career physicians. These can be replicated as pipeline opportunities beginning in medical school.
Acknowledge and combat affinity bias	Affinity bias can lead to creation of noninclusive teams, working groups, and informal work-related social activities, although the intent is not malicious. Putting out broad calls for membership, as opposed to selection from among those with whom we have inherent affinity, can counter this bias.[26]
Create enhanced, safe reporting systems	Equity response teams can capture and address microinequities when they are witnessed or experienced, which allows organizations to create greater transparency and real-time course correction.
Conduct meaningful, regular evaluations	A well-executed 360 review process represents a missed opportunity in many organizations. Value is added when the evaluators are first asked, "have you ever spoken with this person about your concerns?" before completing the evaluation. This creates a culture in which clear and ongoing feedback is the norm rather than the exception. This allows opportunity to course correct early in careers.
Examine the organization's definition of success and opportunity	When an organization believes it provides equal opportunities, there is a tendency to attribute lack of success to individual characteristics or motivation. This can lead to a stated commitment to change without a process for change and thus a devaluation of diversity. Organizations should examine whether typically "male" attributes are overvalued and examine themselves for the presence of a performance tax and motherhood tax that may limit advancement of equally qualified women.[27]
Commit to compensation, transparency, and equity	Publicly posted salary data are useful for comparisons by position or title; however, they may not accurately reflect other sources of compensation. Women and physicians who are BIPOC are more likely to be involved in nonpromotable or uncompensated work. Deliberate examination and salary audits that assess total compensation can lead to a decrease in gender and racial disparities.[28,29] Salary review should take into account race and ethnicity, sexual orientation, and other potential sources of marginalization.
Commit to gender and diversity in promotions and hiring actions	Deliberate commitment to proportionate gender and diversity balance is culture change. Health care organizations should seek to understand the gender assumptions that exist, which can be done by creating a culture in which it is safe to discuss gender issues. This also requires examination of which behaviors are rewarded and valued within the organization. Gender and race equity programs should be all-inclusive rather than focused solely on including women and people of color: this presumes that men do not have a role in gender equity and places the burden of fixing the lack of equity on the people experiencing inequity.

CASE 4

Dr T started at the University of X, where she completed her pediatric year as chief resident. She had multiple offers and chose to enter academic medicine. Seven years later, as an assistant professor, she has served on several committees, including the admissions committee, the student progress committee, and the global health committee. She has been the chief of the division of gastroenterology. She was instrumental in building this division. She has written several articles and received a grant and a teaching award from the medical students at her university. As one of the few faculty members of color at her medical school, she has mentored 8 to 11 minority mentees each year. She asked her chair if she could submit her dossier for promotion to associate professor. He told her that she was not ready, but he allowed 2 men with fewer accomplishments to submit their

TABLE 3 Continued

Strategy	Benefit
Value nontraditional contributions to excellence	Several academic organizations award clinical excellence.[30–32] These clinician excellence awards are virtually cost free, other than the time invested in crafting the nomination. Physicians who are BIPOC carry a disproportionate load in often uncompensated and unrecognized diversity, equity, and inclusion work, which is usually not valued in promotions criteria. Diversity brings excellence to the mission and values of universities and medical settings and should be similarly rewarded within promotion criteria. In addition to recognition, this helps to counter the BIPOC tax paid by marginalized faculty.[33,34]
Conduct meaningful and consistent exit interviews	These are critical to gain insight into why personnel leave, where they are going, what real or perceived barriers existed to retaining them, and what else factored into their decision. If we are not collecting these data, we are left to speculate. Exit interviews can provide valuable insight into the hidden cultural norms that drive women and individuals who are BIPOC out of an organization.

ELAM, Executive Leadership in Academic Medicine.

dossiers for promotion. The next month, she was in a faculty meeting in which a new faculty member hired as an associate professor was introduced. She learned that the person was hired with a higher salary and financial support for conference attendance despite fewer teaching and clinical responsibilities. On multiple occasions, Dr T has had requests to attend conferences denied despite presenting original articles. Dr T rarely meets with the chair and does not receive annual evaluations. She is frustrated with her lack of advancement, minimal investment, and support by leadership and lack of acknowledgment of her contributions and is questioning her perceived value to her chair and institution overall. She begins to search for open positions.

This case reveals many issues. Some can be improved by enhanced mentorship and coaching that begins immediately. Development of intentional mentorship programs that begin on hiring is essential to prevent this from happening to others. Development of multiple leadership pipelines, including an institutional commitment to programs like the Executive Leadership in Academic Medicine program can assist. Implementation of safe reporting systems is key. Regular, transparent organizational climate assessments with a commitment to action, including addressing affinity bias, could be implemented. Organizational commitment to equity and transparency is essential. Should Dr T leave, there is an opportunity for exit interviews to assist in identifying the organizational challenges that can be addressed moving forward (see Table 2).

CONCLUSIONS

Cultural intervention should be a priority rather than a last resort within institutions and professions seeking to achieve gender and racial equity. In recent discussions about achieving justice, people often speak of disassembling, dismantling, and deconstructing current practices and beliefs to achieve change. However, we must also collaborate, strategize, and engage others in developing the desired environments and culture for equity and justice. Culture change is difficult, but it is achievable. Kintsugi, the Japanese practice of transforming broken pottery into fine art, is 1 way to think about culture change. In Kintsugi, brokenness is embraced, the pieces are reconnected, and the cracks filled with gold or other precious metals.[25] Previously broken pieces, which would have been discarded, now have greater value by virtue of reconstruction and restoration within the newly formed art piece. To achieve equity, inclusivity, and justice in medicine, the fractures within the current system must be restructured and restored to create a new culture that embraces, values, and adequately supports all the pieces of this wonderful profession.

ABBREVIATIONS

BIPOC: Black, indigenous, and/or people of color
COVID-19: coronavirus disease 2019
GPS: greater purpose statement
M&M: morbidity and mortality

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