News from here and there

JAMA under fire for minimizing effects of racism in healthcare

Racism in medicine was at the centre of a fresh controversy in America recently. A 16-minute podcast on 23 February 2021, titled 'Structural racism for doctors—What is it?' posted on the JAMA Network and the AMA Ed Hub along with a tweet promoting it, questioned whether racism existed at all in the American healthcare system.

Earlier too, the American Medical Association (AMA), which was founded in 1847, has had to confront its past of maintaining racism and discrimination. It was only in the 1960s that African American physicians were allowed into its ranks. The *Journal of the American Medical Association* (*JAMA*), a member of the JAMA Network family of journals, which now includes 11 specialty journals and the *JAMA Network Open*, has been published continuously since 1883.

Now, following backlash, anger and concern from many physicians and researchers in the medical community, the podcast episode was taken down and replaced with a message of apology from Dr Howard Bauchner, editor-in-chief of *JAMA* and the JAMA Network. The tweet, which said 'No physician is racist, so how can there be structural racism in health care?', was deleted shortly afterwards.

The podcast featured host Dr Ed Livingston, the deputy editor for clinical reviews and education at *JAMA*, and guest Dr Mitchell Katz, President and CEO for NYC Health+Hospitals and deputy editor for *JAMA Internal Medicine.* As an aside, both, host and guest were white, and there were no non-whites on the programme.

The blurb of the episode stated that many physicians were skeptical of structural racism as well as the possibility that economic, educational and other problems of society preferentially disadvantaged African Americans and other communities of colour.

In this podcast, Katz and Livingston discussed healthcare disparities and racial inequality. Livingston stated that he did not understand the concept of racism, suggesting that since racism had been outlawed in the 1960s, the focus should be on socioeconomic status, and not on the term 'racism'. He also added that many people like him were insulted by the insinuation that they were somehow racist. While Katz repeatedly stated his belief that structural racism *did* exist in American healthcare, he was subsequently criticized by some for mollycoddling Livingston. Later, Katz indicated that he was not involved in the production of this podcast. The host, Ed Livingston, was later asked to resign by *JAMA*.

Howard Bauchner, who has been editor-in-chief of *JAMA* since 2011, apologised saying that both the language used and certain portions of the podcast did not reflect his commitment as the editorial head to continue to discuss the hostile effects of racism, injustice and inequity in society and medicine. He was put on administrative leave.

The CEO and executive vice president of AMA, James L. Madara, MD, in response to the hostile responses said that AMA's leadership recognized racism as an urgent threat to public health. Structural, systemic, cultural and interpersonal racism exists and they were acutely concerned by the podcast and the affiliated tweet promoting the same. While *JAMA* has editorial independence, both the podcast and tweet were not consistent with AMA's policies and views.

Over the years elite medical journals, including the *JAMA,* have either minimized, excluded or mismanaged issues associated with race. A systematic review of peer-reviewed public health literature from 2002 to 2015 found that of all articles published in the top 249 journals representing public health in the USA, only 25 articles named institutionalized racism explicitly in the title or abstract (*https://journals.sagepub.com/doi/full/10.1177/0033354918760574*).

The Human Rights Watch, a not-for-profit organization registered in the USA, informs us that racial discrimination is a human rights problem in the USA and involves all domestic issues, including the over-incarceration and excessively harsh sentences meted out to African American and Latinx people, the failed war on drugs, surveillance of specific minority groups, hostile immigration policies, and more.

Dr Amar Jesani, editor of the *Indian Journal of Medical Ethics,* told this correspondent, 'The denial of existence of structural racism by the deputy editor of the *JAMA* exposed his deep-seated racial prejudice. While he consciously articulated such prejudice, there are many in the leadership of medical profession and institutions who harbour unconscious prejudices and have made inadequate efforts in the fight against racism. This situation resonates so well in India. The denial of casteism and communalism—the prejudices against Dalits and Muslims—and their institutionalization is rampant among professionals and in institutions, and is often consciously and sometimes aggressively articulated without attracting any punishment from the profession. The sacking of the deputy editor and apology by and subsequent replacement of the editor-in-chief of the *JAMA* are testimony of the fact that in the USA there are still many in the profession who actively defend the secular and humane legacy of medicine and refuse to provide impunity to the racists. The leadership of the Indian medical profession and journals has a lot to learn from this episode. Medical journals must open up to the conversations on the real and perceived discrimination suffered by the Dalit and Muslim users of the services, on the overt show of religiosity by many members of the profession and institutions, and above all, the conscious and unconscious prejudices having detrimental effect on public health.'

P.M. NISCHAL, *Mangalore, Karnataka*
ORCID iD: *https://orcid.org/0000-0003-3491-5500*

Compulsory 3-year rural posting for MBBS graduates

The 126th Parliamentary committee has recommended, on 8 March 2021, a 3-year compulsory rural posting for all doctors, on passing their MBBS examinations. This is to address the perennial shortage in human resources in the Indian health care

system, a problem that has become even more acute during the current pandemic. In 2019, there was a shortfall of 1484 allopathy doctors at primary health centres in rural areas. According to the health ministry annual report 2020–21, there has been an enormous shortage of human resources in the public healthcare sector in India. According to a recent projection by WHO, by the year 2030, India needs minimum 1.8 million doctors, nurses and midwives to achieve the minimum threshold of 44.5 health workers per 10 000 populations. Attempts are being made to fulfil this requirement, including providing training to increase skill development, appointing public health manager and programme management staff, keeping additional workforce on contractual basis, co-locating AYUSH services, etc.

The committee recommended those violating the rule of 3-year rural service be de-registered and prohibited from undergoing medical practice for the de-registered period. The report further mentions that all the basic facilities such as recreational avenues, quality educational institutes, marketing centres, etc. must be provided to the doctors posted in the rural areas.

The Indian Medical Association (IMA) in response to the suggestion of rural posting observed that the shortage of doctors in rural areas had to be addressed as a special problem and that special solutions had to be implemented by way of higher salary, facility for accommodation, transport, children's education and reservation for postgraduation. In many instances, PHCs are at considerable distances from the nearest city. Just like railway stations in remote areas have a railway colony with residential accommodation, shops and educational institutions, it is appropriate that every PHC should have a mini-township approach to accommodate doctors, paramedical personnel, pharmacists, health workers and others. Further, in many states, hardship allowances are being provided to medical and paramedical staff who work in difficult conditions, so that the doctor–patient ratio is maintained. This principle could be universalized so as to increase the voluntary outreach of doctors to rural areas.

ANIKA SULANIA, *New Delhi*
ORCID iD: *https://orcid.org/0000-0002-6422*

Second wave of Covid-19 pandemic hits India

Beginning mid-March 2021, India started witnessing the second wave of Covid-19, which has contributed to it becoming the third leading country with Covid-19 cases, following USA and Brazil. By the end of April, India led the world in new and active cases. The spread of infection is unequal and haphazard, with some states such as Maharashtra and Uttar Pradesh severely affected.

Huge uncontrolled gathering of unmasked people in elections and by-elections in several states, the largest Hindu congregation—the Kumbh Mela in Haridwar, the farmers' movement in and around Delhi, along with wedding and festive get-togethers, added to the rapid rise in cases. All these along with the callous attitude of the public ignoring Covid-appropriate norms, prematurely, has led to the unabated risk of transmission with sudden and massive upsurge in the Covid-19 cases. An effective government policy to guide and control the public in this hour is clearly missing.

As per the available data from various sources, on 30th April 2021, India reported 19 157 097 total cases, 3 270 089 total active cases, 402 110 daily new cases and 214 002 total deaths. The death and recovery rates were 1.35% and 98.65%, respectively. As a result of lack preparedness and scarce resources, the country has been hit hard, with several cases and deaths going unreported.

India's first encounter with a pandemic in a century, has exposed several short comings. The country is facing scarcity of hospital beds, oxygen supply, medicines and vaccines. Healthcare workers are also facing fatigue. Vaccinating an enormous population is also an onerous task.

During the first wave, a 21-day strict nationwide lockdown was imposed very early (from 25 March 2020) and was extended several times. Travel restrictions, both national and international helped disrupt the transmission link, curtailing the infection rate. India's lockdown policy, despite some shortcomings, was accepted and also followed by several countries. However, in the second wave, there seems to be unwillingness to accept the failure of preparations on the part of the administration, ignoring the fact of recurring waves in pandemics and false sense of protection from the virus. As a consequence, the second wave seems to have a high mortality rate.

A war-level strategy is needed to combat the health crisis and there has to be a clear division of responsibilities which ensures adequate availability of drugs, medical oxygen and vaccines. Identification and detection of new variants, mass vaccination drives, obeying Covid-19 protocol such as wearing mask, temperature checks, social distancing, sanitization, avoiding mass gatherings, following travel restrictions and contact tracing are mandatory to truncate the spread of infection and contain the second wave.

JYOTI PRIYADARSHINI SHRIVASTAVA
Gwalior, Madhya Pradesh
ORCID iD: *https://orcid.org/0000-0002-0032-3681*