

heat meals, refined breads, and sauces and condiments than other UPF. In contrast, UPF made with more healthful, less-processed ingredients — such as whole grains, fruits, vegetables, legumes, or yogurt — generally have neutral or positive health associations.<sup>5</sup> To survive litigation, carve-outs or exemptions from UPF policies must be based on standardized, accepted regulatory definitions. One sensible approach could be to exempt UPF that falls under a December 2024 Food and Drug Administration (FDA) rule governing which products can be labeled as “healthy.” In contrast to the previous, decades-old policy, which emphasized selected nutrients and allowed manufacturers to market vitamin-fortified UPF as healthy, the new rule prioritizes healthful ingredients. Any product labeled as “healthy” must contain minimum amounts of fruits, vegetables, whole grains, nuts, beans, dairy, or lean proteins and may not contain excessive amounts of added saturated fat, sodium, or sugar. This FDA rule provides a reasonable approach to considering exemptions to UPF policies.

 An audio interview with Dariush Mozaffarian is available at NEJM.org



Alternative regulatory definitions of “ultraprocessed” have been

proposed, such as definitions based on amounts of saturated fat, sugar, and sodium — in keeping with a front-of-package labeling rule recently proposed by the FDA. However, such criteria wouldn’t capture all UPF-related harms and are only moderately sensitive and specific to ultraprocessing. Many UPFs are high in refined starch and additives, rather than sugar, sodium, or fat, for example; healthful, minimally processed foods can contain cane or beet sugar, honey, salt, or natural fats. Definitions focused on isolated nutrients don’t reflect the innovative approach introduced by Nova, which centers commercial processing and its multifaceted adverse effects.

Federal, state, and local policies have successfully defined other categories of heterogeneous foods — such as “junk food,” which is taxed in multiple states — to promote public health. Given high rates of diet-related disease and evidence of harms of UPF, I believe the federal government has the responsibility to ensure food safety and protect the public’s health by regulating UPF. The food sector, in turn, should comprehensively evaluate specific processing methods and additives to inform regulatory updates and

support the production of safer, more healthful packaged foods. Sufficient evidence and imperative exist for defining and taking action to address UPF.

Disclosure forms provided by the author are available at NEJM.org.

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## The Health Equity, Medical, and Scientific Costs of Dismantling DEI

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Current attacks by the Trump administration on diversity, equity, and inclusion (DEI) initiatives — in the form of executive orders and administrative actions

— reveal a critical misunderstanding of the relationship between DEI and health equity.

DEI initiatives are structured efforts within organizations de-

signed to create inclusive educational and work environments, redress discriminatory policies, and mitigate the effects of systemic inequities. In medicine, these

initiatives influence the recruitment, retention, and support of the workforce that delivers care, generates knowledge, and translates evidence into practice. DEI initiatives in health care include pathway programs for first-generation students, mentorship and research training programs for faculty and trainees, pay-equity and parental leave policies, and accessibility programs.

Today, DEI is being misrepresented as divisive, exclusionary, or a form of indoctrination that undermines meritocracy. Such mischaracterizations fuel a harmful “zero sum” narrative. In reality, DEI initiatives challenge the myth of a level playing field and promote policies that help make true meritocracy possible. Talent is evenly distributed across populations, but opportunity is not. DEI efforts aim to expand access to opportunity so that all talented people can contribute to society.

Anti-DEI actions will reverse decades of progress toward building a more inclusive health workforce and improving patient outcomes — distinct but related goals. Greater racial and ethnic workforce diversity has been shown to improve patient health by enhancing communication, satisfaction, trust, and treatment adherence; increasing culturally and linguistically sensitive care; expanding access to care in underserved and sicker communities, where non-White clinicians are more likely to practice than their White counterparts; and broadening research questions and methods, including participation of patients from racially and ethnically minoritized groups in clinical and biomedical studies.<sup>1</sup>

However, diversity alone is not enough. Realizing its benefits requires inclusive policies, equitable

practices, courageous leadership, and accountability.

Health equity is an aspirational goal: ensuring that everyone has a fair and just opportunity to be healthy. Achieving health equity requires removing structural and social barriers, such as discrimination and limitations on access to care, education, employment, housing, and safe environments. Health equity initiatives target health care disparities affecting groups defined by race, ethnicity, age, language, gender, sexual orientation, ability, insurance status, or geography, by increasing access to and quality of care. Ensuring accountability for health equity requires tracking disparities using data disaggregated by social and demographic variables, engaging in quality-improvement (QI) efforts, and implementing evidence-based practices.

Health disparities have been well documented for decades, since the “Heckler Report” was issued by the U.S. Department of Health and Human Services in 1985, and they remain persistent and costly. In 2022 alone, health disparities cost the United States \$320 billion in excess medical spending and lost productivity. The figure is projected to increase to \$1 trillion by 2040 because of demographic shifts and rising per capita costs.<sup>2</sup> Health disparities are not random; they are predictable outcomes of policies, practices, and decisions about where, how, and in whom society invests resources. When segments of the population are excluded from the benefits of health care’s triple aim — better experience, improved health, and lower costs — the health of the entire population suffers. For example, during the Covid-19 pandemic, rural areas of the United States with fewer medi-

cal professionals and health care facilities had substantially lower vaccination rates than nonrural areas. These access disparities led to lower vaccination coverage and higher Covid-19 transmission rates, resulting in higher overall mortality.<sup>3</sup>

Ultimately, within health care, health equity is the goal; DEI is a strategy for achieving that goal. Recent federal actions conflate DEI and health equity, placing both at risk. Examples include the removal of public health websites and data sets that track population health disparities; removal of guidance on diversity in clinical trials; disbanding of critical health equity advisory committees; withdrawal of funding from low-income countries; termination of millions of dollars in research grants, including those focused on environmental justice health disparities and minoritized populations and those focused on training of groups that are underrepresented in the science workforce; and massive layoffs at health-related federal agencies. These sweeping actions are dismantling the infrastructure needed to eliminate health disparities and improve patient outcomes.

Equity is not only one of the six domains of health care quality, as defined by the National Academy of Medicine — it is also a cross-cutting domain that bolsters all the others. Equity-focused QI often involves tailoring interventions to marginalized groups that experience disparities. For example, tailored interventions for Black birthing people aim to reduce long-standing racial disparities in maternal mortality. Yet such initiatives may now be deemed unlawful if they’re perceived as “preferencing” a protected group, as defined by race, sex, or national origin, among others.

An alternative approach — designing general QI interventions in hopes that they disproportionately benefit at-risk groups — may avert legal scrutiny but often fails to eliminate disparities and may even exacerbate them.<sup>4</sup>

The assault on DEI and health equity has caused underrecognized psychological harm to clinicians and scientists. Anti-DEI directives have led to abrupt termination of research grants, dismantling of the federal research infrastructure, self-censorship to avoid flagging of “target words” in research proposals and papers, and loss of funding to academic and other nonprofit organizations. The loss of research funding,

mands that increase instability during a time when many are working to build their careers and progress through the academic ranks.

The frenetic pace of these changes and the speed at which universities have scrambled to mitigate financial risks are fueling fear, burnout, and uncertainty, especially among early-career clinicians and scientists. Reframing a research program to comply with shifting political mandates requires more than replacing flagged terms such as “disparities,” “equity,” or “women.” It requires time to reflect and reconceptualize research questions and approaches.

***Clinicians and researchers working to achieve health equity must clearly communicate the goals and evidence for DEI as a strategy to advance health equity, which benefits everyone.***

which pays for critical infrastructure within academic institutions, has heightened pressure on care delivery systems to cover budget shortfalls with increased clinical revenue. To compensate, health systems are reducing staff and growing lucrative clinical services while limiting care and services for uninsured and underinsured patients. Scientists, particularly those conducting health equity research, are being pressured to pivot their research agendas, write more grants, and increase clinical work to maintain salary support — de-

mands that increase instability during a time when many are working to build their careers and progress through the academic ranks. The frenetic pace of these changes and the speed at which universities have scrambled to mitigate financial risks are fueling fear, burnout, and uncertainty, especially among early-career clinicians and scientists. Reframing a research program to comply with shifting political mandates requires more than replacing flagged terms such as “disparities,” “equity,” or “women.” It requires time to reflect and reconceptualize research questions and approaches.

For clinician–scientists who may themselves identify with the communities in which they conduct research or provide clinical care, the harm is amplified. Many of them are experiencing a profound sense of moral injury and grief. They cycle through denial, anger, bargaining, and depression — trying to resist acceptance, yet feeling powerless to do so. Accepting the regressive ideologies and practices of the current administration feels like a betrayal of the very communities their work aims to uplift.

How should the health care and scientific community respond? Clinicians and researchers working to achieve health equity must clearly communicate the goals and evidence for DEI as a strategy to advance health equity, which benefits everyone. DEI initiatives should be intentionally designed to effect meaningful changes in outcomes, not just meet process metrics (e.g., participation rates or numbers of trainings). These changes should be measured and tracked, and strategies should be adjusted to ensure accountability. We must highlight the danger to the health of the nation of defunding and divesting from health equity and DEI research, programs, and offices.

Academic leaders must also be sensitive to the psychological toll on faculty, staff, clinicians, and trainees navigating the current environment — many of whom are experiencing a profound sense of loss — and seek creative ways to support them.

Institutions and individuals committed to science, freedom, and justice must vehemently resist efforts to censor scientific inquiry, revise history, and erect barriers to health and opportunity. The stakes for science, medicine, and the nation’s health are simply too high for us to stand by and watch the destruction.

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## My Brother's Keeper

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My eldest brother, Ravi, died on Father's Day 2008, while handcuffed to a hospital bed. Intubated and chemically sedated, he had lain immobile for 6 days and ultimately developed multiple deep venous thromboses that resulted in a massive saddle pulmonary embolism. Initially, I blamed the doctors, nurses, hospital, and police officers. But though they directly contributed, they were only part of the problem. Iatrogenic injuries aside, Ravi was caught in a system that worked against him at every turn.

He was born in Guyana, South America, a former British colony that had gained independence in 1966. For the first few decades after that, the country was beset by political and economic turmoil, which led to a mass exodus. My parents immigrated to New York in the early 1980s, becoming part of the Guyanese diaspora. Ravi came to the United States when he was 6 years old and attended local public schools. A child of the 1970s and '80s, he came of age as personal computers and, later, Internet access were becoming commonplace. After graduating from high school, he immediately went to work, bypassing a college degree to immediately start supporting himself and our family. Ravi eventually

started his own information technology company that provided real-time stock quotes. Initially promising, the company hit rough times when the tech bubble burst, and began struggling financially by the early 2000s.

My brother saw his dreams vanish — investor money dried up, and so did his. Without a college education or vocational training to fall back on, Ravi felt he had to give everything to try and save his company. But in the end, he was the one who needed saving. Ravi fell deep into debt, despite moving back in with my parents and taking other measures to save money. Depressed, he became addicted to alcohol, cocaine, and fast food, which compounded his financial and health problems.

On a warm summer night in June 2008, Ravi was driving under the influence and hit a parked car. Fortunately, no one else was injured, but he sustained a few superficial cuts and abrasions. When he was in police custody, he was taken to a public hospital for treatment. It was meant to be a short stay, but he never left.

The day after admission, he developed a fever. As my family and I sat at his bedside, I asked to speak with a doctor, but no one ever came. A nurse told us

that Ravi "had a drinking problem," hinting, as I only later realized, that he was most likely experiencing alcohol withdrawal. They oversedated him, and on day 3 my parents received a call that the doctors wanted permission to "give him medicine through his neck." Later that day, he was intubated and had a central line placed. The medical team reassured us that it was a temporary setback.

My parents were at Ravi's side every day, which required visiting the local police precinct each morning to receive clearance for visitation rights. He was never arraigned and remained in police custody during his hospital stay. My parents stayed with him under the watchful supervision of two police officers, stationed there to prevent my handcuffed, intubated, sedated brother from escaping. More than once, the officers asked my parents and other visitors to leave, citing "regulations." On Father's Day, day 6 of his hospitalization, my parents had decided to spend the morning at home with my other siblings and me, intending to visit Ravi in the afternoon. But we received a call asking us to come back in — he wasn't doing well. After being held up at the police precinct for an hour for paperwork, we made our