POINTS OF VIEW

Diversity, Equity, and Inclusion That Matter

My pending exodus from academic medicine after 15 years is prompted by my belief that the institutional and systemic racism so obvious to me would never be fully acknowledged, much less addressed. This belief was formed after several experiences that left me — a Black woman — feeling stifled, unheard, unvalidated, unsupported, and concerned for my health.[1]

Too often, academic medical institutions' idea of addressing institutional and systemic racism begins and ends with naming a titular diversity-equity-inclusion chief. Every so often, they tout their racial and ethnic diversity, not mentioning that it resides primarily in janitorial and food services, while historically underrepresented groups remain largely absent on the path to full professorship and division chiefdom.[2]

But now we find ourselves in an unprecedented time. With Covid-19 disproportionately affecting Black, Indigenous, and Latinx communities,[3] and after the murders of Ahmaud Arbery, Breonna Taylor, and George Floyd, academic medical institutions are issuing pretty statements declaring that Black Lives Matter and denouncing systemic racism. I hope they will take real action to address these issues within their own hallowed walls.

At the trainee level, real action is accepting candidates that may not fit all the criteria that favor people who've always been highly favored. Letters of recommendation are often tinged with racial bias, and test scores are biased toward those who can afford prep courses.[4] Institutions should consider what hardships candidates have endured to reach the same place as privileged candidates in order to create the workforce that can best understand and meet the needs of communities disproportionately affected by chronic illnesses.[5]

At the faculty level, real action is offering faculty and leadership positions to non-prototypical candidates. As the only Black member of division-chief search committees, I often heard colleagues remark that the Black candidate's CV was thinner than the White man's — fewer manuscripts, leadership positions, and grants — without acknowledging that the White man had been groomed, sponsored, and uplifted by people who looked like him throughout his 400-year head start. And without ascribing value to the time and energy Black candidates had dedicated to recruiting and mentoring people who look like them.

Black-CV "thickening" requires not only valuing these beneficial nonacademic endeavors, but also inviting Black faculty to lecture on topics beyond racial disparities. There were no lectures by Black people when I was in medical school or residency, and the only ones during my fellowship were by me. A 5-day nephrology board review course I attended last year included no Black presenters. Our absence on such platforms implies that there are no Black experts on any topic except race.

Once Black candidates have opportunities, institutions must provide support to ensure their success — including equitable financial support. According to the 2018 Medscape Physician Compensation Report, Black men make less than White men and Black women make significantly less than everyone else.

Yet institutions shouldn't just focus on the number of prototypical minority faculty in leadership positions — the ones White people feel comfortable with because they settle for micro-incremental change rather than upset the White establishment. These prototypes lull Black junior faculty and trainees into a false belief that a leader will support them when racism issues are raised. Instead, in my experience, they tend to remain deafeningly silent or, worse, gaslight Black colleagues by agreeing that the person speaking out is the real problem. This dynamic undoubtedly contributes to the flight from academic medicine of Black physicians who decline to sit quietly smiling for everyone else's comfort.

Finally, to retain Black faculty, institutional leadership has to believe, validate, and act on Black people's experiences of racism; the fact that someone denies that a racially biased act

was intentional doesn't mean it didn't happen. Real action goes beyond, "I'm sorry that happened to you" or a one-time "diversity" training. It requires shifting to a culture that allows open dialogue and continuous learning at all levels — no one can be exempt.

It's time for academic medical institutions to prove their statements aren't just pretty words by acting to create diversity, equity, and inclusion that matter.

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