Reflections on Diversity and Inclusion

Déjà vu All Over Again

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Déjà vu is the feeling that one has lived through the present situation before. . .

As we reflect on the past, present, and future, it feels like we have seen this before. Despite significant career and professional growth as an underrepresented academic surgeon, I am actually quite amazed to find myself in this place at this time in these circumstances. I feel proud and fortunate to be one of the very few, if not the first, African American leaders of any Department at Johns Hopkins University School of Medicine. But I am not sure that is the most remarkable thing at all. I am sure that my journey is very similar to others – the life of people of color in America in the postJim Crow Era from the 1950s to now – a combination of hard work, resilience, good fortune, and perseverance in the face of structural racism, discrimination, and explicit and implicit bias. What may have changed, is the realization that the lived experiences of being **Black in America** are now a point of consternation and concern for those who live in the world of White majority privilege, thanks to social media and irrefutable evidence in the real world of violations of human rights directed against those who are most vulnerable based upon race, gender, socioeconomic status, and color.

The intention of this reflection is to not only identify the obvious societal failures throughout the country, but to also point out that we, as accountable academic leaders, have an extraordinary challenge and unprecedented opportunity to change the part of this world where we have the greatest impact and influence: the world of academic medicine. I am impressed by a concept and want to share the idea of "***inclusive excellence"*** championed by organizations like the Association of American Medical Colleges and the NIH. *"**inclu-is defined as** the recognition that an academic community or institution's success is dependent on how well it values, engages, promotes, and includes the rich diversity of students, staff, faculty, administration, and alumni constituents.* ***In this model, diversity is a key component of a comprehensive strategy for achieving institutional excellence – it*** *embraces the academic excellence of all learners and faculty, but inclusion must be part of the effort to be more diverse. Active, intentional, strategic, thoughtful, and* ***ongoing engagement*** *help us have a better understanding of the experiences of the people around us, a better understanding of the complex environment in our school, our city, and our country.* ***This is an essential component of our effort if we want to be successful in making this a better place.***[1]

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"Carve a tunnel of hope through the dark mountain of disappointment."

- Dr Martin Luther King, Jr.[2]

Our lived experiences often tell a story. My mother and father met in Nashville in the 1950s when my father graduated from Meharry Medical School, one of a few places where a person of color could get medical training in the 1950s. After graduation, they married and moved to Camp Pendleton, where my dad served in the United States Navy as a physician attached to the Marines. I was born in San Diego in 1958 and a few years later, my family moved to Charleston, South Carolina to start one of the few general medicine practices in my father's hometown. Life was good – until someone ran a stop sign and killed my father in a car accident – he had no life insurance (because he was going to live forever) and my mom was widowed with three young boys, ages 5, 3, and 1 years old. ***A devastating loss, for sure***. We moved to upstate New York to live with my grandparents and extended family network, who helped raise 3 hell-raising boys. Throughout my childhood, we experienced a nurturing environment where discipline, academic excellence, and service to the community above self were taught and expected.

In 1965, my grandfather, fresh on the heels of a promotion as legal counsel and the regional director of the New York State Commission for Human Rights, contracted to buy a house in an all-White neighborhood, ***only to have that house burn to the ground in what police termed as "suspicious circumstances."*** He was quoted as saying in the local news that, "They better get another fire lit – there's something else involved now, something personal, but we're used to that."[3] Our family later relocated to another home a few blocks away and lived in a desegregated neighborhood for many years until my grandparents' death. Violence against people of color is not a recent phenomenon. During the past 30 years, there have been many other examples of racially motivated discrimination during my training as a cardiothoracic and transplant surgeon – random traffic stops in my neighborhood as a Black man driving a nice car; patients asking if I am the orderly or environmental services worker in the hospital; senior majority faculty questioning my opinions and or judgment in the clinical setting. . .

So what lessons do we learn from these experiences? Many would be disillusioned, angry, and despondent, yet my brothers and I were taught to be strong and resilient, coached to keep our goals in sight and to work hard to have a positive influence in the world. We were taught that, at some point, we would impact change in thought by our deeds and actions. Although these are lessons many people of color learn in their lifetime, in the current context, it is a part of the reality of being Black in our country. It will be difficult to move forward if we do not acknowledge how things have been in the past, as well as the current state of affairs for people of color in this country.

How should we respond when the death of George Floyd and so many other people of color send a seismic shockwave through the academic landscape, and create a geopolitical firestorm across our

country and the world? Although I cannot speak for everyone, my informal– and now more formal voice (in my recently appointed role as Senior Associate Dean for Diversity and Inclusion at Hopkins) –is positioned to join the chorus of those who want to have an impact in places like Johns Hopkins. As we celebrate the 75th anniversary of the pioneering efforts of Alfred Blalock, Helen Tausig, and Vivien Thomas, who innovated the famous surgical treatment of the Blue Baby Syndrome in the 1940s, we are reminded of the miraculous circumstances under which these things occurred. In a place where structural racism and discrimination were evident and obvious, Vivien Thomas was prevented from having full rights as a surgeon or scientist, which created barriers to full acceptance and collaboration between Black and White. Yet, despite these barriers, commitment to the well-being of these children helped to create the dawn of a new era in cardiac surgery.

> ''Excellence of performance will transcend artificial barriers created by man.''
>
> - Charles Drew, M.D.[4]

Many of our predecessors and mentors, like Levi Watkins (the first African American cardiac resident at Johns Hopkins and the first to implant the automatic cardiac defibrillator in a patient), shook the foundation of the academic world. They demanded that academic medicine create a place at the table for people of color and those who were underrepresented in medicine.

Many now call for partnership between majority and minority concerns to influence academic processes like promotion, recruitment, and retention in medical admissions and research training. Although I believe that many of these efforts are well-intentioned, they only scratch the surface of equality, diversity, and equity – **most academic environments at majority institutions struggle to create real change in these areas.**

> ''Privilege is invisible to those who have it – for those who have privilege, equality feels like discrimination.''
>
> - Professor Michael Kimmel[5]

A lack of clear understanding of these concepts may be why we struggle to accomplish substantive improvements and goals. ***Diversity focuses on representation***, any collective mixture characterized by differences including, but not limited to, socioeconomic status, race, ethnicity, language, religion, sexual orientation, gender identity, and ability status. ***Inclusion focuses on involvement*** – the practice of encouraging and belonging, participation, and celebration of differences.

Equity and equality are 2 strategies that are used in an effort to produce fairness. Equity is giving everyone what they need to be successful. Equality is treating everyone the same – it aims to promote fairness, but it can only work if everyone starts from the same place and needs the same help. These concepts resonate now more than ever.

There has been a proliferation of articles, analyses, training opportunities, and organizational reflections about diversity, equity, and inclusion during the past several years. In 2015, my family and I arrived in Baltimore to search for a new home during the time of the disturbance and riots after the death of Freddie Gray. My kids thought it was wild to have armed National Guard troops and armored vehicles on street corners in downtown Baltimore. The outpouring of concern and activity by the Johns Hopkins Medicine leadership and academic community to stand up and be counted against police brutality, structural racism, and explicit bias in Baltimore struck me in a profound and positive way then. ***Five years later, we should ask ourselves: Has anything changed?***

I do believe that there is a general acknowledgment by people of all races that we have a better understanding of the obstacles people of color face. There is greater awareness of the problem of race and equity issues thanks to social media, **but there has been little recent change in actual conditions –** it may even be worse! Organizations have invested extensively in diversity, equity, and inclusion initiatives – bias training as the most frequent activity – but there are fewer shifts toward equity in the academic workplace. Perhaps we have seen some improvements in career support. You can be the judge if you think it is better overall. The current macro and micro-aggressions people of color face every day in academic medicine are evidence that we still have work to do.

> ''Justice will not be served until those who are unaffected are as outraged as those who are affected.''
>
> - Unknown

Johns Hopkins has a storied history of extraordinary patient care, education, innovation, and groundbreaking research for over 130 years. In my opinion, one of the greatest challenges for Hopkins and other academic institutions in the modern era is to extend its impact in the identification, training, and professional development of healthcare professionals from underrepresented groups in medicine, including ethnic minorities, women, and those from diverse religions, national origins, lower socioeconomic status, and sexual orientation. ***Critical to this effort must be the development of an environment that fosters acceptance and professionalism where those who are underrepresented in medicine are not only admitted, but welcomed to these institutions as an academic home.***

As we move forward in the current world, we are likely to learn many more lessons. *But how much more do we need to understand?* In addition to the need to provide better health care coverage to the underserved and minority populations and developing a more effective public health response to a potential crisis like the COVID pandemic, ***the recruitment, training, and deployment of a diverse healthcare workforce has never been more important.*** Calls to action in those areas hardest hit by this crisis not only emphasize the shortage of physicians, nurses, respiratory therapists, and allied health professionals, ***but it underscores the need for a more diverse healthcare workforce dedicated to serving those in need.***

In addition to acknowledging our shortfalls, what actions can we take to create a more diverse and inclusive academic environment here and in medicine in general? **Sincere, earnest listening and reflection** to understand the Underrepresented in Medicine (URM) perspective and challenges– followed by **thoughtful and intentional action** to address these issues to bring about a more equitable and sustainable future.

From my perspective, there are areas to focus on as a starting point, which include improvements in **process, promotion, and programming:**

- ***Process – Recruitment****:* For example, provide scholarships for URM subinternships, premed/medical student research opportunities in Science, technology, engineering, mathmatics and manufactoring, organize second-look recruitment activities for admitted medical students, increase URM faculty identification and recruitment when hiring new fellows/PhDs/faculty.
- ***Promotion – Retention and Faculty Development:*** For example, meet with Department Directors and Chairs to assure and even mandate URM candidate inclusion in new faculty recruitment/retention, support portfolio preparation for academic promotion of URMs and women being considered for promotion to Associate/full Professor to ensure their success.
- ***Programs – Racial and Multicultural Competency and Inclusion****:* For example, introduce and require implicit/unconscious

bias training for School of medicine students, faculty, and program leadership; leadership training for any and all who would benefit from learning how to ''Navigate the Maze in Academic Medicine''; consider monitoring/incentivizing program and departmental leadership based upon their performance in addressing diversity initiatives.

In my opinion, there is an additional dimension, which continues to undermine our current URM representation in academic medicine and in healthcare specialties like surgery. **Our current medical culture is a relatively unsupportive environment for URM students and faculty.** *Speaking from my personal experience, it can be a very isolating experience in academic medicine as a person of color or URM. When there is a very small percentage of those who are from a similar cultural experience or racially sensitive backgrounds to share academic experiences,* ***it is very difficult****.*

Creating a racial and multicultural environment that is inclusive and supportive with ***a network of supportive faculty and staff – a critical mass of URM professionals –*** would have a huge impact and lead to the successful recruitment and retention of more URM students, staff, and faculty.

Our goal for every faculty member, particularly those underrepresented in medicine, is to avoid the past and create a future where we can be ''seen, heard and valued.''

A. Haggins, MD.[6]

In the final analysis, this is the call to action in our time –to positively affect change in healthcare across the country and to create a better future. We have to avoid Déjà vu all over again.

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