Diversity, Equity, Inclusion, and Justice

Diversity, Equity, and Inclusion Officer Position Available: Proceed With Caution

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In order to address health inequities and structural racism, health institutions have recently recommitted to, or are now establishing, diversity, equity, and inclusion (DEI) officer and leadership roles. While DEI officers are tasked with upending all forms of oppression and marginalization[1] as well as supporting compositional diversity in medicine,[2] the DEI position should not be the only role responsible for effecting change.[3] This role is best leveraged to support the work of all units of the enterprise to achieve DEI goals through added experience and expertise.

Collectively, we the authors have more than 70 years of service in senior DEI leadership roles, provide consultative feedback, and use evidence-based approaches to our work when it exists. We wish to share 3 institutional strategies to support the success of DEI professionals, including action items to address particular barriers. Institutions should (1) provide resources for the development and advancement of DEI officers; (2) create an inclusive climate that broadly includes the DEI officers' own culture, language, and tone; and (3) share structural power to support the officers' autonomy and agency.

1. Operationalize Development and Advancement

Junior faculty members are often placed into DEI positions with limited training, development, and/or career advancement plans. Once in place, they dedicate themselves to supporting trainees and faculty from marginalized communities. They work to improve the "hidden curriculum"[4] that affects climate, support resident and faculty recruitment and retention efforts, and lead or assist with community engagement initiatives. This work can be transformational for an institution, its trainees, and faculty.

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Yet, these service activities are accorded little value in terms of promotion or compensation. If valued, they are often subordinated relative to the time-honored skillsets of excellence in clinical care, research, grant attainment, and publishing. Many leaders persist and become national experts on recruitment, retention, structural racism, implicit bias, health inequities, and institutional climate change. They bring important insights and an equity perspective to planning committees for clinical practice and hospital policies, quality metrics, and improvements in training program educational initiatives, but they are rarely included in senior clinical and educational leadership circles. Their contributions, regardless of value, are often not considered promotable academic work. As many faculty who take on the DEI roles are underrepresented in medicine (UiM),[2] the result is a disparity of UiM individuals at ranks of senior faculty and departmental leadership.[5]

The neglect felt by faculty who strive to address critical issues of identity leads either to an acceptance of their limited roles or to an early departure from the field.[6] Ensuring their work is scored with the commensurate academic value is critical to retaining and promoting faculty in DEI roles and academia. Academic institutions, funding agencies, and scientific journals[7] must place equitable importance on this work. Institutions should create novel venues to display this scholarship. Inclusion of diverse representation needs to be intentional.

Finally, since many DEI leaders are early career individuals, fungible elements in the officer's package when offered the position could include support for additional training—a Master of Public Health, Master of Public Policy, Master of Business Administration, or other certificate-bearing development, or executive coaching or leadership programming that can deepen their skillsets and demonstrate commitment to their careers.

2. Ensure That DEI Officers Are Their Authentic Selves Regarding Culture, Language, and Tone

DEI faculty are often called upon to provide education to faculty, staff, and trainees on bias and racism.[8]

Tough but closeted subjects, such as the impact of neighborhood disinvestment, racial segregation, mass incarceration, immigration policy, and over-policing on the health and well-being of marginalized populations when taught by minoritized faculty often lead to challenges of their scholarship. These are difficult subjects to discuss because racism remains unacknowledged, in the United States and other settings, which promotes continued racist practices.

This work is strewn with land mines for DEI officers. Frequently, they share, in excruciating detail, personal moments of experiencing discrimination for the benefit of others. These activities can retraumatize a minoritized individual and may exact many costs, including moral injury. They may be held to unfair standards when discomfort among learners is induced by the subject matter. DEI officers have at times received poor evaluations, reprimands, or worse, for discussing "political issues."[6,9]

DEI professionals are often torn by the need to represent the institution and its historical and contemporary acts of injustice while encouraging their workplaces to find pathways toward distributive and restorative justice. DEI officers often find the need to censor their voices, or at times are censored when describing their own institution's history. This silencing is often about the way that the institution is contributing to the gentrification of surrounding neighborhoods, the provision of segregated care to prior generations, or the participation in medical experiments done without informed consent. Academic medical centers' focus on payor mix may conflict with faculty who advocate for access for uninsured and underinsured patients. Security on campuses is often fraught for minoritized individuals. DEI officers may themselves be subjected to the very bias and discrimination they are working to root out of the learning and working environment, all while calling for the implementation of equitable practices for all students, trainees, health care providers, and patients. DEI officers often feel constrained from "doing the right thing" for fear of retaliation, isolation, or rejection.[6,9]

Leadership can validate equity work by publicly endorsing an equity mission to all institutional members, acknowledging their institution's historic role in oppression, and providing appropriate administrative and funding support for DEI work. Institutions must enact robust bias reporting mechanisms to curb attacks and provide fair due process when challenges threaten DEI leaders' positions and employment.

3. Share Structural Power to Allow for Autonomy and Agency

Exclusion from the executive leadership structure limits DEI officers' autonomy and agency. Despite titles of Associate Dean, Vice President, Director, or Officer, leadership structure is often unclear, resources ill-defined, and job descriptions and requirements varied across institutions. DEI leaders need to be empowered to ask, "To whom do I report?" "On what metrics will the value of my work be judged?" and "Which resources will I have and what agency will I have over those resources?" DEI officers need autonomy to define goals and metrics and to ask for resources appropriate to support change.[10]

Data-driven approaches to improve extant compositional diversity, climate, and health equity require institutional assessments at multiple points in time. Meaningful assessments reflect institutional concerns and capture insights on microclimates. Transparency in data collection and maintenance promotes agency for DEI officers in supporting interventions targeted at addressing inequities.

Conclusion

DEI work has long been the invisible fragile pillar alongside those of research, patient care, and education. Barriers to advancement, the need to cater to cognitively dissonant institutional tone and language, and a lack of autonomy and agency may leave DEI "folks" tired and weary. DEI scholarship must be elevated and appreciated. Institutions can empower and protect individuals charged with leading these efforts. DEI leaders must be provided with the autonomy to speak truth to power in structures that have heretofore upheld the hegemony of the dominant culture in medicine.

In speaking truth, the collection of data and willingness to make these findings transparent is necessary to regain the trust of marginalized individuals and draw them into careers in academic medicine. This work can be morally taxing and socially isolating, and yet incredibly rewarding. Despite watching colleagues across the country lose their titles and positions, become embattled, belittled, and beleaguered, DEI officers persist. We have a message for our minoritized colleagues, especially those who enter as junior faculty: Enter with your eyes open.

References

1. Vela MB, Chin MH, Peek ME. Keeping our promise—supporting trainees from groups that are underrepresented in medicine. *N Engl J Med*. 2021;385(6):487–489. doi:10.1056/NEJMp2105270
2. National Institutes of Health. Populations Underrepresented in the Extramural Scientific Workforce. https://diversity.nih.gov/about-us/population-underrepresented. Accessed September 15, 2021.
3. Ross PT, Lypson ML, Byington CL, Sánchez JP, Wong BM, Kumagai AK. Learning from the past and working in the present to create an antiracist future for academic medicine. *Acad Med*. 2020;95(12):1781–1786. doi:10.1097/ACM.0000000000003756
4. Rajput V, Mookerjee A, Cagande C. The contemporary hidden curriculum in medical education. *MedEdPublish*. 2017;12(1). doi:10.15694/mep.2017.000155
5. Xierali IM, Nivet MA, Syed ZA, Shakil A, Schneider FD. Recent trends in faculty promotion in U.S. medical schools: implications for recruitment, retention, and diversity and inclusion. *Acad Med*. 2021;96(10):1441–1448. doi:10.1097/ACM.0000000000004188
6. Blackstock U. Why Black doctors like me are leaving faculty positions in academic medical centers. *Stat*. https://www.statnews.com/2020/01/16/black-doctors-leaving-faculty-positions-academic-medical-centers/. Accessed September 15, 2021.
7. Fontanarosa PB, Flanagin A, Ayanian JZ, et al. Equity and the JAMA Network. *JAMA Netw Open*. 2021;4(6):e2118381. doi:10.1001/jamanetworkopen.2021.18381
8. Peek ME, Vela MB, Chin MH. Practical lessons for teaching about race and racism: successfully leading free, frank, and fearless discussions. *Acad Med*. 2020;95(12S Addressing Harmful Bias and Eliminating Discrimination in Health Professions Learning Environments):139–144. doi:10.1097/ACM.0000000000003710
9. Thompson P, Lozano AV. "No glass ceiling": Tulane doctor files discrimination lawsuit against medical school. *NBC News*. https://www.nbcnews.com/news/us-news/no-glass-ceiling-tulane-doctor-files-discrimination-lawsuit-against-medical-n1259358. Accessed September 15, 2021.
10. Lane-Fall MB, Butler PD, Mahoney KB. Promoting racial justice and equity in academic medicine: moving beyond the honeymoon period. *JAMA*. 2021;326(7):603–604. doi:10.1001/jama.2021.9324

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