Diversity and Inclusion

A Brief Career Overview

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The analogy of a fish swimming in water but having no idea what "water" describes a frequent experience I have had with colleagues in emergency medicine. Twenty years ago I beat my head against a wall sharing with fellow residents and faculty in my program that implicit bias and prejudice were adversely affecting the health outcomes of the patients for which we cared. In the words of my mostly white and male colleagues they just didn't see it. To them, I simply "had a chip on my shoulder." When it came time for senior grand rounds presentations and I proposed the topic of racial dissonance and miscommunication leading to poor clinical decision-making and health inequity. My program director advised me that no one on the faculty had any expertise in that area and our department chair's comment was "I don't think anyone here knows what you're talking about." Several residents shared a conviction that affirmative action was no longer needed, as we were serving a largely poor African American community on the South Side of Chicago and "doing these people a favor." One white peer shared that I should feel fortunate to be there as an African American. After all, there were now two of us in the program. Interestingly, though mentors pejoratively suggested I look into an MPH, my black peer and I leaned toward pursuit of an MBA, believing we might have more impact as business leaders than as advocates for health justice policy. Twenty years later the situation in that residency has improved as a result of diversity and inclusion (D&I) efforts; presently there is a senior black mentor in leadership and half of the residents in the program now are women. Unfortunately, the vast majority of training programs are still 'swimming in the water' of white hegemony: even when managing to achieve diversity, they still struggle with inclusion.

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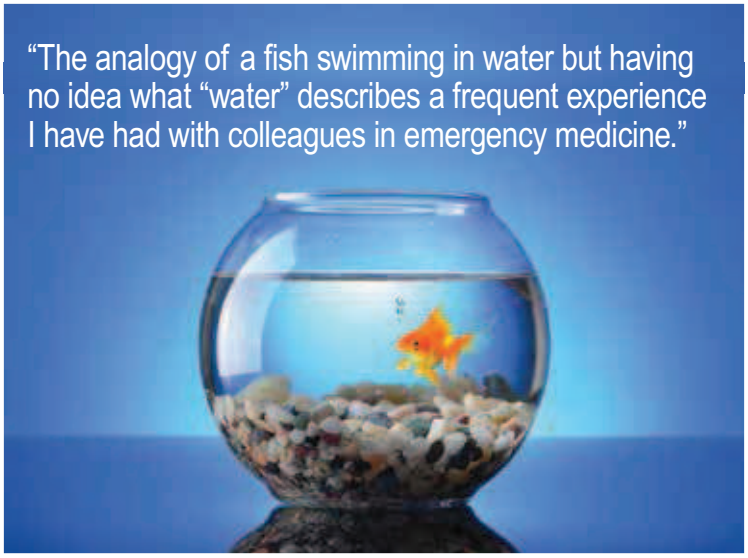

Diversity is not inclusion.

A similar dynamic awaited in the corporate world of contract management groups (CMG). My first job as a newly boarded EDP was as associate medical director for a CMG site at a Catholic Hospital serving a largely Latino community near Humboldt Park on Chicago's West Side. It was useful and gratifying to be the one bilingual physician on staff, even when I didn't have a clue how to fix the problem. The community welcomed me, inviting me to advocate for their interests. The hospital public relations coordinator invited me to record televised public service announcements on health and safety for our local Telemundo/Univision affiliate. Meanwhile, I tried to balance meeting benchmarks (which had already become the sole index used for increasing revenue) against support for patients struggling against the real determinants of health: social and economic constraints. No, cultural competence was not a company priority, even though inclusion was clearly on the hospital's agenda. Any emphasis on community advocacy seemed superfluous to my medical director who I considered an ally until he made clear he was not interested in how health disparities affected the revenue cycle. Eventually the hospital's identity transformed both its mission and its market. It became a designated Stroke Center and tertiary care referral center over the last decade shifting its mission to healing ministry rather than serving the local community. That contract group is now long gone from there and they still have no blacks or Latinos in senior leadership roles, though they do have an Asian American VP.

Inclusion seems a threat to some and possibly irrelevant to those not serving minority communities. With this lesson learned, I moved to where a vast minority Latino community existed, in part because I reasoned it not be made a marginalized market. Herein lies one of the greatest hypocrisies and formidable challenges to understanding diversity and inclusion: Latin American society in South Florida is more vested in white hegemony than Anglo-culture is in America. I thought my childhood experience with racist Cuban-Americans-in-exile would be different tempered by my professional credentials. In fact, Cubans on those hospital staffs routinely expressed the racist view that blacks, particularly American ones, are inherently inferior to whites. I commonly interrupted conversations in the physician lounge peppered with loud references to a black presidential candidate they called "the monkey." This toxic and deplorable behavior is entrenched in the culture. (As recently as a week ago, a new black student movement at the University of Miami was set off by the increased frequency of white students using the n-word, monkey emojis, and calling for the enslavement of blacks. All of this despite the establishment of a diversity task force the year before to combat such bigotry). It was around this time I moved to a hospital in North Miami Beach serving a largely black community. Around that time, I met David Farcy and several other forward-thinking

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physicians, becoming increasingly active in Florida Chapter Division of the American Academy of Emergency Medicine (FLAAEM) as well as the National Medical Association, in part, to call attention to health equity, professionalism and ethics in emergency medicine practice. A culturally diverse group of professional friends and I put together a TV series called "Connections" at a small station in Miami to speak to unity in the minority melting pot of our South Florida community, but it was nowhere near enough to put a dent in the inertia of divisiveness.

Minority presence does not equal diversity or impede hostility in the workplace.

I set out to acquire the language of the C-suite with a health care MBA with a goal to promote a new model prioritizing health creation and helping curb wasteful expenditure on catastrophic care. Clearly everyone could tell health disparities led to a lack of care for chronic disease and the unequal allocation of power and resources. A significant part of the $4 trillion misspent yearly in this country could be addressed by funding relatively simple preventative measures. My classmates and I came up with proposals for strategic corporate philanthropic efforts that included community-based health care academies and clinics, to provide education for local labor pools and career paths into training. We researched how clinical documentation systems could be used to help patients save money and limit health expenditures. Of course none of this fit current business models or ongoing strategies focused on the next quarter. Ultimately it dawned on us that if we wanted to be included in current health care business structure, we could not sell reinventing the wheel. Notably, even in meetings set up by a small consulting group I joined later, we never met black people in leadership to champion novel strategies.

Being open to diversity does not guarantee it and health equity requires powerful leaders.

I headed north to pursue an interest in policy and advocacy, finally accepting that may be a better path to health justice after all. What better area for that than D.C. and the mid-Atlantic? I took part in AAEM's Policy and Advocacy Congressional Elective while awaiting the completion of my credentialing process at a hospital where I accepted another leadership position. This time it was medical director at a small hospital in a rural, mostly farming, community. The welcome can best be summed up this way for anyone familiar with the movie "Blazing Saddles": I was the new Sheriff, Bart. Shortly after I started, two of the scribes and a unit clerk let me know they heard one of the EDPs on my staff repeatedly vocalized racist remarks about me whenever I was not around. I immediately met with that physician about the remarks which he emphatically denied and then notified our regional director (RD) about the issue. The response from the RD: "nothing could be done about it." At this point, I decided this company was not worth any more of my time and energy. I had been active in the National Medical Association (NMA) and a colleague there suggested I join the teaching staff at Howard University College of Medicine. I did, and have been in practice there as an associate professor for emergency medicine since. Initially, there was enthusiasm for collaborative work on social justice, however, since then; the contract was taken over by … another CMG.

Diversity and inclusion requires integrity and commitment.

Last summer while attending Emergency Medicine Section Lectures at NMA Scientific Assembly, I ran into our brilliantly energetic new AAEM president-elect, Lisa Moreno-Walton. She invited me to join the D&I Committee at AAEM and join a panel to speak on that subject at our Scientific Assembly. We all understand that the enthusiasm around D&I in most organizations is fueled by concerns such as avoiding lawsuits or compliance and workplace safety. Many D&I initiatives and officers are not taken as seriously as other leadership, but I can tell you that even my limited involvement has already been immensely rewarding. At my first AAEM Scientific Assembly about 20 years ago I felt isolated and alone as one of a handful of black EM docs wandering aimlessly from one lecture to the next. This time, I wandered about expecting to interrupt those same disconnected countenances. More often the response was simply a positive greeting or suggestion to connect and collaborate, but on one occasion a few weeks ago, I came across a young black physician recently out of residency whose response was: "I have been wandering around this conference not knowing where to go and you just made my week. Thank you for helping me feel part of this."

Inclusion is an open invitation to be valued equally. ●