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VIEWPOINTS

Unmasking Systemic Racism and Unconscious Bias in Medical Workplaces: A Call to Servant Leadership

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"I CAN'T BREATHE!" These heartbreaking words heard by every human being on May 25, 2020, were for medical professionals, a desperate call for help and a mandate to action—to save a life.

The death of Mr. George Floyd erupted into a public outcry of shock, sadness, pain, and anger that spilled from private homes and social media timelines to street protests, birthing a national and international movement. The world witnessed the fatal effects of silent complicity and maintenance of the status quo during injustice. Hospitals and academic institutions joined private and public corporations in statements condemning his inhumane suffering and death, supporting the Black Lives Matter movement, acknowledging the reality of systemic racism, and promising to uphold racial equity in their institutions. Hospital medical and nonmedical staff observed respectful silence for 8 minutes and 46 seconds while wearing masks—seemingly acknowledging the two plagues ravaging our country and humanity—COVID-19[1] and systemic racism,[2] both disproportionately affecting Black people and other racial/ethnic minorities. While masking works for one, the other needs to be unmasked by medical institutions.

RESPONSIBILITIES OF MEDICAL LEADERSHIP

Although the term *minorities* could refer to sex, gender, age, or race/ethnicity, the issue of systemic racism has been increasingly recognized as a public health concern. This perspective article will focus on racial/ethnic minorities. As medical institutions acknowledge the effects of social determinants of health on racial/ethnic minority populations,[3–5] leadership should also address the effects of systemic racism and unconscious bias on their staff. True leadership is not authority, but humble service—*servant leadership*. Unlike traditional leadership, servant leadership is a philosophy of leadership through which the leader's goal is to serve the people working for the leader. Servant leaders put their employees' priorities first, helping them grow as individuals to become healthier, wiser, freer, more autonomous, and more likely to serve others.[6,7] Employees who are so humanely treated are more likely to allow themselves to be guided by their moral conscience, independent of religion, culture, geography, nationality, race, and sexual orientation.[6,7] Servant leaders exemplify the moral and ethical principles they wish to promote in their organization. While unconscious and implicit bias training, team building, racial equity, and diversity work groups are good first steps to arouse individual awareness of prejudices, true change demands more concrete actions to heal the festering wounds of injustice.

Reflections for Medical Leadership

Do leadership committees addressing administrative, clinical, academic, and research areas represent your institution's workforce diversity? Minorities

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should not be overlooked for positions for which they are well qualified. Concerns of minority staff are best represented by those with shared experiences. An invitation for minorities to participate in leadership committees or work groups should not just satisfy appearances but should acknowledge existing disparities and genuinely convey that the unique experiences, voices, and perspectives of minority staff are valued and vital to efforts to eliminate further injustices. In a study by Bennett et al,[8] a comparative analysis of minority representation among basic science faculty from 1998 versus 2018 revealed that 1.6% versus 2.0% of faculty identified as Black or African American, and 3.0% versus 4.4% as Hispanic, Latino, Spanish Origin, or Multiple Race–Hispanic, while 10.9% versus 20.4% identified as Asian. Indeed, there has been little change in over 2 decades, and servant leadership recognizes the critical need to increase minority representation and retention in the medical workforce.

Are the hidden talents of your minority staff being nurtured? Leadership should not ignore the needs and concerns of minority staff or neglect to provide them with the same vigor of attention, resources, opportunities, and support given to similarly qualified nonminority staff. The productivity or contributions of minorities in the workplace may not reflect their skills or value but instead signify their resilience or resourcefulness in the face of challenging conditions. Servant leaders believe that anyone is capable of greatness and seek to nurture and bring out the best in those they serve.

When given a seat at the table, do minorities feel empowered enough to contribute without fear of retribution? Minorities can provide helpful insights regarding racial bias issues but should not be expected to bear the burden of providing solutions, which require collaboration from staff and leadership. Servant leadership strives to create safe spaces for staff to express their views. Leadership should provide staff with trusted and confidential avenues to report bias or aggressions; ensure availability of individual, group, and mentoring support options; and establish follow-up/check-ins with victims of aggressions. Meetings held with minorities to encourage disclosure should preferably involve a trusted minority advocate, to encourage a safe space for honest discourse.

Are mistakes reprimanded more vigorously than acknowledgement of achievements? A servant leader acknowledges accomplishments of minority staff as enthusiastically as those of nonminority staff. Conversely, a servant leader delivers reprimands compassionately to both minority and nonminority staff, without evoking humiliation or fear. This encourages staff to achieve insight and a genuine resolve to maintain the high standards expected of one who is a valued asset to the institution.

Are all providers held to similar standards, or are some treated with kid gloves and others with the hammer of justice? A culture in which minority employees have more clinical or administrative concerns raised against them than nonminority colleagues should alert leadership to the probable existence of bias or undue scrutiny. Staff should be encouraged to resolve conflicts respectfully, promptly, and amicably through effective communication, avoiding presumptions, passive-aggressive behaviors, and silent nuances of disapproval. Effective communication requires adequate preparation, attentive listening and positive attitudes, supportive feedback, conflict management at the appropriate levels to avoid escalation, and managing oneself responsibly with frequent self-evaluation.[9] Anonymous complaints, patient safety reports, and multispecialty peer review committee investigations may unconsciously enable the bias or privilege they seek to avoid when minorities endure negative consequences, prolonged investigations, and escalations of alleged concerns, despite clarifications offered, evoking feelings of preconceived bias and injustice. Empathy (feeling others' suffering) without compassion (doing something to alleviate others' suffering) only prolongs suffering, even when trying not to be punitive. Servant leaders acknowledge mistakes and act to reverse, end, and change the status quo, sans ego.

Servant Leadership Involves Accountability

Servant leaders hold one another accountable for promoting equity and diversity. In addition to diversity and inclusion initiatives, leaders of medical institutions should investigate existing structures, policies, procedures, and workplace cultures, to unmask hidden or inherent systemic inequities, and work to initiate more inclusive and equitable remedies that confer value to every staff member, regardless of sex, race, or ethnicity. When addressing workplace concerns, leadership should provide equal protection or disclosure to involved parties. The presumption that racial inequities do not exist in the workplace because no one has complained about them would be naïve and erroneous. Workplace racial inequities can have serious negative effects on the physical health and emotional well-being of employees. Strategies to combat racism among medical staff and trainees include simulations to prepare for real-life scenarios; cultural competency and implicit bias training; establishing a chain of command for escalation; supportive debriefs; confidential longitudinal tracking surveys; and establishing a multidisciplinary task

force of physicians, nurses, support staff, and risk managers to lead educational and policy changes.[10] Diversity strengthens and determines the productivity and success of all institutions.

RESPONSIBILITIES OF MEDICAL STAFF

Medical staff interactions are the building blocks of workplace culture. Hospital care units should be a home and safe haven for both patients and staff. The medical team is like a family, consisting of people with different personalities and talents with shared values working toward a common goal—compassionate care of the patients under their care and gentle support of their families. Medical staff spend more hours together in a working day than with their families, and need to compassionately care for each other. Differences in opinion should not immediately arouse suspicion of a malicious intent or be characterized as negligence or incompetence. Successful work families give each other the benefit of the doubt, trusting individual commitments to the common goal.

Promoting Cultural Diversity

Cultural diversity should be respected. A random sample of 1833 faculty from 106 US public and private medical schools, comprising 82% non-Hispanic White, 10% underrepresented minority, and 8% nonunderrepresented minority, revealed that 48% of underrepresented and 26% of nonunderrepresented minorities reported experiencing racial/ethnic discrimination from a colleague or superior and lower career satisfaction scores.[11] Because of innate biases, people are usually more comfortable with others of similar backgrounds. However, judging others on the basis of race, sex, or religion is an unconsciously learned behavior that can be consciously unlearned. Being well meaning and biased are not mutually exclusive, and claiming to be color-blind may not be realistic. Hard-to-pronounce names should not be shortened to appeal to others' cultural naiveté, unless offered by the minority staff member. The way minority colleagues speak should not arouse more curiosity than their spoken words. Minorities may feel that their strength is viewed as too assertive and their meekness as not assertive enough, clouded by an unspoken expectation to dim their light, mute their success, or become invisible so others feel comfortable in their skin. Despite different skin hues, the blood coursing through our veins has one hue.

Formal and informal opportunities to promote cultural diversity in the workplace will encourage minorities to share the beauty of their culture, fostering camaraderie in a shared humanity and values of love, family, health, and happiness. In a survey of 300 information technology employees, admitting to biases and prejudices, recognizing the existence of diversity, learning to value and respect cultural differences, and dismissing myths about diverse others when in a group of associates were considered the most effective strategies for increasing awareness of workplace diversity.[12] Diaz et al[13] determined that a successful approach to reducing implicit bias and increasing cultural diversity and inclusivity was a comprehensive, collaborative, institutional approach involving increasing recruitment and retention of a diverse group of learners and educators, teaching cultural humility, and building trust. When minority staff feel valued, safe, and at home in the workplace, they undoubtedly excel.

Combating Microaggressions Among Medical Staff

Minorities may encounter negative attitudes and unprofessional behaviors, including macro- or microaggressions, restrictions of practice autonomy, and undue questioning of their professional judgment, sometimes clouded by acceptable justifications, such as concerns about patient safety, variations from protocols, communication, or clinical skills. Originally used in 1970 by Professor Chester Pierce,[14] microaggressions have since been defined as minor and damaging humiliations and indignities, extending beyond insults and verbal abuse, to include disrespect, subtle snubs, slights, dismissive body language and tone of voice, devaluation, and exclusion.[14–16] Sue and colleagues[16] further describe 3 forms of microaggressions—microassault (deliberate verbal and nonverbal acts of discrimination), microinsult (unintentional demeaning subtle snubs or humiliations), and microinvalidation (verbal statements denying or dismissing others' thoughts, feelings, or realities).

Nadal et al[17] suggests 3 questions when experiencing microaggressions: Did this really occur? Should I respond? How should I respond? Addressing microaggressions calmly and respectfully can be effective and enlightening for all involved. One could clarify the offending statement or behavior from the perpetrator or a trusted witness, and convey how it made one feel, while giving the perpetrator the benefit of the doubt. In a workshop for 163 medical and dental students, barriers to addressing microaggressions included difficulty recognizing them, being unsure what to say or do, lack of allies, lack of familiarity with institutional supports, and fear of retribution.[18] When minority medical staff share their experiences with colleagues or leadership, attentive listening and genuine empathy encourage trust and full disclosure.

Concerns of racism or workplace discrimination should be acknowledged, not trivialized, rationalized, minimized, or ignored. Responding that the minority's

perception of an experience is different from the perception of others, or that the perpetrator was likely being passionate about their work, or the false equivalence that similar experiences happen to nonminority colleagues, or that the minority should not take things too personally (akin to victim blaming) only serve to invalidate an authentically hurtful and often dehumanizing experience as an exaggerated perception of bias, further deepening feelings of injustice and alienating the minority. Nonminority staff should respect that their experiences, in a similar scenario, could be different from the realities of their minority colleagues. Nonminorities and leadership speaking up can be effective in combating macro- and microaggressions in the workplace.

Coping Mechanisms for Racial Minorities—a Personal Reflection

As a Black physician-scientist of Nigerian heritage, whose doctorally trained parents instilled a love for learning and a passion for service in their 7 daughters (1 lawyer/accountant, 3 subspecialist medical doctors, 2 pharmacists, 1 optometrist/public health specialist) and 3 sons (engineers/information technology specialists), it is saddening to learn that education, professional experience, or social status does not automatically overcome bias in our society. Medical and nonmedical minority professionals use several coping mechanisms while striving to achieve professional success and personal fulfillment, including ignoring most aggressions as unnecessary distractions and maintaining a bird's-eye focus on one's goals, choosing to address some encounters to provide critical insights or prevent grave injustice, working twice as hard and being creative with available resources to achieve personal excellence regardless of external recognition, or keeping silent and limiting interactions to avoid conflicts.

From personal experience, effective coping with life's stressors begins with humble self-knowledge, which leads to better insights about oneself, others, and life's greater purpose. Self-knowledge enables critical reflection on past experiences, present truths, and future aspirations, encouraging personal responsibility and awareness that one cannot control others' opinions, words, or actions but only one's reactions to them. This focused self-knowledge is empowering, and enables one to choose to show empathy and compassion to others, even when not reciprocated, because one's treatment of others is a reflection of one's inner state. Knowing one's truth projects inner light, even in the midst of darkness, because like light, truth cannot be hidden. Retreating daily to support systems, such as family, friends, creativity (poetry, writing, music, art), hobbies, humanitarianism, faith, or spirituality, refuels and renews one's passion and purpose. Living with passion and purpose brings joy, even in the face of suffering, when one believes that challenges and victories teach invaluable lessons that propel one to unimaginable heights along life's journey.

All Black people, in Africa or the diaspora, and racial minorities are descendants of a noble lineage of nurturers, conquerors, and story keepers with vast talents like nature's colors, stoic strength like the *Iroko* tree, bending-never-breaking spirits like palm trees in the storm, and soaring joy-filled hearts like eagles. If you hear our voices, LISTEN to our pain. Do not just look at us, SEE our suffering. Do not just stand with us, SPEAK truth to power.

Systemic racism and unconscious bias in medical workplaces can be unmasked and eradicated only when staff and leadership collaboratively renew individual commitments to serve, learn, love, heal, and teach—not just with words but by compassionate example, striving to become servant leaders. Once unmasked, we all CAN BREATHE and not only survive but thrive to become the best versions of ourselves.

ARTICLE INFORMATION

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Disclosures

None.

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