Getting into good trouble: Black lives matter and Black professors matter

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Our obligation to social justice

In the wake of the brutal murders of Ahmaud Arbery, Sean Reed, Breonna Taylor, and George Floyd and amidst international outcries for social justice, many of us are asking ourselves what we can do to effect change. How can we be impactful allies in the medical profession? How can we support and protect our Black students and foster their careers? How can largely White, male-dominated academic institutions recruit more underrepresented students, residents, postdoctoral fellows, and faculty; give wings to their dreams; and build a better, more diverse team of physicians and scientists to tackle the immense health care threats currently facing our world?

Why Black representation matters

The lead author of the present Viewpoint, Briyana Chisholm, is a medical student who was profoundly influenced by an experience underscoring racial injustice in higher education. In an undergraduate freshman STEM class predominantly made up of White students, Ms. Chisholm was thrilled to befriend a fellow Black woman classmate who shared her drive to excel and passion for science. As two intelligent Black women in a system saturated with whiteness and its perspective, they challenged one another, delving far beyond the scope of the class material.

One day, however, a racist incident during class forever changed Ms. Chisholm's friend's path. After being placed into different groups for a class assignment, two White male classmates in her friend's group began reciting a racist fraternity chant, referring to "lynching a nigger." She tried to redirect their attention to the assignment to no avail. Another White student in the group laughed in response. After class, she was visibly shaken and silent.

Later that evening, as her friend recounted the incident, Ms. Chisholm experienced a series of emotions: rage, anger, frustration, abjection, and exhaustion. Although her friend reported the egregious example of racist harassment to the professor, there were no apparent consequences. They attended a large public mid-Atlantic university, an institution with a Black student population of 5.3% and at which only 3.6% of the professors were Black. Frustrated, Ms. Chisholm retorted, "They have to do something!" As exhaustion gave way to resignation, her friend reminded her of their reality, stating simply, "but they won't".

For the affected student, this incident inexorably extinguished her fire for pursuing a career in science. The next semester, she switched to a nonscience major. She eventually left the university, feeling she did not belong in college at all. This experience left Ms. Chisholm stunned and saddened by the loss of a brilliant peer with immense promise and potential.

Academic objectives

Unfortunately, similar racist experiences in higher education are not uncommon. Historically underrepresented students face daily macro- and microaggressions and are consequentially pushed out, deterred, discouraged, and actively hindered from reaching their full potential by the people and structures around them (1). While education is extolled as the way out of poverty and oppression, this example clearly demonstrates that education is not sufficient. Black students and trainees have adapted coping mechanisms to endure systemic racism, which threatens to smother their potential at every stage in their trajectory.

The COVID-19 pandemic raises even more challenges for Black students, trainees, and faculty who know that their families and community face a higher burden of morbidity and mortality. This anxiety is further compounded by recently highlighted murders of unarmed Black people at the hands of law enforcement. Across the country, Black students have been writing to their medical school administrations, advocating for themselves and their communities in order to receive institutional support amidst the pain and outrage of current events. This current reality underscores the need for two things: (a) strong mentorship from leaders with diverse backgrounds who will create educational systems that support underrepresented students, thereby enhancing creativity and innovation, which are at the heart of biomedical discovery, and (b) a medical and scientific community united in the commitment to promote training and service that benefits our patients, their families, and our society as a whole.

Diversity committees and leadership in general at our academic institutions recognize the importance of quality education from early childhood onward to prepare our best minds for future work in science and medicine (2). The Johns Hopkins Medicine Office of Diversity, Inclusion and Health Equity, led by one of our authors (Dr. Hill Golden), and the Johns Hopkins University School of Medicine have spearheaded important initiatives, including a pipeline program that led Ms. Chisholm to consider a career in academic medicine (Table 1). In fact, she currently attends a leading medical school with plans for a career in academia focused on advancing health care for underserved populations. However,

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Table 1. Recommendations for ending institutional racism and improving diversity and inclusion among physicians and scientists at academic institutions

Diversity and inclusion committee aims	Recommendations to amplify efforts and dismantle institutional racism at academic medical centers
Create funding programs for lower school, high school, undergraduate, and medical students for scientific research at academic institutions to expose and recruit students of diverse backgrounds to academic medicine and the physician-scientist career path	• Evaluate program success over time and identify areas of improvement by following up with participants as they journey to their goals • Showcase successful students, physicians, and scientists • Recruit and support BIPOC leaders in graduate programs and executive committees to help recruit future BIPOC student and faculty leaders at all levels
Increase the number of URM medical trainees	• Create a dashboard to annually track BIPOC medical students, residents, and postdoctoral fellows • Increase engagement by creating mechanisms for trainees to share their concerns/needs with leadership through creation of affinity groups, house staff diversity councils, and postdoctoral diversity councils • Create holistic mentoring networks for diverse medical trainees and faculty • Conduct exit surveys (by neutral parties) to ask medical students why they decided to train at other institutions/their opinion on the climate at the institution
Increase recruitment and retention of BIPOC faculty members, especially at the highest academic ranks, who are educating medical students	• Create a dashboard to annually track the number of BIPOC faculty hires and promotions over time • Require departmental leadership to develop diversity and inclusion strategic plans to support recruitment, retention, and mentorship of BIPOC faculty and to address structural and institutional racism in policy and practice under their purview with monitored deliverables • Establish incentives for departmental leaders who exceed milestones • Conversely, institute consequences for departmental leaders who fail to meet diversity milestones • Conduct systematic exit surveys (by neutral parties) for faculty who leave an institution to determine why they left and how they perceived the institutional climate
Increase representation in leadership at all levels, including deans and associate deans, department directors, division directors, graduate programs, executive committees, fellowship programs, and editorial boards of prominent journals	• Track the number of BIPOC faculty advanced into departmental and school of medicine leadership positions • Require leadership to develop individual development plans for BIPOC faculty under their purview so that they can attain the skills and visibility to position them for leadership roles • Conduct systematic exit surveys to ask why faculty decided to pursue leaderships position at other institutions • Recruit and support BIPOC leaders on editorial boards for journals focused on advancing science and medicine
Diversity training requirements for all students, trainees, and faculty	• Administer-required evidence-based IDARE training (this includes unconscious bias training) for students, trainees, and faculty annually • Conduct an evidence-based institutional diversity climate survey to measure to assess effectiveness over time
Safe and retaliation-free mechanisms to report harassment	• Collection of data on reported incidents of racial bias so that progress can be tracked overtime and training programs can be implemented where needed to address and bring to light specific issues (in collaboration with Institutional Equity Office)

BIPOC, Black, indigenous, (and) people of color; URM, underrepresented in medicine; IDARE, inclusion, diversity, antiracism, and equity.

if the environment in which medicine is practiced remains plagued by racism, underrepresented students will continue to be stifled and kept from making impactful and urgently needed contributions to the lives of the people we serve. Prior research shows that Black patients receive more consistent health care and preventative screening tests when their providers include Black physicians (3). Changes in organizational culture are critically needed to ensure that perspectives of Black and other underrepresented people are woven into the fabric of our academic organizations.

The limitations of current diversity efforts are reflected in the lack of Black physicians and medical school faculty members in the US. In 1978, Black people constituted 6.3% of practicing physicians (4). Forty years later, in 2018, this decreased to 5%, with Black physicians and scientists making up only 3.6% of US medical school faculty (5). Thus, our diversity efforts have failed to achieve equity and more closely resemble a Band-Aid on a ruptured aortic aneurysm than the required, emergent surgical repair.

The true solution involves a more comprehensive approach and honest appraisal of how academic institutions can rid themselves of systemic racism to create a truly inclusive environment (Table 1). This starts with representation — actual concrete measures demonstrating that institutions are committed to ending institutional racism — rather than simply saying they support this idea. Medical schools should be composed of diverse perspectives and voices, from students and trainees up to department chairs and deans. Representation must extend beyond tokenism in order to truly maximize the benefits of diversity (6). This will have a domino effect in fostering careers of underrepresented students. As young trainees see people like themselves in leadership, they can aspire to these roles with absolute conviction and confidence.

As physicians and scientists, we have a moral obligation to serve as advocates for all the people we serve, regardless of race, ethnicity, gender, or socioeconomic status. By virtue of our professions, we are acutely aware of the adverse consequences of the COVID-19 pandemic that disproportionately affects Black and Latino people, the

elderly, and those with preexisting conditions. While scientific knowledge expands and evolves with new factual data and emerging technologies, the underlying goal is to seek the truth, and our public health policies must also evolve in concert with the facts. Science must never be considered a controversial topic of public debate. Structural racism that undercuts advances in scientific innovation and health care must be eliminated.

Conclusions

There are no substitutes for academic leaders who share experiences with the students they teach and inspire. Representation is essential to advancing scientific research and healthcare: we cannot achieve health equity without a diverse workforce (7), and we cannot achieve a diverse workforce without adequate representation. Representation is especially important for urban institutions caring for people burdened by health disparities and racism. Such institutions should enact audacious plans that include higher recruitment and retention goals for underrepresented students and faculty. Achieving these lofty goals, however, will require all non-Black colleagues to acknowledge the full scope of institutionalized racism and partner with Black students, trainees, and faculty to adopt widespread, measurable goals; review current policies; and establish new policies to replace failed strategies (Table 1). Just as we do not expect our patients to find cures for their diseases, it is not the responsibility of those who are the target of racism to solve a problem they did not create.

As physician-scientists we are used to challenging dogma and pushing the boundaries of discovery to advance human health. Our most innovative leaders have, in the words of the late Representative John R. Lewis, "made good trouble" in changing scientific paradigms. It is now incumbent upon all of us in the medical profession to make good trouble — necessary trouble — to ensure diversity and inclusion in our institutions. Only through dismantling structural racism can we realize our full capacity for scientific innovation in medicine and achieve health equity.

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