# A Letter on the COST for Black Faculty

Dear Duke School of Medicine, Health System, and PDC Faculty,

We, Black Faculty across Duke Health, greet you as fellow co-investigators, colleagues, clinicians, and companions with a simple statement: **We can't breathe**.

The challenges of 2020 and now 2021 have been inexplicable. Like many of you, we are stretched thin by intermittent quarantine and isolation, virtual meeting participation, electronic message intensification, and home school administration. As we navigate a pandemic that has disproportionately impacted people of color, we are also coping with an unrelenting haze of police brutality and hateful rhetoric that openly devalues our existence. Over the last several months, we, and other Black people, have not only seen family, friends, and community members die at higher rates from COVID-19, we have watched people who look like us gunned down while going for a jog, murdered in their own homes, threatened while bird watching in Central Park, and mercilessly choked on camera. Moreover, we recognize that these are the tragedies that have come to national attention. As recent directives from the White House surreptitiously support supremacist notions and actively dismantle diversity trainings, the burden on people of color is unequal and unsustainable. As put so well in the title of an op-ed by Danielle Cadet, "Your Black Colleagues May Look Like They're Okay — Chances Are They're Not." Yet, we come to work every day to serve this institution and community even as we face marginalization, racism, and other institutional impediments to our professional success and personal well-being. Because of the weight of these injustices, **we can't breathe**, or as similarly expressed over half a century ago by civil rights leader, Fannie Lou Hammer, **"We are sick and tired of being sick and tired."**

We recognize that as Black faculty across Duke Health, our experiences are not unique. Isolation, demoralization, underrepresentation, and racism are common for Black faculty and other faculty of color in academic institutions across this country. Despite the facts that these experiences are ubiquitous, long-standing, supported by the evidence, and have been the subject of institutional initiatives to improve diversity, equity, and inclusion, significant change in these areas has been slow to nonexistent. Even as the institution has grown and flourished, the current state of Black faculty and other faculty of color across Duke Health is clear evidence that a rising tide does not lift all boats.

We, therefore, created this document (COST for Black Faculty—Communication to Operationalize Sustainability, Solidarity, Sponsorship, and Trust) to share our experiences, elucidate what we believe are some of the most pressing institutional challenges, and provide recommendations to address them as part of a comprehensive strategy to dismantle racism and achieve equity. The stories in this document reflect the collective experiences of Black faculty who are clinicians and non-clinicians across clinical and basic science departments. Although this document is written from the point of view of Black faculty, the recommendations are also applicable to efforts to improve equity for faculty from other underrepresented groups. The successful implementation of these recommendations will require full integration across all Duke Health entities. What we propose should not be viewed as a series of one-time events but should inform an approach that leads to permanent changes to inequitable policies and structures—an approach which simply becomes "the way we do things at Duke." **We highlight 3 broad categories for action:** (1) Representation, Recruitment, Retention, and Advancement; (2) Culture; (3) Accountability, Administrative Structure, and Oversight.

We share this document with you as colleagues and Duke family members, utilizing a voice both academic and authentic, collectively and carefully crafting concerns rooted in facts, yet resonating with feeling. Each section contains first-person accounts from faculty, gathered to identify themes that reflect the painful realities of Black and other underrepresented faculty across Duke Health. We ask that you read these accounts with an open heart and open mind and reflect on our stories. Resist the urge to: offer an alternative explanation for what was described; diminish the gravity of the situation; relegate the experience to an isolated event; blame the account on "one bad apple"; or compare the experience to that of other marginalized groups ("All lives matter."). We want you to hear us. Our hope is that this document will not only increase your awareness but will also move you towards action.

## Part 1: Representation, Recruitment, Retention, and Advancement

*"A nurse at the desk told me that the space was for the doctors and inquired as to my identity. I gave her no answer but pulled my nametag closer to her face and stared at her. Response: "Oh, you don't look like one of our doctors." How many of my white colleagues have ever been greeted this way?"*

The proportion of Black faculty in academic medicine nationally has remained largely unchanged over the past three decades, and Duke is no exception. Currently, Black faculty make up 3.8% of academic faculty across the

United States. Despite being seated in a county that is 36.9% Black, within a state that is 22.2% Black, and over the last 5 years enrolling a medical school class that is 12% Black, only 4.2% (109/2568) of full-time faculty in the SOM are Black. Disparities in representation are largest at the most senior faculty ranks and in leadership roles. Further, there is significant variation across units, with particularly dismal representation in the basic science departments where Black faculty make up about 2% of academic faculty nationally. Across the 6 basic science departments with laboratory-based facilities in the SOM, only 1 Black faculty member leads a wet-lab. Similar patterns of underrepresentation of Black faculty exist across educational programs, such as physician assistant and doctor of physical therapy.

Although much work is needed to increase the pipeline of Black faculty, even more problematic are the absence of intentional and equitable processes to identify and recruit Black faculty. The underrepresentation of Black faculty is too often attributed to false claims of the absence of "qualified" Black candidates or biased descriptions of Black trainees and faculty candidates as "not a good fit." Like in many other institutions, long-standing practices and policies across Duke Health have, at best, not supported efforts to increase the number of Black faculty and, at worse, have served as barriers to doing so. Further, too many of the current Black faculty find themselves victims of either neglect or active discrimination. This is demonstrated by lack of recognition of our numerous and important contributions, inequitable support (salary, resources, administrative, mentorship, sponsorship etc.) and the absence of timely considerations for promotion or leadership opportunities.

Below, we describe three broad areas of inequity related to representation, recruitment, retention, and advancement, and share their impact on the lived experience of Black faculty. These include:

1. Stagnant growth in the proportion of Black faculty in the SOM
2. Inequitable mentorship, sponsorship, support (salaries, resources) and advancement and lack of consistent efforts to retain Black faculty
3. Minimal inclusion of Black faculty in leadership roles in the SOM, Health System, or PDC

## Stagnant growth in the proportion of Black faculty in the SOM

*"The transition from fellow to faculty is challenging for everyone, but far worse for underrepresented racial/ethnic faculty. I have seen majority faculty transition with ease, while my division had a moving target for me. I was told, "You have to have a K award." Then it was, "You need more papers." I even prepared a grant but could not submit it because I did not have "institutional commitment." It was a year before I was "allowed" to submit it (funded the first time). Other fellows were offered faculty positions when their CVs did not look different from mine. When I was finally transitioning to faculty, there was no onboarding, no identification of office space or equipment, etc. I even had to justify obtaining a laptop and was told I would be responsible for replacing it if it were damaged. I didn't know how blatant this unequal treatment was until I watched a white colleague transition from fellow to faculty 12 months later (red carpet treatment with designated office, name plate, etc.)."*

Between 2010 and 2017, the proportion of Black faculty in the SOM increased from 3.8% to 4.6%. However, this proportion decreased to 4.2% in 2018 and has since remained largely stagnant (4.3% in 2020). Despite a stated commitment to faculty diversity, there are no systematic policies to ensure that Black faculty are represented in candidate recruitment pools across Duke Health or among trainees who represent the largest faculty pipeline at our institution. In addition, as noted above, discussions about recruitment of Black faculty and trainees are often filled with the language of bias related to perceptions of "qualifications" and "fit" for the institution. As a result, the SOM has made little progress in increasing the proportion of Black faculty, and current Black faculty frequently face the isolation of being the "only one" (if there is one) in many spaces, including their divisions, on clinical services in inpatient and outpatient settings, or in labs and other research settings.

## Inequitable mentorship, sponsorship, support (salaries, resources) and advancement and lack of consistent efforts to retain Black faculty

*"As Black faculty, you feel like you have to work ten times as hard to get to the same level as White faculty. I have been working at Duke for 6 years, and in spite of my high productivity, I have not had a pay increase. I was told that there was limited funding, yet I have heard that students that I helped to train and mentor have received a starting salary commensurate with mine, despite my more than 10 years of experience in the field."*
*"I feel like my promotion "slipped through the cracks" and was delayed for over a year even though I met every requirement necessary to fulfill advancement. In contrast, my white counterparts who started at the same time as (or even after) me were all promoted on time and before me."*

Black faculty across Duke Health are disproportionately affected by lack of mentorship, sponsorship, and inequities in resources, specifically, support for clinical work and research. Additionally, Black faculty suffer from

inequities in salary, unfair delays in promotion, lack of access to leadership roles which are often appointments without transparency in the process for selection and without apparent consideration for accomplished underrepresented faculty. Moreover, Black faculty experience greater expectations to serve in roles that meet the institution's need for diverse representation on committees or in other areas but have little to no influence on considerations for promotion (the minority tax). These inequities are reflected in the current distribution of Black faculty across ranks. Only 10.9% (12/110) of Black faculty in the SOM are tenured compared to 27.5% (513/1864) of White faculty. Black faculty make up only 1.4% of full professors. Among the 110 Black faculty, 8.2% are professors, 24.5% are associate professors, and 60.9% are assistant professors. In contrast, 28.7% of White faculty are professors, 25.8% are associate professors and 39.4% are assistant professors. That is, the proportion of White faculty who are full professors is more than 3-fold higher than the proportion of Black faculty who are full professors while the proportion of Black faculty who are at the assistant professor level is 1.5 fold higher than that of White faculty. Sadly, this situation represents a worsening picture over the past decade. Ten years ago, there were more Black professors in the SOM than there are now. In 2009, 14% (11/74) of Black faculty had achieved the rank of full professor in the SOM compared to 8.2% (9/110) in 2020.

Like recruitment, little attention has been given to efforts to retain Black faculty. In a 2015 Faculty Survey of satisfaction with professional and intellectual life, compared to other racial and ethnic groups, Black faculty were more likely to report intention to leave Duke in the next 3 years. The proportion of Black faculty departing Duke has exceeded the all-SOM estimated faculty departure rate in 3 of the last 10 years. In 2018, Black faculty had the highest departure rate of any other racial or ethnic group at 5.7%—a rate that was 2.7 times higher than the all-SOM faculty departure rate and 3.4 times higher than the departure rate for White faculty. In exit interviews of underrepresented faculty leaving SOM from 2007-2020, reasons shared for departure included: having reached the ceiling of opportunities and growth at Duke, feeling undervalued for contributions, enduring behaviors by leaders and fellow faculty that undermined their professional success, and absence of efforts to retain them. These narratives echo the experiences of current Black faculty.

## Minimal inclusion of Black faculty in leadership roles in the SOM, Health System, or PDC

*"I have built a national reputation for my work. Despite invitations to interview for major leadership positions at other institutions, I believe that my name will never come up in considerations for similar roles at Duke. While I watch my white colleagues receive appointments to high level leadership positions at Duke, leadership has decided that what I am currently doing is good enough, without any thought about how my talents could benefit the broader SOM enterprise. In many ways, I am invisible until someone wants to showcase my expertise or accomplishments. Black faculty represent an enormous amount of untapped potential.*
*"I have been passed over for promotions to leadership positions that pay. But then I see my white colleagues getting promoted to positions so that "we keep them here at Duke." I am disappointed that Duke SOM does not consider Black faculty worth keeping."*

Black faculty across Duke Health are not provided equitable opportunities for advancement. Major leadership roles are frequently filled without transparency in the selection process or opportunities for broader faculty to express interest or receive consideration. As a result of these ***appointments***, despite a long history of matriculating, graduating, and hiring excellent Black clinicians, educators, and researchers, there is minimal representation of Black faculty in leadership roles across Duke Health. As of July 2020, there was only **one** Black program director (PA Program), **one** Black department chair, **two** Black division chiefs (one is also the only Black vice dean), and **two** Black co-associate residency directors (both in Family Medicine and Community Health). There are approximately 146 endowed professorships at Duke Health and only **two** are held by Black faculty. As some evidence of progress, the Chancellor of the Health System is a Black man, the first in Duke's history. However, there are no Black faculty members represented on the executive leadership teams of the Health System, Duke Primary Care, or the PDC (with the exception of the Associate Chief Medical Officer for Diversity, Equity, and Inclusion, appointed October 2020). These disparities further reflect the devaluing of our expertise and contributions. In addition, because diverse teams have been shown to outperform others, the lack of leadership diversity is a missed opportunity for Duke Health to achieve its highest potential by taking advantage of the diverse ideas, perspectives, and talents of Black faculty. The lack of diversity also results in missed opportunities for leadership to hear about and address issues relevant to DEI and anti-racism in all of its operations, policies, and programs.

## Recommendations

Given our extensive contributions to Duke Health, unwavering commitment and loyalty even in the face of inequity, and the right to equitable opportunities to reach our full potential, we recommend the following actions to

help the SOM, in alliance with DUHS and PDC, dismantle systemic racism and realize its highest ideals of diversity, equity, and inclusion.

1. Develop a strategy to substantially increase the number of Black faculty in the SOM over the next 5 years. This should include a specific goal for growth (for ex: 100% increase) with clear benchmarks and accountability that consider demographic diversity of the nation and Duke patients, overall expected faculty growth in the SOM, and need for increasing diversity throughout faculty ranks. Leadership should consider successful strategies employed by other sectors or institutions.
2. Review current faculty salaries and resources (administrative, clinical, and research support, protected time, discretionary funds, call schedules, etc.) and enhance transparency to address inequities by race, ethnicity, and gender. This review must be longitudinal and ensure equity beginning with start-up packages and onboarding of new hires and extending through all faculty ranks and positions.
3. Provide appropriate recognition for diversity, equity, inclusion and other service-oriented work, which is disproportionately undertaken by Black faculty. This should include clearly defined considerations in promotion and tenure criteria and access to other resources commiserate with the work. These include, but are not limited to, protected time, administrative support, supplemental compensation, etc.
4. Invest in programs to increase the number of well-trained, high quality mentors for Black faculty and ensure regular review of mentorship plans. The National Research Mentoring Network is one program with some content addressing the mentorship challenges disproportionately faced by Black faculty. Consider providing resources to support those who spend a significant amount of time mentoring faculty, including protected time, administrative support, supplemental compensation, etc.
5. Create a systematic process with designated persons across SOM units to review eligibility of Black faculty for promotion at least annually. This should include immediate review of current faculty with immediate steps to initiate promotion to appropriate faculty rank for those who are eligible. Given experiences shared by Black faculty related to delays in promotion, we also recommend a process that includes external (outside of Division) mandatory annual review to reduce risk of bias, provide feedback to faculty, and access to resources needed to move to next promotion level.
6. Create systematic processes to identify Black faculty at risk for leaving the institution and develop strategies to “rescue and retain” these threatened positions. The loss of Black faculty due to work culture, dissatisfaction with their current position, or lack of opportunities for advancement should be viewed as a serious event. Strategies should include a high-level leader (Vice Dean) who is fully empowered to negotiate vigorously to retain Black faculty. This would extend beyond efforts at division or department levels which traditionally have not consistently employed equitable retention processes and often reflect apathy towards retention of Black faculty.
7. Develop strategies to increase the representation of Black faculty in leadership positions (department chairs, endowed chairs, vice deans, division chiefs, program directors, vice chancellors, medical directors, chief medical officers, etc.) across the SOM and other Duke Health entities. These strategies must include transparent, systematic, equitable processes for soliciting broad faculty interest in leadership roles and ensuring consideration of Black and other underrepresented faculty. Rules are needed that require open searches for leadership positions with systematic processes to ensure underrepresented faculty are included in applicant pools. Although Black faculty as a group have substantial expertise in DEI-related issues, consideration of Black faculty for leadership roles must not be limited to DEI positions. Black faculty must also have the opportunity to be considered for broader non-DEI related leadership roles across Duke Health.

# Part 2: Culture

*“These are not the actions and words of the Old South, the Old Duke. These are the here and now. The continuous drumbeat. The continued impression that because you are African American you really don’t belong. I think about what we [African Americans] endure while working at Duke. It’s like death by a thousand cuts.”*

Organizational culture and climate are constructs often used to describe the psychosocial environment of organizations. For many Black faculty, our lived experience within this culture is increasingly intolerable and inequitable, which is subsequently impacting our overall well-being, productivity, and success.
Survey data related to climate reinforce the disparate realities of Black faculty in the SOM. In a 2015 survey, compared to faculty of other racial and ethnic groups, Black faculty reported higher levels of agreement with not having a voice in decision-making that affects the direction of one’s unit or department, feeling excluded from informal networks in the department/unit, and working harder than colleagues to be perceived as a legitimate scholar. Black faculty also reported the lowest level of agreement on questions regarding the level of commitment

to diversity demonstrated at the center/institute, department, and division levels. Lastly, Black faculty reported the lowest levels of agreement regarding feeling the climate and opportunities for minorities in the department/unit were at least as good as those for non-minorities. Similarly, in the 2018 Association of American Medical Colleges Diversity Engagement Survey (AAMC DES) assessing perceptions of inclusion and engagement in academic medicine among faculty in the Duke SOM, Black faculty had the lowest overall perceptions of the climate of belonging, inclusion, and engagement, specifically reporting the lowest positive sentiment/agreement in 31 of 33 domains assessed by the survey.

We wish to amplify the reality that Duke Health's institutional environment, i.e., its ethos, processes, and policies, is having a major impact on our experiences and productivity. The culture for Black faculty is steeped in inequity as manifested in the daily experiences of Black faculty in the following key areas:

1. Discrimination and racism
2. Lack of allyship and advocacy
3. Pervasive demoralization and isolation

## Discrimination and Racism

*"As a clinician educator of color, it is hurtful when students attack you personally on evaluations, often using unprofessional language under the protection of anonymity and a lack of accountability. Learners need to know that there is MORE potential harm for faculty of color personally and professionally when evaluations are filled with biased and racist undertones...and that some of the faculty already struggle with the burden of being isolated, not to mention feeling like they can never make the type of mistakes their majority colleagues can."*

*"As an attending, I've had ancillary staff call my colleague to question my decision making. Instead of redirecting the staff to converse with me, my colleague also felt it necessary to call me to check my decision on patient care. Patient safety was never in question. While the hospital should be a collaborative place where decisions can be questioned, the staff member should have reached out to me directly. This was disrespectful and unnecessary. As one of the few Black faculty in the department, it forces me to wonder if this was targeted disrespect.*

Discrimination and racism are manifested at Duke by frequent experiences of humiliation, shame, and marginalization in multiple settings.

## Lack of Allyship and Advocacy

*"When my team and I left the room, everyone was silent. No one talked about what had happened. But I wanted to know that I was not alone. I wanted to know that my white coworkers also felt like bigotry and racism were offensive, even if they were not directly on the receiving end. But no one spoke. I know how uncomfortable it must have been. Perhaps, they did not have the words to say. So, I asked if everyone was OK given the exchange we had just had in the room. They chalked her use of slang up to her "being country" or "redneck," but no one seemed to have been injured by it. I kept my perspective to myself, not seeing a receptive audience clued me in to the depth of offense that I just experienced."*

*"At a faculty meeting, I asked a question about an aspect of programmatic policy. In front of the entire faculty, the Division leader said, "You should be embarrassed for asking that question," which was humiliating. No one spoke up about how inappropriate it was to single me out and unprofessionally criticize me in front of my colleagues. After she was confronted by the only other person of color after the meeting, she offered an apology privately, but she should have apologized in the same venue in which the attack occurred. It is hard for me not to believe this was racially motivated as I was only one of a few people of color on faculty. Would she have said this to a white faculty member? To this day, the memory still stings and makes me hesitant to speak up in meetings. What makes it worse is that I can almost hear my white colleagues minimizing this fear instead of validating it. No, I can't "get over it"...I take it with me in every meeting. Not only that, but I am always reminded that most of them sat in that meeting and didn't stand up for me, nor say anything to me after the incident."*

As noted above, Black faculty are frequently subjected to acts of discrimination, racism, and bias which cause job dissatisfaction and poor morale. This is especially concerning and isolating when our colleagues witness this behavior, are unaffected, or frankly downplay the impacts.

## Ubiquitous Demoralization and Isolation

*“I was told outright that I was being hired because I was minority and female. After that, it didn't matter how many mentors told me that I had earned the right to be here. I will always doubt my right to be here, my worth to Duke for anything beyond being "minority and female.”*

*“A patient of mine was presented at an M&M conference. During the discussion of a commonly reported, well-described complication, other faculty commented by raising their voices. Comments to me included that they doubted that my practice was “within the standard of care,” accusations of “almost killing the patient,” that I was “irresponsible,” and taking care of patients with “people who have no idea what they were doing” [residents]. One faculty member laughed during the discussion. I was the only Black faculty in the room.”*

The demoralization and isolation that Black faculty experience is ubiquitous. When leadership and fellow faculty serve as silent bystanders or even perpetrators of these experiences, Black faculty experience further isolation, additional barriers to success and advancement, and attrition.

### Recommendations

The data and narratives demonstrate a culture of hostility, disrespect, discrimination, and isolation for many Black faculty across Duke Health. While we appreciate and acknowledge the recent anti-racism efforts, to push the administration from their spoken intent to actionable changes in policies and practices that improve the institutional climate and experiences of marginalized members, we recommend the following.

1. Establish a longitudinal assessment tool with benchmarks that specifically measure change in domains of culture/climate relevant to the experience of Black faculty, including acts of aggression (often referred to as micro/macroaggressions), discrimination, racism, etc. Findings should be shared broadly with the development of strategies to address areas where ongoing improvement is needed.
2. Stratify and report findings of future and current climate surveys by race and ethnicity with the goal of developing strategies which specifically target those at increased risk of experiencing adverse effects of current culture and climate.
3. Create a user friendly and effective reporting system that provides increased accountability for acts of aggression, marginalization, racism and other discriminatory behaviors, and develop a mechanism for regular reporting to the Duke Health community and tracking incidents over time (e.g., racial equity report card). Processes must ensure the protection of the reporter against retaliation.
4. Invest substantial financial resources into anti-bias, anti-racism, cultural humility, and other equity training programs across Duke Health for faculty and staff, especially for current and future leaders in all divisions, departments, centers, and institutes. These trainings should be longitudinal and well-integrated into Duke Health processes rather than marginalized “one-offs.”

## Part 3: Accountability, Administrative Structure, and Oversight

*“A lot of things don’t happen because there’s no will to make them happen.”*

Authentic mechanisms for accountability and appropriate oversight of initiatives to promote equity are vital to Duke Health’s goal of dismantling racism. Indeed, the absence of accountability and oversight has led to a failure of the few existing measures to ensure equitable treatment of Black faculty and resulted in an environment where Black faculty are too often left with no voice and no recourse when treated inequitably but to keep working while suffering in silence. Such accountability and oversight must be clearly articulated, implemented, monitored, and strictly enforced at the highest levels of leadership. All recommendations and initiatives raised thus far in this document will fail if Duke SOM, in partnership with the Health System and PDC, does not prioritize the concerns and recommendations raised in this section. Without legitimate accountability and oversight, recommended initiatives on anti-racism will not be sustainable, leaving our Black faculty to contend with business as usual. Below we share the experiences of Black faculty and provide recommendations for accountability, administrative structure, and oversight of antiracism efforts in the following areas:

1. Lack of clearly defined, mandatory, longitudinal metrics with processes of accountability across the Health System, PDC, and all SOM units (departments, divisions, centers, institutes) to combat racism and enhance diversity, equity, and inclusion
2. Absence of accountability with corrective action for students, trainees, faculty, and staff who commit acts of aggression, discrimination, and racism
3. Decentralized ineffective DEI leadership and siloed administrative structures without clear processes of accountability to ensure implementation of policies and practices

## Lack of clearly defined, mandatory, longitudinal metrics with processes of accountability across the Health System, PDC, and all SOM units to combat racism and enhance diversity, equity, and inclusion

*"We keep talking about the same issues over and over again. Nothing ever changes because leadership, which is predominately white, has the privilege of not having to make any changes. They pretend everything is alright. The status quo works for them. We take culture surveys, but they don't seem to matter to anyone."*

The issues raised in this letter are longstanding, familiar, and well-documented but have remain unaddressed over many decades. In many ways, policies, practices, and goals to ensure equitable treatment of Black faculty are treated as suggestions to be considered when convenient or easy or at the discretion of individual units. Efforts to address DEI across entities have been thwarted by complacency and pushback from some leaders and the absence of the will and the courage to demand compliance from others. This has resulted in the absence of substantive change, and Black faculty who too often find themselves barely surviving rather than thriving.

## Absence of accountability with corrective action for students, trainees, faculty, and staff who commit acts of aggression, discrimination, and racism

*"This person was speaking in derogatory terms about other physicians of different racial backgrounds. Given this person's status, for years, many of these issues were simply swept under the proverbial rug. Also, such behavior has been previously reported to leadership and nothing was done to address or punish such actions."*
*"Since I started working at the PDC clinic, I have struggled to be treated equally, as an underrepresented minority and woman, compared to my non-minority male colleagues. I am treated differently, in many ways, as simple as the way I am addressed when I arrive, making my patients wait longer than my male colleagues' patients, or not having my Inbasket messages part of the "clinic pool." I was actually yelled at by a staff member in front of patients and in front of other staff, without any negative repercussions to the staff member who did this to me. I was just told, "She won't be assigned to work with you going forward." I have emailed clinic and divisional leadership on several occasions about this mistreatment. All I ever get is, "I will look into it." However, there is never any change. When will Duke demand that discrimination like this be put to a hard stop by implementing real change (with negative repercussion) should I be treated differently by staff?"*

Failure to hold faculty and staff accountable for racist acts, including discriminatory language, disrespectful behavior, and inequitable support is counterproductive to the creation of an anti-racist environment. Although Duke has attempted to implement a zero tolerance policy for discriminatory or racist acts by patients directed at Black or other underrepresented clinicians and staff, faculty and staff are not held to the same standard and frequently face no consequences for their actions.

## Decentralized ineffective DEI leadership and siloed administrative structure without clear processes of accountability to ensure implementation of policies and practices

Decentralized efforts in DEI across the SOM have led to consistent inability to coordinate and strategize effectively and efficiently. The Office of Diversity and Inclusion has limited resources with only a few staff members and unclear power to affect any significant change in SOM culture. This has led to issues of sustainability, fragmentation, and a lack of coordination of DEI efforts. Although these issues were brought to light years ago, nothing has been done to create effective structures to increase effectiveness of DEI efforts.

## Recommendations

Without processes that ensure accountability and well-resourced structures for oversight at the highest levels of leadership, the SOM and other Duke Health entities will fail to make good on their pledge to dismantle racism. To maximize the effectiveness of DEI and antiracism strategies, we recommend the following.

1. Implement annual reporting of common DEI metrics across Duke Health, including all SOM units (departments, divisions, centers, institutes), with a clear timetable for achievement of benchmarks. These metrics (for example, implementation of equitable hiring strategies, racial/ethnic diversity of faculty and leaders, equitable pay and resource allocation, time to promotion, climate assessment, mentorship

training/processes, etc.) must be mandatory and measurable, with accountability tied to resource allocation and academic advancement. Failure to meet defined common metrics should have real consequences and accountability should extend to all units. For example, if a division fails to implement recommended DEI initiatives or meet benchmarks, this should negatively affect the annual financial package received by the Division Chief from the Department Chair and by the Department Chair from the Dean with similar processes across all Duke Health entities.

2. Develop a systematic process of timely review and plan of corrective action for students, trainees, faculty, and staff who commit acts of aggression, discrimination, and racism. This process would be linked to the review of all incidents entered into a newly created user-friendly reporting system (see previous section--Culture) and include an oversight board responsible for review of incidents and recommendations for corrective action. Guidelines for corrective action should consider the frequency (patterns of behavior) and severity of incidents and recommendations may include participation in processes of restorative justice, completion of relevant training, loss of compensation, suspension and even termination for repeat offenders, demotion from leadership role, loss of resources, etc. To ensure transparency, leaders should report annual, aggregate, de-identified data on acts of aggression and racism along with corrective actions taken to address them.
3. Create an Office of Vice Dean for Diversity, Equity, and Inclusion (DEI) to oversee and ensure compliance with antiracism and DEI initiatives across SOM. This office will provide a centralized structure to ensure accountability across all individual SOM units, and its leader should report directly to the Dean and be fully integrated into the Dean's leadership team. The position will have reach into departments, centers, and institutes across the SOM which would be facilitated by interactions with Vice Chairs (or similar roles) for Diversity, Equity, and Inclusion across each SOM unit (departments, centers, and institutes). The Office of the Vice Dean for DEI would be fully supported financially with dedicated administrative staff and faculty to guide DEI strategy development, implementation, and monitoring of progress. This position will also provide administrative oversight of new SOM DEI initiatives, lead communication on progress to dismantle racism and promote equity and engage in real time communication with the SOM community to receive regular feedback and elicit new recommendations. This office would also serve as the central administrative hub for ensuring compliance with recommendations included in all sections of this document. We recommend similar leadership roles as appropriate for the Health System and PDC.
4. Create a similarly supported position as noted above as part of the Chancellor's leadership team (ex: Vice Chancellor for DEI). Institutional accountability for dismantling racism and improving DEI requires integration across all Duke Health entities. This position would report directly to the Chancellor, monitor the overall progress of individual Duke Health entities (ex: SOM, Health System) on achieving specific DEI metrics, and direct plans and timelines for corrective action as needed.

# Closing Comments

Breathing is a basic, yet necessary component of living. This document contextualizes some of the many aspects of our experiences as Black faculty in the SOM that stifle us, at times making us feel as though we cannot breathe. We are your colleagues, your companions, your confidants, and even your clinicians. The obligations we have to each other are beyond fiduciary. They are built around friendships we share, families we created, collaborations we forged, and frankly lives both saved and lost...all done together. When we say we cannot breathe, what we really mean is that we cannot breathe alone, at least not anymore. We need you to be active participants in this movement. We need you to embrace this moment with us. Inaction and apathy will undermine everything we have built together as a community and perpetuate a status quo that has created inequity in personal and professional success for Black and other underrepresented faculty in academia.

We, therefore, invite you to actively engage in the fight against inequity with us. Share this document. Reach out to your colleagues. Do the internal, individual work and participate in the collective action necessary to bring about real change and dismantle racism. **Breathe with us**.