Everyday Heroism: Maintaining Organizational Cultures of Wellness and Inclusive Excellence Amid Simultaneous Pandemics
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Abstract

Health care professionals and the institutions in which they work are being stretched to their limits amidst the current COVID-19 pandemic. At the same time, a second longstanding pandemic has been brought to the fore: the entrenched system of racial injustice and oppression. The first pandemic is new, and to date, substantial resources have been allocated to urgently addressing its mitigation; the second has a long history with inconsistent attention and resources but has recently been spotlighted more intensely than at any time in the nation's recent past. The authors contend that these 2 simultaneous pandemics have brought forth the need for institutions in the United States to make a renewed commitment to respect, wellness, diversity, and inclusion. While investment and leadership in these domains have always been essential, these have largely been viewed as a "nice-to-have" option. The events of much of 2020 (most notably) have illustrated that committing to and investing in policies, programs, centers, and leadership to drive change in these domains are essential and a "need-to-have" measure. The authors outline the necessity of investing in the promotion of cultures of inclusive excellence at both individual and organizational levels to coordinate a united response to the simultaneous pandemics. It is in the interests of health care systems to consider the wellness of the workforce to overcome the longer-term economic, systemic, and social trauma that will likely occur for years to come at both the individual and institutional levels. Maintaining or augmenting investment is necessary despite the economic challenges the nation faces. Now is the time to cultivate resilience and wellness through a renewed commitment to cultures of respect, diversity, and inclusion. This commitment is urgently needed to support and sustain the health care workforce and maintain outstanding health care systems for future generations.

The COVID-19 pandemic has evolved rapidly from its very beginnings. The first reports of this disease, caused by the SARS-CoV2 virus, were reported from China on December 31, 2019, and first affected the U.S. health care system on January 20, 2020. By December 14, 2020—when the first vaccines were administered in the United States, and just 9 months after the World Health Organization declared a pandemic—there have been over 72 million cases confirmed globally, and over 16 million infections in the United States, with over 300,000 deaths. Health care professionals here and worldwide have worked around the clock to treat patients in an uncertain high-stakes environment: what is known invokes fear, uncertainty, and anxiety.1 It is in these rapidly evolving situations that individuals rely on their gut impulses to act and interact.

Simultaneously, on May 25, 2020, the murder by police of George Floyd, a 46-year-old Black American man was captured on video and disseminated across the globe. The horrific nature of the video and the personal trauma it caused to so many Black Americans who knew "It could have been me"2 has led to intense awareness of an ongoing racial pandemic wrought by an entrenched system of racial injustice and oppression. Unlike the COVID-19 pandemic, this racial pandemic is not new but has recently been spotlighted more intensely than at any time in our recent past. In this case, reactionary thinking, which can sometimes serve us well in the health care setting, will not provide any quick fixes to the pervasive structural inequities that exist, and can in fact erode teamwork and trust at the individual level precisely when needed the most.

Two Pandemics, Two Responses
At the institutional level, we have experienced highly disparate responses to each of these pandemics. On the one hand, broad efforts have been rapidly galvanized across institutions nationwide and globally to detect and eliminate the virus and to ensure that high patient care standards are maintained—all critically important for ending the pandemic. However, the racial pandemic has been propagated by years of organizational inertia and stagnation, which have ensconced the racist structures that break down inclusive, diverse, and respectful workplaces. We argue that organizational apathy and inexperience toward building cultures of respect, diversity, and inclusion will deter the full recovery of our biomedical systems in the wake of both COVID-19 and the national conversations on race.

In addition to caring for patients clinically, each person in our author group has also led efforts at our respective institutions and nationally that foster physician wellness; promote professional development; and ensure diversity, equity, and inclusion. These domains are strongly interrelated where inclusion, justice, and equity are foundational to wellness. Despite the fact that evidence...
substantiates the role of these efforts in improving quality of care and patient satisfaction, as well as in organizational cost savings, many U.S. institutions have historically considered leadership and programs to drive progress in these domains as “nice-to-have” luxuries. However, it is precisely in stressful situations, such as during the COVID-19 pandemic, that best practices to maintain wellness and promote an equitable environment for health care providers from diverse backgrounds must escalate from “nice-to-have” to an urgent “need-to-have” measure. It has become apparent that organizations that had already established leadership and developed the infrastructure to drive organizational change in these areas have been better able to respond and support faculty, although the effectiveness of these responses is still evolving. It is critical to maintain (or initiate) such investment despite the economic challenges we face.

This is, of course, not the first time organizations have faced crisis and emergency; however, these particular simultaneous pandemics are the first of their kind in modern history in terms of global scale and impact. Previous recent crises (e.g., the events of September 11, 2001, the Ebola pandemic, Hurricane Katrina, the global financial crisis) have provided some lessons for organizations to consider in the current context, particularly the fact that organizational culture—including leadership tone, collaboration, employee well-being, adaptability, and imagination—can serve as the differentiating factor between success and failure. For example, following 9/11, James Dunne, managing partner at investment bank Sandler O’Neill, recounted how he held his business concerns in one hand and taking care of the people in his organization in the other hand, finding that the more he focused on his people, the more efficiently the company was able to handle its business concerns. The lesson for leadership in academic medicine is to double down on this focus on people.

In this article, we argue that these 2 simultaneous pandemics in the United States have brought forth the need for institutions to make a renewed commitment to respect; wellness; diversity; and inclusion in the form of investment, policies, programs, centers, and leadership. Below we outline the necessity to address both the individual and organizational dimensions to these challenges to eliminate the structural inequities highlighted by the Black Lives Matter movement, while simultaneously being responsive to the highly reactionary, fast-paced movement of the COVID-19 pandemic and its impact on clinician well-being.

**Individual Responses**

Daniel Kahneman’s 2011 book, *Thinking, Fast and Slow*, distinguishes 2 modes, or systems, of thought. System 1 operates quickly and automatically, whereas System 2 requires continuous exertion from slow and deliberate cognitive processing. In times of crisis, health care professionals must often use System 1 to make the right medical decisions as swiftly as possible. Dependence on System 1 relies on the amygdala, which responds to emotional stimuli and may be reactionary in nature, sometimes resulting in disrespectful, unprofessional, and counterproductive interpersonal behaviors.

Research shows that even the language we use can trigger System 1 processing and result in biased judgment and unintended effects. One current example is the use of the term “social distancing” during the COVID-19 pandemic. This phrase, while intended to protect us, may trigger potential exclusionary behaviors. In fact, what we really mean is to enforce “physical distancing” to reduce the risk of viral transmission while still maintaining the principles of inclusive behavior and social connection. As recently noted by Damon Williams in “The COVID-19 DEI Crisis Action Strategy Guide,” the COVID-19 pandemic is a “diversity and inclusion crisis, with potential for flashpoints and serious damage at any moment.” In the health care setting, reliance on System 1 thinking can lead to unintentional yet harmful insults that can serve as the “flashpoints” Williams describes, as when a Black cardiologist is paged for a consult and upon entering the patient’s room is told by the surgeons: “We don’t need transport, we’re waiting for cardiology.”

In addition, it is important to remember that new social norms, specifically in the workplace, can be spread at all levels of an organization. Our behavior is influenced by social norms and social learning from our interactions with others. For example, the more we interact with colleagues who are willing to share their challenges around, for example, racism in the workplace or even the stigma associated with childcare during COVID-19, the more we will strive to learn how to adapt our behaviors and the behaviors of our teams to meet the needs of others.

Every institution’s plan to fight COVID-19 should include a response strategy, ensuring that inclusive excellence is not only maintained but also enhanced. Resources at the individual level to foster awareness of mechanisms by which we can lean into System 2 thinking and promote empathy through (virtual) social interaction, particularly in times of crisis, can help. These strategies should include evidence-based education on cultivating compassion and emotional intelligence; promoting mindfulness, team building, effective interpersonal communication, and leadership development; and mitigating negative influences such as implicit bias and microaggressions. Also helpful are opportunities for peer support and community-building forums. Just as in more routine times, we must continue to treat one another respectfully, attend to our colleagues’ wellness as well as our own, and ensure that all of our interactions are based on equitable, inclusive, and, as much as possible, evidence-based and not fear-driven practices.

**Institutional Responses**

In addition to mitigating the stress associated with COVID-19 and recently highlighted entrenched racial injustices at the individual level, another important focus for academic leaders is to consider the impact of the pandemics on the workforce. There are already concerns being voiced from trainees and faculty physicians regarding the uncertainties about their careers, including fears about negative effects on faculty hiring, promotion, and research funding due to the effects of COVID-19. As the pain of racial discrimination comes to the forefront, similar ambiguity abounds about how academic institutions can move forward to make meaningful structural change. Academic leadership should quickly address professional development concerns and provide
frameworks for mitigating career bottlenecks that may occur due to restrictions in COVID-related clinical and academic productivity because of the pandemic. At the same time, we must undertake a longer-term examination of policies and processes that reinforce inequities.

In accordance with Helen Lewis’ vivid account in The Atlantic, pandemics create significant gendered and racialized effects with important impacts on women’s health, social roles, economic decisions, and workforce consequences. For example, one stress caused by the COVID-19 pandemic to be considered at the institutional level is the need for 1 member of a dual-career couple (historically, the woman), even among physicians, to cut back on work to meet the family’s childcare needs in the midst of school and daycare closures. We fully anticipate that with over 90% of the U.S. workforce affected at the peak of the stay-at-home orders, the COVID-19 pandemic will result in a recession of recent gains in gender parity and inclusion within our academic health care institutions. The gendered nature of the career impact of COVID-19 has already become manifest in women’s publication of scientific articles.

Various negative consequences will be even more pronounced for individuals from underrepresented racial and ethnic groups. Already burnt-out minority physicians are being asked to give even more of themselves. This “minority tax” or “cultural tax” refers to the disproportionate burden minority faculty may face as they serve to bolster diversity efforts within their institutions, confront everyday racism and a heightened sense of isolation from colleagues, and are asked to take on additional mentorship and, in some cases, clinical responsibilities. It is therefore critical to consider diversity, inclusion, and physician well-being in our strategic approaches to managing our institutions during these concurrent crises.

Unfortunately, large institutions such as academic medical centers are well known for organizational inertia. While some institutions have managed to act more nimbly, for example, those in the Beyond Flexner movement, it is generally difficult to make rapid cultural and policy changes in large, complex environments. However, we must be proactive and break through this pattern. Faculty at all institutions nationwide need to know that they will be supported and that their organizations continue to care not only for the well-being of the patients who are coming through the doors in increasing numbers but also for the well-being of their own workforce. For example, several universities are instituting tenure clock extensions to help to mitigate uncertainty. These tenure clock extensions should be opt-out rather than opt-in to reduce any additional stigma and burden on the individuals most affected. Nationally, the National Institutes of Health is taking steps to address the effects of stoppage of its funded research due to COVID-19 and to ensure timely peer review of applications. These seemingly small policy gestures can lead to great impact as junior faculty at academic health centers must not be made to feel like second-class citizens as they struggle to maintain productivity due to both home stressors and the closure of lab research at most institutions.

In addition, this rapid response to the COVID-19 pandemic must also be taken with full understanding and recognition of the potential impact on reinforcing inequitable institutional structures. Research in organizational behavior and strategic management maintains that an organization is affected by both its internal and external environments. In this sense, an organization is a product both of its employees and their everyday experiences (e.g., faculty worries about productivity affected due to COVID-19, faculty trauma related to experiences of racial injustice brought to light) as well as of the society that surrounds it (i.e., a simultaneous health pandemic and social justice movement). As Holden Thorp, editor-in-chief of Science, writes about racism in scientific disciplines as a whole: “It is time for the scientific establishment to confront this reality and to admit its role in perpetuating it.”

A Call to Action

As institutions come to realize the roles they play in preserving racist norms, longer-term structural change needs to be addressed beginning now, including, among other strategies prominently and purposefully featuring the work of Black and other underrepresented scientists; educating everyone within our institutional communities about diversity within our disciplines and across biomedical science as a whole; diversifying our institutions, with a particular focus on diversifying leadership; and continuing, as leaders, to listen. This listening must come with no strings attached—marginalized faculty at our institutions are not the ones who should be called upon to “fix” the problem; it is incumbent upon our institutions to act quickly but meticulously to fight the concurring pandemics by focusing efforts on overhauling policies associated with faculty hiring, development, and promotion with the express purpose of equity in the face of both COVID-19 and racial injustice.

Ameliorating the unavoidable stress around these issues requires that we as leaders across institutions commit to a shared responsibility through a robust and coordinated response to the unprecedented pressures of these pandemics. While the economic fallout of the COVID-19 pandemic continues to increase, we must focus on the needs of our people. Indeed, it is in the interests of our health care systems to consider the wellness of faculty and trainees, as we all work together not only to battle COVID-19 but also to overcome the longer-term systemic injustices we face.

Watching the truly heroic efforts of health care professionals during the COVID-19 crisis brings to light the “inherent humanitarianism” of the medical profession. Indeed, the role of the doctor and other health care professionals practicing medical professionalism is to “improve outcomes and counter our vulnerability to the unseen biases we all harbor.” While organizations often consider these values as beneficial in prosperous times, the critical and foundational nature of these efforts to our mission is revealed in times of distress. Now is our time to cultivate resilience and wellness through a renewed commitment to cultures of respect, diversity, and inclusion. This commitment is urgently needed to support and sustain the health care workforce and maintain our outstanding health care systems for future generations.
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References


19 Thorp HH. Time to look in the mirror. Science. 2020;368:1161.

