Eliminating Systemic Racism: Ethical Choices for Leadership Development

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Eliminating systemic racism is a multi-generational effort and there is no single project, class, or law that will achieve racial equity. However, though "organizational leaders may not be able to change the world, they can certainly change *their* world" (Livingston, 2020, para 1). But to do that, leaders must first be able to recognize racism, and White people are not very good at this. Just this year, the University of Maryland Critical Issues Poll showed that not only are White Americans not good at recognizing racial discrimination against non-White groups, more and more White Americans are perceiving racial discrimination against other Whites (Rouse and Telhami, 2022). This trend has shown itself at my own workplace (hereinafter "the hospital" or "Hospital"), an attitude that is severely limiting the effectiveness of our IDEA (inclusion, diversity, equity, and access) efforts.

Hospital leadership is unclear what steps might be more effective. I posit that for leaders devoted to equity, diversity, and inclusion, ethical analysis points to devoting their limited professional development time to sustained, focused racial equity education and practice. This becomes an ethical dilemma because leaders have limited professional development time and must choose how to devote it (i.e., improvement for the self vs. improvement for others). I argue that—aside from necessary hours to maintain licenses and required certifications—all available leadership professional development resources are most ethically applied to our anti-racism work, as we have made a commitment to our patients, families, and community to eliminate systemic racism at the hospital.

Narrative and Summary of the Issue

Over the past few years, Hospital IDEA efforts have led to improvement in some areas, particularly targeted improvements in patient care and increased diversity hiring. However, retention rates for Black and Hispanic employees have worsened in the past two years and exiting employees of color continue to cite systemic racism as the first or second driving factor for leaving. In addition, our

experience confirms what a 2021 study by Iheduru-Anderson found--that non-White nurses are reluctant to leave secure union positions to move into leadership roles, citing lack of mentorship and lack of racial leadership representation.

Senior leadership at Hospital is about 70% White, an improvement over the national average, of 89% (Haefner, 2021), but the top five jobs (CEO, COO, CNO (nursing), CMO (medical), and CFO) are held by Whites. This is not necessarily bad, but it may handicap those leaders when it comes to "recognizing certain behavior patterns *as* racist" (Mills, 1997/2022, p. 127, emphasis his). As Livingston (2020) puts it, "[m]any White people…assume that racism is defined by deliberate actions motivated by malice and hatred" but "defined simply as differential evaluation or treatment based solely on race, regardless of intent, racism occurs far more frequently than most White people suspect" (para 1). Though senior leaders express concern when racial incidents are reported, not much has changed at the mid-level of management, and HR continues old practices (despite new written guidelines). And our staff keep leaving.

The problem, in summary, is that we have a group of White leaders attempting to lead IDEA efforts that are not working with respect to employees, which can and does lead to impact on our patients.

Analysis

Dialogic Ethics

Dialogic ethics emphasizes the relationships between people, rather than philosophical theory (Ballard, et al., 2016). Dialogic ethics calls on us to value difference as a source of learning, to create deliberate space for dialogue, and to train ourselves as leaders and communicators to be ready to engage in dialogue when opportunities arise (Arnett, et al., 2017). This model invites us to think about how we view ourselves and others, and to ask ourselves how we might learn from others through dialogue (Arnett, et al., 2017). However, dialogue must never be forced, and both monologue (which

"looks to the self for answers") and technical communication (which "looks to public feedback") are both valid communication modes (Arnett, et al., 2017).

This theory provides both a justification and model for racial equity leadership education. As a justification, dialogic theory demonstrates that understanding and respecting others is a continuous process. Until we have achieved racial equity within our spans of control, we still have work to do. As a model, it provides a structure for approaching difficult conversations about race and equity with guideposts for how to pursue those conversations respectfully.

Potter Box

The "Potter Box" is a tool to guide an individual, group, or organization through a "model of moral reasoning" that highlights areas of common misunderstanding (Christians, 2013, p. 3). By defining the problem or situation, then identifying the underlying values and principles, we can pinpoint the loyalties of a decision-maker faced with an ethical issue and understand the actions taken (Christians, 2013). Christians (2013) argues that understanding loyalties is the most important part of understanding or making an ethical decision, as this is the area "we tend to beguile ourselves" (p. 4). The Potter Box can be used as both a retroactive analysis tool to understand or explain the actions of someone else, or as a proactive tool to guide decisions, actions, or policies (Christians, 2013).

Situation: Retention rates and promotions for Black and Hispanic employees remains unsatisfactory. White employees complain that diversity programs are unnecessary and punitive.	**Loyalties**: 1. Patients and families (first) 2. Employees 3. Community
Values: Equity, Excellence, Collaboration, Compassion, and Excellence* **Note: These are 5 of our 6 corporate values. The 6th is innovation and relates primarily to research, facility design, and processes*	**Principles:** 1. Healthcare outcomes are tied to patient/provider racial [and gender] concordance (Trent, et al., 2019) 2. Diverse teams perform better (Rock and Grant, 2016) and provide safer care 3. Commitment to become an anti-racist organization

As stated above, Hospital has made progress toward achieving racial equity in some areas of patient care. Two examples are reduction in code purple (security) calls for non-White families and significantly reduced readmission rates for Asian surgical patients in one division. Both gains were because of approaches learned from other institutions or from research and applied at Hospital. In the case of surgical readmission reduction, they saw unexpected improvements in other areas, which the team believes is because of the heightened awareness of certain unconscious behaviors. However, when it comes to employee relations, the same focused effort has not been applied. There have been 1–3-day seminars, book recommendations, and discussion groups that ebb and flow, but not a sustained cycle of education (all leaders), application, analysis, improvement. If the same approach were taken with employees that has been taken with patients—that is, *learn* what is working somewhere and apply it at Hospital—we might see similar results in our employee retention and promotions, which is part of the commitment we have made to the community to eliminate racism at Hospital.

Rest's Model

James Rest offers a four-step model of moral decision making: moral sensitivity, moral judgment, moral focus, and moral character (Johnson, 2011). Rest argues that moral sensitivity (recognition) starts with considering "how our behavior affects others" (Johnson, 2011, pp. 236-7). Rest notes that emotional response is often a sign of an ethical dilemma and differentiates between other-facing emotions and self-facing emotions (Johnson, 2011). Paying attention to our emotions can help us determine if we are facing an ethical or moral situation (Johnson, 2011). Once the problem is recognized, we then make a judgment about right or wrong based on our level of moral maturity, then determine our course of action based on moral motivation (e.g., honesty vs. self-preservation) (Johnson, 2011). Finally, our moral character is defined, per Rest, by whether we follow through with action (Johnson, 2011).

Rest's model provides a clear ethical argument for Hospital leadership to devote their professional development time to anti-racism work. If, as our leadership team says, becoming an anti-racist organization has primacy, then the morally mature choice is to devote our resources to the task and follow through with action.

Power, Politics, and Influence

This is not a theory, but a set of interrelated ideas. Johnson (2019) provides guidance on types of power (coercive, reward, legitimate, expert, and referent), explaining that no "form of power is inherently immoral" (p. 122). Rather, understanding how power works and when to employ it is the key to using power influence ethically. Likewise, he explains that organizational politics are not inherently negative or unethical, but rather a type of informal power that can be wielded for the good of organizational objectives (positive) or personal gain (negative) (Johnson, 2019). Finally, Johnson (2019) explains that any influence tactic (such as framing, impression management, etc.) has an ethical element, and we should use care and judgment when choosing how we wield our influence.

For leaders, learning how to effectively exert influence to achieve racial equity would be a valuable use of professional development time. Senior leaders, who are role models for the entire organization, could both teach and learn better when to exert different types of power and use their informal networks to influence behavior. Particularly in our human resources and middle management level, continued, sustained education and practice is needed to learn specifically how to use referent power, rather than resorting to coercive or legitimate power to try to get results. There is a place for both in anti-racism work; however, as we are seeing a "White backlash", more gentle forms of influence may be more effective. This is hard work that middle managers often do not feel they have time to do, and this is an area where senior leaders could use their own formal power to prioritize this type of learning for subordinate leaders.

Formal and Informal Culture

The formal elements of a culture are those that are "officially acknowledged and recorded" and include things like mission and value statements, the board of directors, code of ethics, evaluation and communication systems, and structures (Johnson, 2019). Informal elements are the language, norms, rituals, and stories that are not necessarily officially codified (Johnson, 2019). If informal and formal elements are not aligned, Johnson (2019) asserts that the informal elements will likely be more prevalent in the organizational culture.

This is very evident in our anti-racism work, and one of the reasons I think ongoing leader education is so important. We have written policies and values statements documenting our commitment to racial equity. Yet employees, patients, and families continue to experience racial discrimination. In 12 years at the Hospital, I have met exactly two people I would characterize as "bad people"—one is no longer with the organization, and the other is not in a position to wield much influence. Therefore, the discrimination experienced is being perpetrated by good people with good intentions who likely do not know they are behaving in a biased manner. Having leaders who are skilled at seeing and coaching unconscious bias, microaggression, and other forms discrimination will be the most important element, I believe, in evolving our culture.

Memory and Dwelling

Arnett (2017) describes memory as "a sense of organizational conscience, retaining what a given organization deems as good" (p. 138). This concept is primarily focused on how together we create and maintain the story of an organization, which then evolves over time, but is never the story of a single individual (Arnett, 2017). Dwelling, as I understood it, is the collection of stories and memories that makes an organization unique. For example, at my hospital, we have the story of how we were founded over 100 years ago by a group of prominent women who went door-to-door collecting pennies to open a hospital for children which, from the beginning, provided care to all regardless of race, religion, or ability to pay. There are stories of the early volunteers, of the foundation members seeking out sick

children and convincing their parents to bring them for treatment, and our halls are lined with pictures of those women and captions with their stories.

On the other hand, we have recent incidents of a prominent Black physician leaving the hospital less than two years ago, citing systemic racism, as well as specific racially derogatory comments leveled at him by a senior leader (who was eventually dismissed). There were media stories about his departure, as well as stories from parents of former patients who died or had negative experiences due to racial discrimination. Those stories do not align with how we see ourselves at my hospital, and I know it is not how I want my generation of Hospital stewards to be remembered. In order to preserve the community of memory and dwelling of this special place, our leadership team needs to be prepared with the education, skills, and fortitude to persevere until we can look at patient outcome and employment statistics and see no differences attributable to race.

Recommendations

I recommend that that every leader in the Hospital who has direct reports engage in 3-5 hours per week of specific racial equity and ethics education for two years. I also recommend bringing back our outside consulting agency to oversee the curriculum and provide specific coaching and practice opportunities. Finally, I recommend adopting Ron Livingston's (2020) PRESS model: 1) problem awareness; 2) root-cause analysis; 3) empathy; 4) strategies; and 5) sacrifice ("willingness to invest the time, energy, and resources necessary for strategy implementation").

Though this is an unusual use of development resources, and would require specific funding and structure to support, we are attempting to eradicate systemic racism in an organization that has existed, as noted above, for over 100 years, within a society that cannot consistently recognize systemic racism, much less eradicate it.

The American Academy of Pediatrics called racism "a socially transmitted disease passed down through generations, leading to the inequities observed in our population today" (Trent, et al., 2019, p.

3). In the same white paper, Trent, et al., (2019) examine the impacts of redlining on current neighborhoods, including lack of access to healthcare, and linked poor healthcare outcomes to both race outright and patient/provider racial concordance. If my hospital wants to maintain its historical memory as a place that cares for all children, as well as be one of the best children's hospitals of the future, we must find a way to achieve our goal of eliminating racism from our hospital. Since the majority of our workforce enjoys skin privilege and has to work to see or understand how insidious the discrimination is for those who do not, the investment in racial equity and ethics education is both necessary to achieve our goals, and the *right thing to do* for those leaders who are being held accountable for progress of our IDEA efforts.

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