



THE ASSOCIATION OF PROGRAM DIRECTORS
IN SURGERY

DIVERSITY & INCLUSION **TOOLKIT**



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TABLE OF CONTENTS

DEFINING THE PROBLEM	7
I. ESSENTIAL DEFINITIONS	8
II. DEFINING UNDERREPRESENTED POPULATIONS	9
WHERE ARE WE NOW?	11
I. ADDRESSING HEALTH CARE DISPARITIES	12
II. CURRENT STATE OF AFFAIRS	13
III. ACGME DIVERSITY & INCLUSION REQUIREMENTS	14
IV. ASSESSING YOUR READINESS	15
V. RECRUITING DIVERSITY CHAMPIONS	16
VI. COMMON CONCERNS: DIVERSITY & INCLUSION	17
VALUE OF DIVERSITY & INCLUSION	22
MAKING AN IMPACT	25
I. CURRENT SURGERY RESOURCES	26
II. DEVELOPING A DIVERSITY STATEMENT	27

III. INCREASING THE PIPELINE	28
i. OUTREACH THROUGH NATIONAL STUDENT ORGANIZATIONS	28
ii. URM STUDENT OPPORTUNITIES	30
iii. PREPARING STUDENTS FOR RESIDENCY APPLICATION	31
iv. RESIDENCY RECRUITMENT	33
IV. SUPPORTING, RETAINING, AND PROMOTING DIVERSE RESIDENTS	42
i. SHOWCASE DIVERSITY	42
ii. PROMOTE REPRESENTATION IN NATIONAL SOCIETIES	43
iii. ACCOMMODATE RELIGIOUS DRESS	46
iv. SUPPORT INTERNATIONAL MEDICAL GRADUATES	46
v. RECOGNIZE THE MINORITY TAX	47
vi. RESPOND TO BIAS INCIDENTS	49
vii. SUPPORT, MENTOR, & SPONSOR URM RESIDENTS	51
viii. EDUCATE & TRAIN ON DIVERSITY & INCLUSION	52

BIBLIOGRAPHY	70
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INTRODUCTION

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ABOUT THIS RESOURCE

Diversity, inclusion, and equity have been highlighted by the Accreditation Council for Graduate Medical Education (ACGME) as key elements for training. **William A McDade, MD, PhD**, who was named the first ACGME diversity and inclusion officer in March 2019, explained, “In order to train the next generation of physicians to be prepared to care for the American public, we must ensure that opportunities to train in all areas of medicine are open to diverse populations... Additionally, the clinical learning environment must be safe and inclusive for all residents and fellows to afford the best possible means to achieve this.”

This toolbox was created as a collaborative, multi-institutional effort and represents the **Association of Program Directors in Surgery’s (APDS)** determination to uphold the highest standards of inclusion and promote equity and diversity in training programs. By compiling practical resources and data on the subject of diversity as it pertains to race, religion, sexual orientation, and other groups underrepresented in surgery, we hope to promote unity.

This toolbox was developed in response to several described limitations to promoting diversity and inclusion in surgical training. Many programs have difficulty identifying candidates underrepresented in medicine (URM) to interview or interview and rank but don’t match URM candidates. Ultimately, those involved in surgical training must be willing to do the hard work to promote inclusion of diverse trainees throughout programs, departments, hospitals, and systems. All efforts to recruit surgical trainees who are URM depend on a program’s ability to support, retain, and promote these trainees. The resources here are meant to help training programs identify areas of improvement within their institutions and offer up solutions.

Each contributor emphasized the importance of working with the residency program’s sponsoring institution, Title IX office, Graduate Medical Education office, and department leadership to impact meaningful change. Many meaningful changes to support diversity and inclusion occurred across programs at a single institution.

Promoting diversity and inclusion is important for all health care organizations and should be undertaken with the help and support of the department, hospital, health system, and/or university leadership.



SECTION 1:

Defining *the* **Problem**

In order to have a conversation about diversity and inclusion in surgical training, we need to share a common language regarding these issues, recognize the value of a diverse workforce, and evaluate the current state of underrepresented groups in surgery.

ESSENTIAL DEFINITIONS

As defined by [Race Forward's Race Reporting Guide](#).



DIVERSITY

“There are many kinds of diversity, based on race, gender, sexual orientation, class, age, country of origin, education, religion, geography, physical, or cognitive abilities. **Valuing diversity means recognizing differences between people, acknowledging that these differences are a valued asset, and striving for diverse representation as a critical step towards equity.**”



INCLUSION

“Being included within a group or structure. **More than simply diversity and quantitative representation, inclusion involves authentic and empowered participation, with a true sense of belonging and full access to opportunities.**”



EQUITY

Refers to “fairness and justice and focuses on outcomes that are most appropriate for a given group, recognizing different challenges, needs, and histories. It is distinct from diversity, which can simply mean variety (the presence of individuals with various identities). It is also not equality, or ‘same treatment,’ which doesn’t take differing needs or disparate outcomes into account. Systemic equity involves a robust system and a dynamic process consciously designed to create, support and sustain social justice.”



CULTURAL COMPETENCY

Taking responsibility for learning about the cultures of others with whom we work, teach, and serve and using this knowledge as a basis for interaction.

DEFINING UNDERREPRESENTED POPULATIONS

“

Underrepresented in medicine means those racial and ethnic populations that are underrepresented in the medical profession relative to their numbers in the general population.”

- ASSOCIATION OF AMERICAN MEDICAL COLLEGES

WHO'S CONSIDERED UNDERREPRESENTED?

Groups considered Underrepresented in Medicine (URM) have been traditionally disadvantaged, underrepresented, or inadequately supported in medical training. These groups historically include those identifying as Black or African American, Hispanic, Latino or of Spanish origin, American Indian or Alaskan Native, or Native Hawaiian or Pacific Islander. While groups identifying as Asian are not underrepresented in medicine, based on their minority population status in society, they are subject to bias and discrimination and require specific support. While efforts to increase diversity may center on people from URM groups, achieving inclusivity and equity requires focus on all minority groups.

While race, ethnicity, and gender are important, diversity also takes into account qualitative and experiential attributes, including:

- socioeconomic status
- experiences within the medical community
- interactions with diverse or disadvantaged communities
- growing up in a rural versus an urban area
- being a member of the armed forces
- multiple language fluency
- immigrant status
- gender identity
- sexual orientation and sexual diversity

THE IMPORTANCE OF UNDERREPRESENTED POPULATIONS

Adopted by the Association of American Medical Colleges' (AAMC) Executive Council on June 26, 2003, the definition [of underrepresented populations] helps medical schools accomplish three important objectives:

- shift focus from a fixed aggregation of four racial and ethnic groups to a continually evolving underlying reality. The definition accommodates including and removing underrepresented groups on the basis of changing demographics of society and the profession,
- shift focus from a national perspective to a regional or local perspective on underrepresentation, and
- stimulate data collection and reporting on the broad range of racial and ethnic self-descriptions.

[The 2003 Institute of Medicine report on racial and ethnic disparities in health care](#)



SECTION 2:

Where Are We Now?

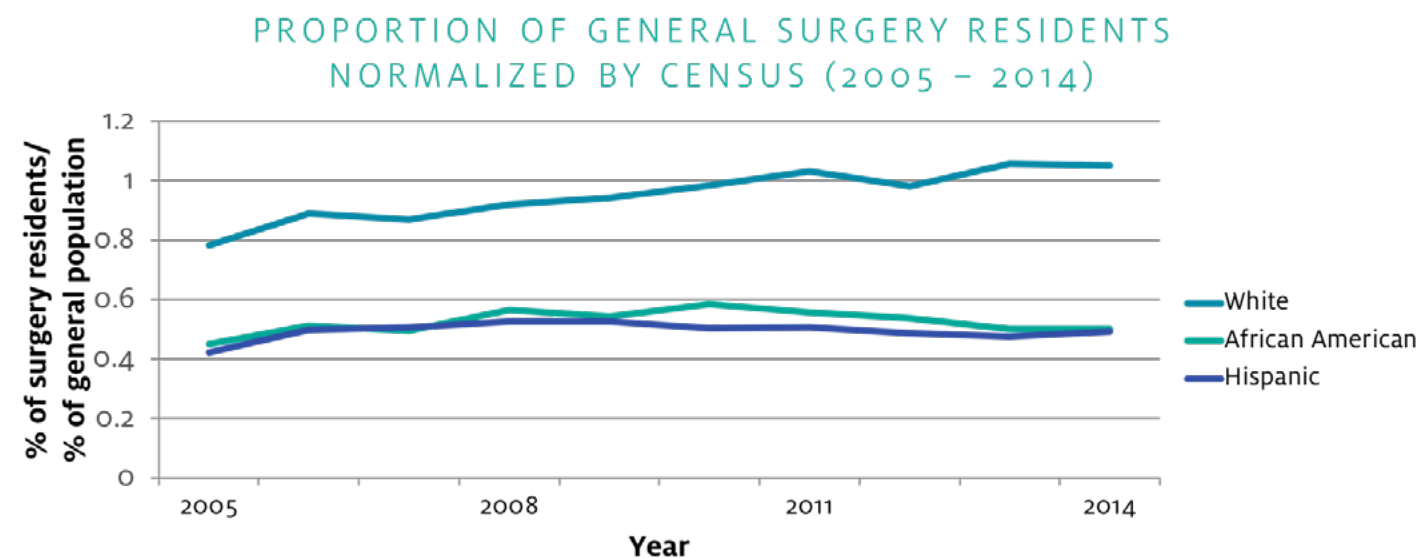
This section contains actionable tools to help surgical residency programs invite diversity and inclusion and assess their readiness to support a diverse group of surgical trainees.

ADDRESSING HEALTH CARE DISPARITIES

initiated a focus on increasing participation of underrepresented minorities as health care providers to change the inequity in care for people who are racial or ethnic minorities.

“Racial and ethnic minorities tend to receive a lower quality of health care than non-minorities, even when access-related factors, such as patients’ insurance status and income, are controlled... The health care workforce and its ability to deliver quality care for racial and ethnic minorities can be improved substantially by increasing the proportion of underrepresented U.S. racial and ethnic minorities among health professionals.”

While racial makeup of medical students and faculty is collected and reported, little is known about racial diversity in residency because all data is self-reported and optional. We have statistics regarding gender, but a relative absence of data on underrepresented trainees (e.g., ethnicity, sexuality, or socioeconomic status).



CURRENT STATE OF AFFAIRS

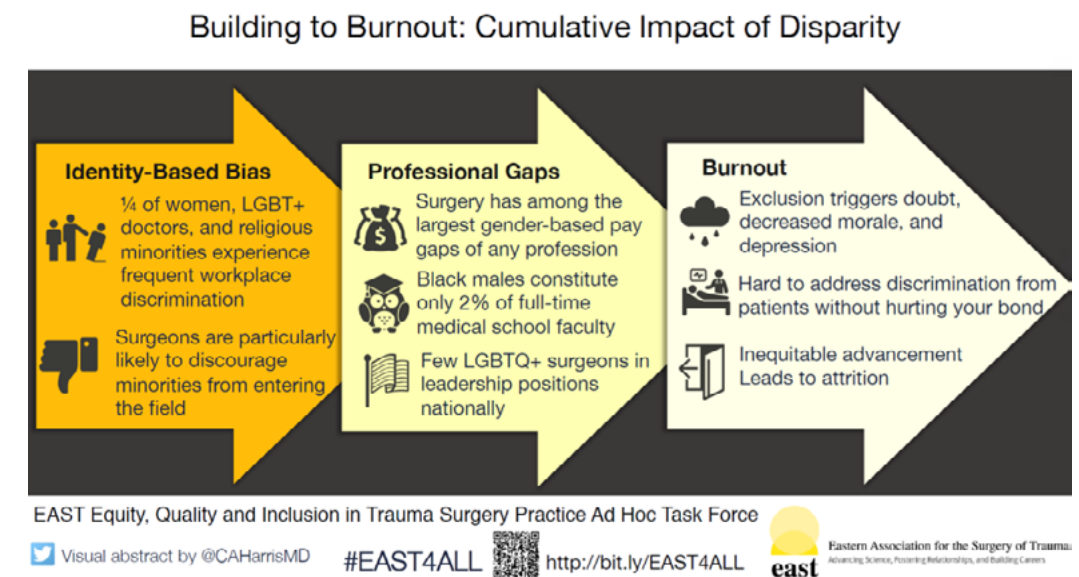
The current state of racial diversity in academic surgery demonstrates that Blacks and Hispanics continue to be underrepresented:

According to Abelson, et. al., “In 2014–2015, Blacks represented 12.4% of the U.S. population, but only 5.7% graduating medical students, 6.2% general surgery trainees, 3.8% assistant professors, 2.5% associate professors and 2.0% full professors.

“In 2014–2015, Hispanics represented 17.4% of the U.S. population but only 4.5% graduating medical students, 8.5% general surgery trainees, 5.0% assistant professors, 5.0% associate professors and 4.0% full professors. There has been modest improvement in Hispanic representation among general surgery trainees (0.2%/year, $p < 0.01$), associate (0.12%/year, $p < 0.01$) and full professors (0.13%/year, $p < 0.01$).”¹

Role of Black/African American women in US academic surgery (Berry C, Ann Surg, 2020)²:

- 0.79% of US medical school surgical faculty (123/15,671; 59% assistant professors)
- 10 full professors of surgery
- 0 chairs of departments of surgery
- Recipients of 0.34% of NIH grants awarded to academic surgeons in the last 20 years (31/9139 grants)



ACGME DIVERSITY & INCLUSION REQUIREMENTS

The Accreditation Council for Graduate Medical Education (ACGME) has made diversity and inclusion an important consideration of the accreditation process for graduate medical education in general surgery. As of July 1, 2019, the common program requirements state that the program, in partnership with its Sponsoring Institution:

- Must systematically recruit and retain a diverse and inclusive workforce, including residents, fellows, faculty members, and senior administrative staff members.
- Must assess the program's efforts to recruit and retain a diverse workforce.
- Must consider workforce diversity in the program evaluation committee's evaluation.
- Must have residents demonstrate competence in respect and responsiveness to diverse patient populations (including but not limited to: gender, age, culture, race, religion, disabilities, national origin, socioeconomic status, and sexual orientation) as part of the educational program.



ASSESSING YOUR READINESS

The tools below help institutions consider their readiness to develop a culture that supports diversity, inclusion, and equity.



THE DIVERSITY AND INCLUSION PULSE CHECK

Consisting of 10 questions, this “pulse check” is a short quiz that will help you determine whether your organization is ready to leverage diversity and engage every employee.



DIVERSITY AND INCLUSION PULSE: 2017 LEADER'S GUIDE

Russell Reynolds Associates surveyed 2,167 executives internationally to understand how companies align themselves around diversity and inclusion. Check out some of the key insights in this excerpt.



INCLUSIVE EXCELLENCE TOOLKIT

Designed by University of Denver CME staff to assist in implementing inclusive excellence, this resource is intended for staff, students, deans, vice chancellors, managers, directors, chairs of committees, and other individuals who want to begin the discussion, exploration, and practice of embedding inclusiveness throughout their areas of responsibility.



READY FOR EQUITY IN WORKFORCE DEVELOPMENT

Designed as a guide for workforce development organizations to evaluate their programs, practitioners can use this toolkit to familiarize themselves with various practices and policies that support institutional racial equity, evaluate their current efforts, and plan action steps.

RECRUITING DIVERSITY CHAMPIONS

“History will have to record that the greatest tragedy of this period of social transition was not the strident clamor of the bad people, but the appalling silence of the good people.”

-MARTIN LUTHER KING JR.

“When you’re accustomed to privilege, equality feels like oppression.” - Unknown

THE ROLE OF THE WHITE GUY IN DIVERSITY & INCLUSION

(Adapted from “The Role of the White Guy in Diversity and Inclusion” by Dr. Dan Dent, General Surgery Residency Program Director, University of Texas, San Antonio (presented at the Diversity and Inclusion panel, APDS 2019))

White men have traditionally had power and opportunity in surgery. This is the group most poised to help strengthen the field of surgery through inclusion of other types of people and ideas. They are the people most able to sponsor women and URM groups by recommending them for inclusion on a committee, panel, presentation, project, or award.

Perhaps most important thing that someone working in diversity and inclusion needs to bring to the table is a willingness to listen. It is not enough just not to be the enemy. White men can be excellent allies. To be an ally, you cannot keep quiet when you see discrimination, inequality, or microaggressions; you must speak up.

Recognize diversity and inclusion is good for all people. It is *not* about giving opportunities to people who are undeserving or denying opportunities for you. It is about identifying those who are deserving through non-traditional means.

COMMON CONCERNS: DIVERSITY & INCLUSION

LOWERING STANDARDS

How do you address the pervasive concern that in order to improve diversity and inclusion, one has to lower standards? Is this a fair concern?

Promoting diversity and inclusion is about expanding your idea of “standards.” It is unfair to assume that all URM applicants are not meeting the rigorous standards required for being accepted to medical school and subsequently completing residency training. However, some differences in resources and experiences may mean these residents need different resources to be successful in their training programs.

Case Study - Residency Applicant Review: You are evaluating 2 students. Student #1 was raised in a safe East Coast community with two professional parents, was a star volleyball player at an excellent private preparatory school with access to private tutors, and earned early admission to Yale, where her academic record included a 4.0 GPA. She was accepted to an Ivy League Medical School and spent her first summer working in the research lab of the chair of surgery, who is a family friend. She has multiple publications from that summer. Her step 1 score was 246, and she received an honors in her surgery clerkship. Student #2 attended an inner-city public school, was self-supporting at community college while working a full-time day job, and then transferred to a state university on scholarship. She was in a work-study program and also helped support her mother and younger brother financially, while earning a 3.7 GPA. She received full support to attend her state medical school, earned a 228 on Step 1, did not perform research, and received an honors in her surgery clerkship.

Student #1 has a more impressive pedigree, research experience, and higher Step 1 scores. However, student #2 has succeeded despite overwhelming obstacles, demonstrating grit, determination, and perseverance. Your program uses 230 as a cutoff for Step 1 score. Is it important to consider student #2 despite quantitatively lower performance metrics than student #1?

Improving diversity in medicine is not about selecting candidates simply based on race, gender, or ethnicity. It’s looking more in depth at candidates to see past indeterminate test score cutoffs to determine who might add a different perspective to your program. For programs with a large Spanish-speaking population, applicants with Spanish fluency

(regardless of race or ethnicity) may be considered more carefully. For programs serving a community that is largely African-American or of a specific religious minority group, it can be very powerful and engender trust from patients to see doctors who not only look like them, but understand their customs and socioeconomic situation and can help navigate our complex medical system.

REVERSE DISCRIMINATION

If your department is supporting special events for women in surgery groups, why aren't there men in surgery groups? Isn't this reverse discrimination?

“Women” in this question can be substituted for any underrepresented group in surgery. All surgery groups have traditionally been “Men in Surgery” groups. Men are not being excluded from Women in Surgery groups, but underrepresented groups require support to thrive. [As described by Zeba Blay](#): “Why isn’t there a White History Month?’ you ask? To repeat a very true cliché: all history is White history. Most Black children in America will learn they are descended from slaves before they learn they are descended from ancient African civilizations.”

Leveling the playing field by supporting underrepresented groups is not “reverse discrimination.”

“BUT I’M NOT RACIST”

Excerpts from Dr. Deborah Cohan’s sincere reflection on how White physicians can honestly consider and act to combat their own implicit biases.

“If I truly want to be part of the solution, I need to explore those parts of me that are most unwholesome, embarrassing, unflattering, and generally not discussed in the context of one’s career. My goal is to dismantle the insidious thoughts that reinforce a hierarchy based on race, education, and other markers of privilege that separate me from others. These thoughts, fed by implicit bias, are more common than I find easy to admit. Although I know not to believe everything I think, I also know that thoughts guide attention, and attention guides actions. Until I bring to light and hold myself accountable for my own racist tendencies, I am contributing to racism in health care...

“I find that dwelling on my shame is counterproductive, that compassionate self-examination allows me to go deeper. I acknowledge my privilege; I recognize that the system that benefits me causes others to suffer. I openly and humbly acknowledge that my racism is harmful. And I commit to a process of uncovering and exploring my biases wherever they lie, lest they wield power and I abet a culture of racism. If we white

physicians are to heal others and ultimately the health care system, we must first heal ourselves...

“The first step, I believe, is to train ourselves to question ourselves and each other reflexively, consistently, and with curiosity: How am I perpetuating systemic inequities for patients? What am I doing to ensure inclusion and promotion of physicians of color? What are my practices for checking myself? And how can we acknowledge the racism within us without making it a character judgment that precludes behavior change?”³





SECTION 3:

The Value of **Diversity & Inclusion**

The major goals of diversity efforts in graduate medical education are to:

- 1. Create a physician workforce that at least reflects the general population of the US and the specific local population of the training program in order to eliminate health disparities and better understand social and cultural determinants of health.*
 - 2. Develop an environment where differences are embraced and supported so that all participants have an equal opportunity for success.*
-

THE CASE FOR DIVERSITY IN HEALTH CARE

SUMMARIZED FROM “THE NEED FOR DIVERSITY IN THE HEALTH CARE WORKFORCE” FACT SHEET:

Diversity improves access to health care for underserved patients:

- African American, Hispanic, and Native-American physicians are much more likely than are white physicians to practice in underserved communities and to treat larger numbers of minority patients, irrespective of income.
- African American, Hispanic, and female physicians are more likely to provide care to the poor and those on Medicaid.

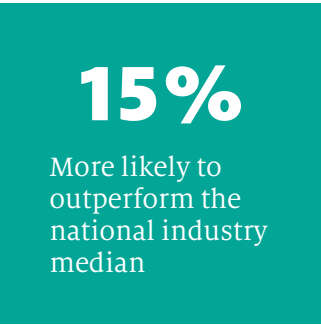
Diversity leads to increased patient choice and satisfaction for racial and ethnic minority patients:

- Racial and ethnic minority patients who have a choice are more likely to select health care professionals of their own racial or ethnic background.
- Racial and ethnic minority patients are more likely to report receiving higher-quality care when treated by a health professional of their own racial or ethnic background.

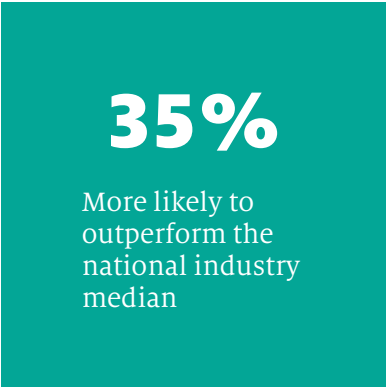
Increasing diversity in medical education helps address current disparities in health care. By encountering and interacting with individuals from a variety of racial and ethnic backgrounds during their training, health professionals are better able to serve the nation’s diverse society by having broadened perspectives of racial, ethnic, and cultural similarities and differences.

IMPROVING PERFORMANCE

According to a McKinsey analysis, diversity correlates with [better financial performance](#) in business⁴:



GENDER-DIVERSE COMPANIES



ETHNICALLY DIVERSE COMPANIES

Diversity also helps [improve organizational performance](#)⁴:

Diversity management helps to...	Rationale
...win the war for talent.	■ A strong focus on women and ethnic minorities increases the sourcing talent pool, a particular issue in Europe. In a 2012 survey, 40% of companies said skill shortages were the top reason for vacancies in entry-level jobs.
...strengthen customer orientation.	■ Women and minority groups are key consumer decision makers: for example, women make 80% of consumer purchases in the UK. ■ Gay men and women have average household incomes that are almost 80% higher than average.
...increase employee satisfaction.	■ Diversity increases employee satisfaction and reduces conflicts between groups, improving collaboration and loyalty.
...improve decision making.	■ Diversity fosters innovation and creativity through a greater variety of problem-solving approaches, perspectives, and ideas. Academic research has shown that diverse groups often outperform experts.
...enhance the company’s image.	■ Social responsibility is becoming increasingly important. ■ Many countries have legal requirements for diversity (e.g. UK Equality Act 2010)



ONE-MINUTE PROFESSOR: DIVERSITY IN HEALTH CARE

Dr. Quinn Capers, IV, an interventional cardiologist at Ohio State University, takes on the institution’s “One Minute Professor” YouTube series to summarize the importance of diversity in medicine.



THE DIFFERENCE: HOW THE POWER OF DIVERSITY CREATES BETTER GROUPS, FIRMS, SCHOOLS, AND SOCIETIES (AAMC)

Scott E. Page, PhD, a leading scholar in the role diversity plays in organizations and society, and AAMC chief diversity officer **Marc Nivet, EdD**, discuss the importance of diversity and inclusion in academic medicine, the value diversity and inclusion add to medical education and health care, and how diversity influences the complex system of health care.

SECTION 4:

Making *an* **Impact**

This section contains actionable tools to help surgical residency programs invite diversity and inclusion and assess their readiness to support a diverse group of surgical trainees.

CURRENT SURGERY RESOURCES

SURGICAL ASSOCIATION DIVERSITY HANDBOOKS

The **American Surgical Association’s** Handbook, [*Ensuring Equity, Diversity, & Inclusion in Academic Surgery*](#), is a living document designed to identify hurdles and develop a set of solutions and benchmarks to aid the academic surgical community in achieving these goals.

“Surgery needs to identify areas for improvement [in diversity, equity, and inclusion] and work iteratively to address and correct past deficiencies. This requires honest and ongoing identification and correction of implicit and explicit biases. More diverse departments, residencies, and universities will improve our care, enhance our productivity, augment our community connections, and achieve our most fundamental ambition – doing good for our patients.”

Eastern Association for the Surgery of Trauma (EAST) developed in 2019 EAST Equity, Quality, and Inclusion in Trauma Surgery Practice Ad Hoc Task Force. This task force developed the [*#EAST4ALL EAST Equity, Quality, and Inclusion Toolkit*](#), which discusses harassment and discrimination, the gender pay gap, implicit bias and microaggressions, and call-out culture. (PDF under “EAST4ALL Toolkit” and “EAST4ALL Visual Abstracts”)



DEVELOPING A DIVERSITY STATEMENT

As an ACGME requirement, residency programs must state their individual and their sponsoring institution’s commitment to diversity.

The ACGME Core Common Program Requirements in Surgery (2019) state: “The program, in partnership with its Sponsoring Institution, must engage in practices that focus on mission-driven, ongoing, systematic recruitment and retention of a diverse and inclusive workforce of residents, fellows (if present), faculty members, senior administrative staff members, and other relevant members of its academic community.”

Diversity, inclusion, and equity statements are important for defining the program’s mission and vision related to these topics. Ideally, the residency program’s statement should reference the supporting institution’s diversity and inclusion efforts.

INCLUSIVE EXCELLENCE

While not exhaustive, the below list includes several examples of university and independent general surgery residency programs with excellent diversity statements and robust programs.

- [University of Michigan](#)
- [University of Washington](#)
- [University of California San Francisco](#)
- [Brigham and Women’s](#)
- [Stanford](#)
- [Tulane](#)
- [Boston Medical Center](#)
- [University of Wisconsin](#)
- [Hennepin Health Care](#)
- [Atrium Health](#)
- [University of Arizona \(Tucson\)](#)
- [Medical University of South Carolina](#)

INCREASING THE PIPELINE



OUTREACH THROUGH NATIONAL STUDENT ORGANIZATIONS

Strategic outreach and partnership with medical schools, undergraduates, high schools, and URM organizations is an excellent way to inform URM students about and encourage them to apply to your program. For example, residents, fellows, and/or faculty could lead a suturing workshop geared toward these groups, serve on informational panels, or participate in “residency fair” forums to showcase their programs and recruit applicants.

Programs can also partner with diverse medical school groups to mentor or sponsor URM members

interested in the specialty associated with the residency program.



Association of Native American Medical Students (ANAMS)

Student organization representing Native American graduate health professions students in the US and Canada. Goals include providing support and a resource network for all Native Americans currently enrolled in various allied health professions schools. ANAMS strives to increase the number of Native American students in medicine and other health professions.



Latino Medical Student Association (LMSA)

National organization founded to represent, support, educate, and unify U.S. Latino(a) medical students.



Student National Medical Association (SNMA)

Committed to supporting current and future underrepresented minority medical students, addressing the needs of underserved communities, and increasing the number of clinically excellent, culturally competent, and socially conscious physicians.



Building the Next Generation of Academic Physicians (BNGAP)

Strives to help develop a diverse academic medicine workforce that will train medical students and residents to effectively address evolving health care needs and work towards health equity in the U.S.



Medical Student Pride Alliance (MSPA)

Activist and social organization committed to empowering sexual and gender minority medical students and allies, increasing the number of physicians trained in LGBTQ+-inclusive health care, and addressing the unique needs of queer communities through research, advocacy, education, and service.

**These organizations are focused on medical students. Information regarding additional national organizations for physician and surgeon URM groups can be found on page 43.*

URM STUDENT OPPORTUNITIES

The Medical Minority Applicant Registry (Med-MAR)

[The Med-Mar](#) enhances admission opportunities for students from groups historically underrepresented in medicine. Medical school applicants who self-identify as being URM or who are economically disadvantaged can elect to participate in Med-Mar.

Participants’ basic biographical information and MCAT scores will be distributed to the minority affairs and admission offices of AAMC-member schools.

Summer Programs

Investigate opportunities at your local institutions for URM undergraduate and medical students to participate in summer programs. Encourage URM students to participate in summer programs locally or regionally. Many summer programs are research-focused but may include clinically relevant activities, speakers, and opportunities for mentorship.

AAMC has a list of summer undergraduate research programs:

<https://www.aamc.org/professional-development/affinity-groups/great/summer-under-grad-research-programs>

Brown University has a list of URM-focused summer research opportunities available in the East and Midwest regions:

<https://www.brown.edu/academics/college/advising/health-careers/resources/activities-related-health-care/opportunities-students-backgrounds-under-represented-health>



PREPARING STUDENTS FOR RESIDENCY APPLICATION

AVOIDING BIAS: GRADES & LETTERS OF RECOMMENDATION

Studies analyzing medical student performance evaluations (MSPE) and clerkship evaluations found that URM students encountered grading disparities compared to their White colleagues and were less likely than other students to receive honors clerkship grades or be selected for honor society memberships.^{5,6}

Narrative evaluations tend to reflect students’ personal traits rather than competency-related behaviors. An observational study of nearly 90,000 clerkship evaluations from core clinical rotations at 2 medical schools in different geographic areas found that many words and phrases reflected students’ personal attributes rather than competency-related behaviors. There was a significant difference observed in narrative evaluations associated with gender and URM status, even among students receiving the same grade.⁷



The Gender Bias Calculator

Plug your letter of recommendation for a candidate into this tool and receive an assessment of “female-associated” and “male-associated” words used.



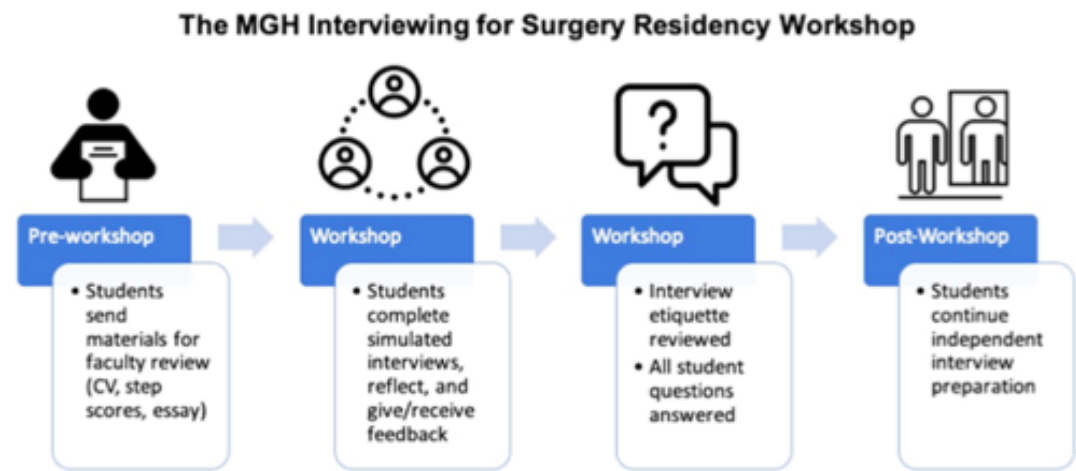
Tip Sheet: Avoiding Gender Bias in Reference Writing

This resource, created by the University of Arizona’s Commission on the Status of Women, provides quick tips to reduce gender bias when writing letters of recommendation.

RESIDENCY INTERVIEW PREPARATION

Consider hosting a residency interview workshop to prepare URM students for success in the interview process. Massachusetts General Hospital’s eBook “**Prepare Students for their Surgical Residency Interviews with a Residency Workshop**” details how one hospital runs its workshops with review of ERAS application, mock interviews with surgeons, and applicant reflection: <https://www.facs.org/education/division-of-education/publications/rise/articles/interview>.

Figure 2. The Massachusetts General Hospital (MGH) Interviewing for Surgery Residency Workshop



MENTORED CLERKSHIPS

Offer a funded, mentored student clerkship for URM students as an opportunity for mentorship and clinical experience. The Funded Away Rotations for Minority Medical Students (FARMS) Database is a directory of away electives for medical students from backgrounds underrepresented in medicine: <https://www.farmsdatabase.com/>.

BEST PRACTICE





University of Pennsylvania developed a 3-faceted approach for surgical residency recruitment: (1) a URM-focused 4-week paid visiting clerkship program with a \$1500 reimbursement for lodging and travel; (2) a holistic review of residency applications that attenuated the focus on traditional metrics such as board scores, grades, and number of authored publications and placed a heightened emphasis on candidates’ experiences and attributes; and (3) targeted outreach to candidates from the University of Pennsylvania’s Alliance of Minority Physicians including a URM-focused housestaff, junior faculty, and medical student support and mentorship network.⁸

RESIDENCY RECRUITMENT

DEVELOPING AN INCLUSIVE RESIDENCY PROGRAM WEBSITE

Create a website that reflects your program’s diversity and inclusion efforts. Consider featuring resident “bios” that include their photo, hometown, medical school, languages spoken, hobbies, and why they chose your program. [Atrium Health’s website](#) provides a great example. Faculty biographies with similar personal information may help demonstrate your program’s diversity and attract diverse candidates.

Also Consider Including⁹

-  Educational support systems available from your department or sponsoring institution.
-  Links to community groups or activities related to groups you would like to attract.
-  Photos of residents and faculty.
-  Your program’s diversity statement.

INTERVIEW SELECTION: DEVELOPING A HOLISTIC APPROACH

Developing a Holistic Approach

Implement a holistic approach to inviting interviewees. Residency programs interested in increasing recruitment of URM residents should consider how USMLE Step 1 cutoffs may exclude many of these candidates. Training programs that use discreet USMLE cutoffs are likely excluding URM applicants at a higher rate than their non-URM applicants. Recruitment efforts directed toward racially and ethnically diverse trainees should include a focused strategy to interview applicants who might be overlooked during conventional applicant screening.

Residency programs may have perceptions different than reality for their diversity efforts related to interview invitations. Based on a 2018 review of ERAS applications, a recent study of 10 general surgery (5 university-based, 5 independent) residency programs with a stated interest in diversity found¹⁰:

- Women and URM applicants had lower USMLE Step 1 scores than male and White applicants, respectively.
- There was a lower proportion of URM applicants with a USMLE Step 1 score >240 (62% of Asian applicants, 59% of White applicants, 50% of Hispanic/Latino applicants, 36% of Other race/ethnicity applicants, 29% of African American applicants, and 25% of Native American applicants [$p < 0.001$]).
- Women were more likely to be selected to interview than men in a multivariate model adjusting for other factors. Women constituted 41% of the total applicant pool but 48% of the selected-to-interview pool, whereas men made up 59% of the applicant pool but 52% of those selected for interviews ($p < 0.001$).
- Identification as a non-White race/ethnicity was a significant independent predictor for decreased likelihood of interview selection (odds ratio [OR] = 0.73, 95% confidence interval [CI] 0.59-0.89; $p = 0.003$). Hispanic/Latino origin applicants constituted 12% of the applicant pool but only 6% of those selected to interview. 50% of applicants were White, but interviewees were 64% White.

Best Practices

University of Texas Houston Health Science Center

The internal medicine residency program at UT Health Science Center in Houston evaluated residents in a holistic manner, evaluating life experiences and personal attributes including demonstrated commitment to the underserved, substantive leadership roles, fluency in Spanish, and being representative of Houston's diverse

population based on self-identification by race/ethnicity. Using a USMLE cutoff 10 points lower than the preestablished USMLE score minimum, the two faculty application reviewers assigned a score of 2 for each applicable experience/attribute and invited any applicant with a minimum experience/attribute score of 4 to interview. This score was not considered in generating the rank list.¹¹

Duke University School of Medicine

In an effort to increase the number of URM invited to interview, the neurology residency program at Duke University School of Medicine eliminated its Step 1 cutoff score as an applicant "screen." The program educated application reviewers in implicit bias and reviewed all applications using a point system that included medical school grades (0-6 points), extracurricular activities and leadership (0-2 points), research experience (0-2 points), letters of recommendation (0-2 points), USMLE Steps 1 and 2 (or Comprehensive Osteopathic Medical Licensing Exam (COMLEX) scores for osteopathic applicants) (-2-6 points combined), and life experiences (0-5 points). Assigned at the discretion of the reviewer, life experience points could be awarded, for example, for military service or for being the first person in one's family to attend college. This strategy increased the number of URM students invited to interview. The only statistically significant difference in this scoring system between URM and non-URM applicants was Step 1 score.¹²

THE INTERVIEW PROCESS

Develop a Diverse Interview Team

Who is interviewing candidates is important in resident selection. The team should be present during interview days and comprise interviewers from diverse backgrounds and perspectives. Having a diverse interview team increases interviewee diversity; for example, Stanford University School of Medicine found that women and URM applicants applying to surgery were more likely than male and White applicants, respectively, to consider faculty and resident gender and racial diversity a positive influence on program ranking.¹³

The percentage of female faculty members in surgical specialty residency programs may also predict the number of female trainees. One study found that for each 1% increase in female faculty in surgical specialties, the percentage of female trainees increased by 1.45% ($p < 0.001$).¹⁴

National Residency Matching Program (NRMP) applicant surveys cited factors that were important to medical students when ranking residency programs (2008-2017). For all specialties, the percentage of residents citing diversity as a factor in program selection increased from 27% to 36% for geographic diversity (cultural, racial, and ethnic diversity of the geographic location) and from 18% to 31% for institutional diversity (cultural, racial,

ethnic, and gender diversity of staff at the target institution). Within surgery programs, the percentage of residents for whom diversity was a factor in selecting a program increased from 24% to 28% for geographic diversity and 19% to 22% for institutional diversity. Applicants’ 5-point ratings of the importance of diversity during ranking (1= not important and 5 = extremely important) rose during this period, geographic diversity from a mean of 2.7 to 4.2 and institutional diversity from a mean of 2.4 to 4.2 for all applicants.¹⁵

Mitigate Implicit Bias

Reducing Implicit Bias in Admissions Interviews



In this short video, Dr. Quinn Capers, IV, Associate Dean for Admissions at the Ohio State University College of Medicine, discusses four strategies his admissions team uses to reduce implicit bias throughout the interview process.



COMMON IDENTITY FORMATION

Don’t stop the interview until you find some common ground, even if it’s something as small as sharing a birth order or a favorite sports team.



PERSPECTIVE TAKING

Empathy actively reduces unconscious bias. Try picturing yourself in the interviewee’s shoes.



CONSIDER THE OPPOSITE

When you have information that leads you to one conclusion, force yourself to go back and consider the opposite before making a decision.



COUNTER-STEREOTYPICAL EXEMPLARS

Instead of focusing on biases against a particular group, look for qualities among people in that group that you admire.

Unconscious Bias Educational Resources



AVOIDING UNCONCIOUS BIAS: A GUIDE FOR SURGEONS

This eBook from the Royal College of Surgeons offers practical steps to recognize and address organizational and individual bias, bullying, and unacceptable behavior.



PROCEEDINGS OF THE DIVERSITY & INCLUSION INNOVATION FORUM: UNCONCIOUS BIAS IN ACADEMIC MEDICINE

This resource explores the role of unconscious bias in seven key areas of academic medicine, outlines benefits of diversity and inclusion, and summarizes potential interventions to remediate the biases in modern academic medicine. It was developed by the AAMC and The Kirwan Institute for the Study of Race and Ethnicity at Ohio State University, with input from national experts (2017).



Project Implicit®

HARVARD IMPLICIT ASSOCIATION TEST

These interactive tests measure attitudes and beliefs that people may be unable or unwilling to report. Tests include bias assessments related to Native American; disability; race; gender-science; Arab-Muslim; Asian American; weapons; gender-career; sexuality; age; religion; presidents; weight; and skin tone.

MODIFYING CURRENT RESIDENT SELECTION PROCESSES TO INCREASE DIVERSITY¹⁶

(Adapted from Gardner AK, Ann Surg, 2018)

Incorporate screening tools that level the playing field for all groups.

Situational judgment tests: confront applicants with descriptions of standardized realistic situations and ask them to select the most appropriate response.

Reconsider the role of personal statements and letters of reference.

Non-standardized and highly subjective. Low reliability and validity, may go against efforts to widen access to certain populations as they may reflect applicant’s unequal access to coaching, resources, and individuals of elite status within the profession.

Become familiar with how your program is making initial screening decisions.

Programs must ensure that use of USMLE cut scores, international medical graduate requirements, and other inclusion/exclusion criteria are fair, evidence-based, and appropriately used.

Select an inclusive interviewing team.

Programs should consider strategically choosing individuals who will bring diverse outlooks and who are respectful of different cultures and characteristics to interview candidates. Have a clear and open conversation with team members before beginning the interview process to ensure that all faculty interviewers are on the same page with the goals and strategies of the interview process. Prepare interviewers with answers for questions diverse candidates may ask (protocols for maternity leave, etc.).

Incorporate structured interviews.

Faculty should be trained on the basics of conducting structured interviews, ensuring all questions are related to the position and asked similarly of all applicants, and that they are using rating tools in the same manner. Programs should also teach interviewers about common biases and interviewer mistakes and equip them with skills to identify and overcome such biases.

BEST PRACTICE

The Internal Medicine Residency Program of the John P. and Katherine G. McGovern Medical School at the University of Texas standardized the interview day process and reduced the influence of subjective interviewer bias during interviews with potential residents. They introduced questions designed to assess specific competencies such as applicants’ ability to work in teams, approaches to problem solving, and capacity to adapt to changes. They developed a standardized list of questions, and faculty interviewers were asked to pose two of these questions (randomly assigned) to each applicant and then to consider the quality of the responses in their overall assessment of the interview.¹⁷

Standardize the Interview Process

Best practices for equitable residency interviews are compiled by the AAMC.¹⁷ You can reference the guidelines [here](#) and the key table on the next page.

Consider your geographic area in determining benchmarks. If you are in a geographic area with a high population of Hispanic/Latino patients, consider factors such as Hispanic/Latino self-reported race and Spanish fluency or near-fluency as benchmarks for recruitment.

Urban Universities for Health has a [metrics generator](#) that allows programs to obtain a customized list of measures to assist in evaluating efforts to enhance and expand a diverse, culturally sensitive, and prepared health and scientific workforce. This tool allows you to select the goals you wish to achieve and provides specific metrics that help you measure your success.

Intentionally Recruit Diverse Applicants

You might also want to **host specific recruitment events for potential residents with interest in diversity and inclusion**. The University of Virginia GME office hosted a “Diversity Day” and a “Second Look Weekend” for potential residents. Applicant travel and accommodations to attend the events was funded through sponsorship by the GME office and medical alumni funding.

Benchmark Your Progress and Desired Outcomes

It’s also important to determine benchmarks for women or minority applicants who are offered interviews. How will they be ranked? Remember to consider other diverse attributes (socioeconomic background, multiple language fluency, etc.), but also keep in mind data on URM is limited based on self-reporting. Self-reported data available through

ERAS that may be helpful in benchmarking applications received, interviews conducted, and matched applicants may include: race/ethnicity, languages spoken (“fluent” or “near-fluent”), gender, place of birth, and hometown. Review your data for the last several years to understand recruitment opportunities. Please see the instructions below on benchmarking internally with data from ERAS:

- 1. AAMC PDWS site
- 2. Application tab at top
- 3. Access the system defined filter “All Applicants.” The rest of the steps are dependent on which field of applicants you select here. Be sure to check the box by “Applicant Name” so that all applicants are checked.
- 4. Select “CSV Export” at the bottom where it says “action to perform on selected applicants.”
- 5. Select “Go.”
- 6. CSV export name: Find the predefined template “Applicant Roster” and modify it. Highlight and select “Edit CSV Export.”
- 7. Find the template “Applicant Roster” and highlight it.
- 8. Type of data to export: “Application Status”: select what you need.
- 9. Type of data to export: “Personal”: select what you need.
- 10. Type of data to export: “Exams/Licenses/Certifications”: select what you need.
- 11. Click “Save as New and Run”: These criteria will then show up in your Templates as a saved filter.
 - a. I selected Applicant Name, Most Recent Medical School, Gender, Date of Birth, Self-Identify, Basis for Work Authorization, USMLE Step 1, Step 2 CK, and Step 2 CS.

To access the spreadsheets, click on the template you desire. Excel will open, and you can then save the template with the appropriate headings.



AAMC’S BEST PRACTICES FOR CONDUCTING RESIDENCY PROGRAM INTERVIEWS

Table 1. The Effects of Components of Structure on Reliability, Validity, Fairness, and Applicant Reactions

Content	Reliability	Validity	Fairness	Applicant Reactions
Ask questions that are job-related		+	+	+
Ask all applications questions that cover the same topics	+	+	+	
Limit probing questions	+	+	+	–
Use behavioral or situational questions	+	+	+	
Use a longer interview	+	+		–
Have no access to applicant information before or during interview	+		+	–
Have applicants not ask any questions	+			–
Evaluation				
Rate each answer or use multiple rating scales	+	+		
Use defined rating scales	+	+	+	
Take detailed notes	+	+	+	
Use multiple interviewers	+	+	+	–
Use the same interviewers for all applicants	+		–	
Have no discussion between interviews	–		+	
Train interviewers	+	+	+	+
Use formulas to create interview total scores	+	+	+	

Notes: “+” means overall positive effect, “–” means overall negative effect, and blank cells mean insufficient research on the effect of the enhancement. **Reliability** refers the extent to which the evaluation process is consistent and candidate responses are evaluated consistently. **Validity** refers to the accuracy of inferences made from interview scores. Source: Adapted from Campion et al. (1997) and Levashina et al. (2014).

SUPPORTING, RETAINING, & PROMOTING DIVERSE RESIDENTS

SHOWCASE DIVERSITY

Demonstrate Your Commitment Throughout Your Institution

Health systems have found many ways to demonstrate the importance of diversity and inclusion. The University of Washington recently included an #ILookLikeaSurgeon series of portraits of female and Black physicians important to the institution's history in its hallway portrait display (below, [credit: Andrea Gahl](#)).



The University of Virginia Medical Center includes a diversity statement on its entryway wall (below).



PROMOTE REPRESENTATION IN NATIONAL SOCIETIES

Applying for institutional membership and encouraging URM residents and faculty to participate is an excellent source of national support and sponsorship for these groups. To be active in these organizations, **residents may need additional time off or financial support** that may not be standard in programs that only reimburse travel for presentations.



Association of Women Surgeons (AWS)

Educational and professional organization whose mission is to inspire, encourage, and enable women surgeons to realize their professional and personal goals.



National Hispanic Medical Association (NHMA)

Represents the interests of 50,000 licensed Hispanic physicians in the U.S. Dedicated to empowering Hispanic physicians to be leaders who will help eliminate health disparities and improve the health of Hispanics.



Society of Black Academic Surgeons (SBAS)

Motivates, mentors, and inspires surgeons and medical students to pursue academic careers and make significant contributions to the advancement of the field of surgery.



Society of Asian Academic Surgeons

Founded to focus on the personal and professional development of Asian academic surgeons with the belief that the best way to increase Asian representation in the leadership of academic surgery is to prepare future generations to succeed.



Association of American Indian Physicians (AAIP)

Strives to motivate American Indian and Alaskan Native students to remain in the academic pipeline and to pursue a career in the health professions and/or biomedical research, thereby increasing the number of American Indian and Alaskan Native medical professionals in the workforce. AAIP strives to improve the overall health of American Indian and Alaskan Native Communities through a variety of programs. AAIP has fostered several programs that directly address widely acknowledged disparities in American Indian and Alaskan Native health.



Excelsior Surgical Society

As part of the Military Health System Strategic Partnership, this society is administered through the American College of Surgeons. The society offers a “home” for the military surgeon within the ACS and serves as both an on-ramp to membership in the College as well as an off-ramp for surgeons as they separate from the military and transition to civilian practice.



Latino Surgical Society (LSS)

Established in 2016 to cultivate, nurture, and support the advancement of Latino surgeons. Membership is open to all surgeons, regardless of racial/ethnic background. The LSS seeks to establish programs to improve professional development among Latino surgeons in community and academic settings. The LSS seeks to develop pipeline programs, support for medical students, and surgical trainees, and faculty development, and professional advancement. The LSS shall advance initiatives to promote the health and welfare of Latino populations, including the study of diseases and healthcare issues of important to the Latino community.



Association of Out Surgeons and Allies (AOSA)

@OutSurgeons (Twitter) is a new organization for surgeons, resident surgeons, and allies interested in promoting acceptance and equity within surgical subspecialties meant to promote the visibility of LGBTQ+ surgeons and develop mentorship opportunities.

ACCOMMODATE RELIGIOUS DRESS

In order for hospitals, medical schools, and medical centers to incorporate and accommodate Hijab in the operating room, policy oftentimes needs to be written or edited. For example: *Disposable hoods are available for those requiring coverage of the head and neck for modesty and/or religious purposes.*

For more information, check out these resources around accommodating religious dress in the OR:

- [Infographic: Hijab in the OR](#)
- [Video: A Guide to Hijab in the OR](#)

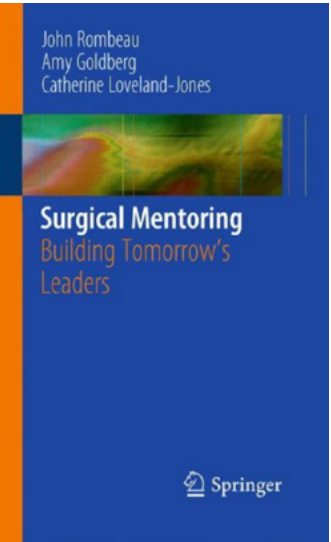
SUPPORT INTERNATIONAL MEDICAL GRADUATES

IMGs make up 16% of the residents in general surgery and 20% of practicing surgeons.¹⁸ In the 2020 NRMP match, non-US IMGs made up 5.2% of the categorical general surgery positions (80/1531) and 27.4% of the preliminary post-graduate year 1 (PGY1) general surgery positions filled through the match (160/583). For reference, in 2020, 5 categorical general surgery positions and 591 preliminary PGY1 general surgery positions were not filled through the match.¹⁹ Despite initially filling few categorical general surgery positions, Datta et al. found that 76% of the IMG residents who filled non-designated preliminary positions in general surgery secured general surgery or surgery-related residency positions.²⁰

[The Educational Commission for Foreign Medical Graduates \(ECFMG\)](#) provides the recognized standard certification for IMGs before they enter US GME, take USMLE Step 3, or are eligible to obtain an unrestricted license to practice medicine in the US. The ECFMG can assist IMGs with the process of applying for US GME positions that sponsor foreign nationals for the J-1 visa.

While not exhaustive, important issues involved in hiring and supporting IMGs during training may include:

- Resources needed to support residents establishing a life in a new country (e.g., difficulty purchasing a vehicle as they do not have “credit,” assistance with setting up utilities or WiFi access)
- Knowledge regarding visa programs and possible legal assistance
- Assistance to help the resident adapt to cultural or language differences or differences in clinical medical/surgical practice



Chapter 6 of *Surgical Mentoring: Building Tomorrow's Leaders* (Rombeau JL, Goldberg A, Loveland-Jones C., Springer 2010) discusses surgical mentoring specific to international medical graduates.



RECOGNIZE THE MINORITY TAX

The “minority tax” was described by Rodriguez et al.²¹ as **“underrepresented minority in medicine faculty responsibility disparity.”** Faculty members from URM backgrounds may experience racism and isolation. In addition to their clinical, teaching, and research obligations, they are expected to serve on diversity and inclusion committees and mentor students and residents from their backgrounds. Their clinical practices may be much more challenging due to more time spent in

caring for underserved populations. These disparities account for extra work and may not be activities important for promotion and tenure, contributing to large disparities in promotion for underrepresented minority in medicine faculty.²²

Rodriguez et al. describe practical methods to address the URM “responsibility disparity” (key approaches summarized below):



1.) Value diversity effort fairly.

- Recognize that the URM responsibility disparity exists and adjust assignment of responsibilities accordingly.
- Assign promotion value to work in the area of diversity, clinical, and community endeavors.



2.) Employ rules that are in harmony with the institution’s stated service goals and mission.

- Increase awareness of and avoid institutional departure from the service mission.
- Fund stated institutional diversity commitments.



3.) Eliminate all forms of discrimination.

- Institute policies and procedures that address and correct bias.
- Establish robust accountability systems for acts of discrimination by including them in annual evaluations.
- Facilitate and support activities to form relationships among faculty, administrators, and learners.
- Encourage positive curiosity when encountering “otherness” and recognize differences in faculty and trainees as benefitting our institutions.
- Seek training in unconscious bias for all faculty and trainees to help recognize its role in discrimination.



4.) Ensure clear, frank, and transparent communication between administration and faculty to avoid faculty discouragement.



5.) Develop an employee retention strategy through faculty development that focuses on institutional culture, networking, and mentoring. Develop professional skills related to:

- Understand the prevalence and acceptance of unconscious bias.
- Teach acceptable institution-specific behaviors to address silent racism.
- Deal with micro-aggressions and stereotype threat.
- Avoid isolation and marginalization.



6.) Develop and implement organizational culture-change activities involving broad participation to provide the experience of learning and collaborating in an inclusive and humanistic culture.

RESPOND TO BIAS INCIDENTS

Have a policy for responding to bias incidents in place. Mayo’s 5-part response to inappropriate patient or visitor behavior is a great example:

<https://journalofethics.ama-assn.org/article/mayo-clinics-5-step-policy-responding-bias-incidents/2019-06>.²³

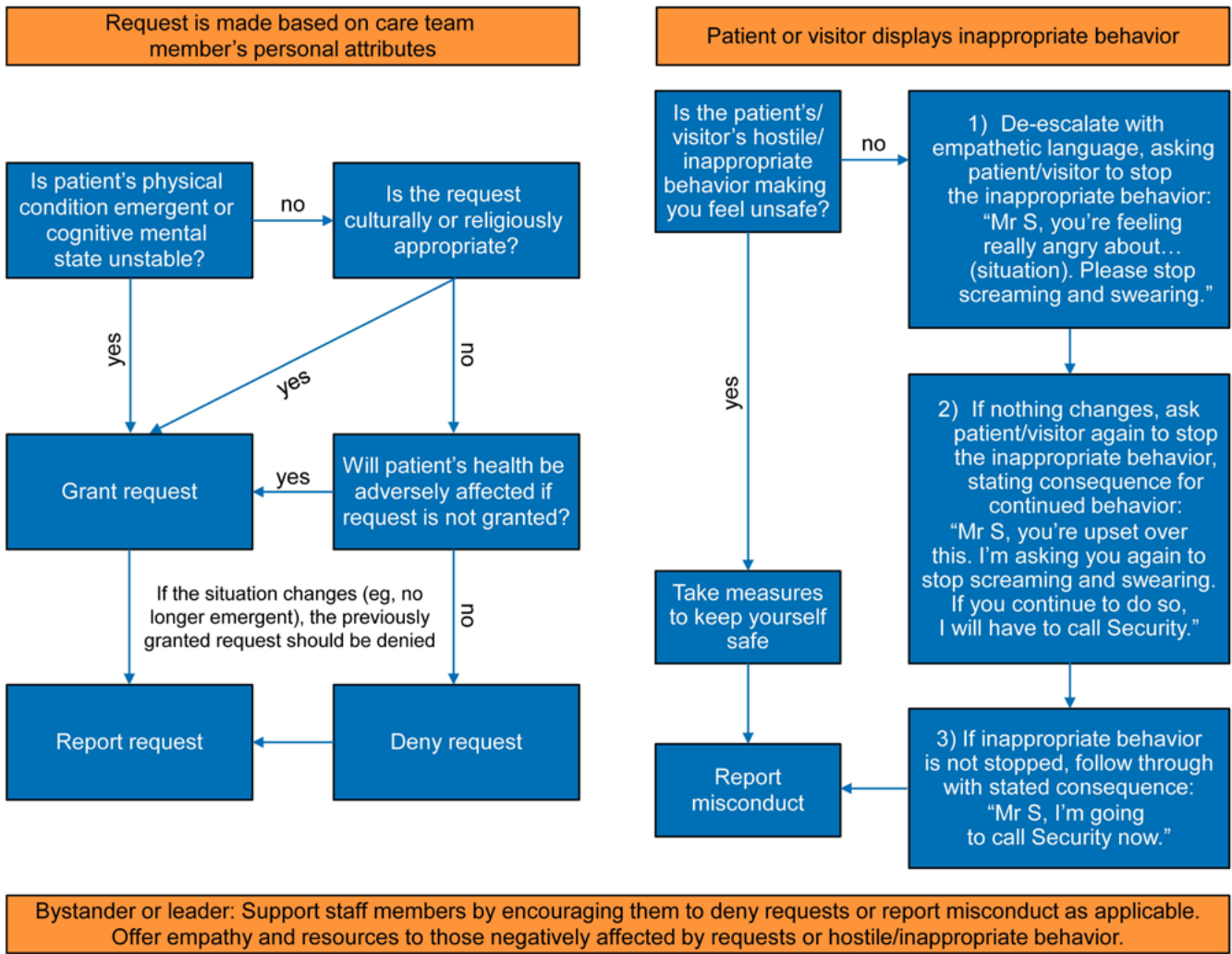


Table. SAFER Model for Recommended Responses to Patient or Visitor Misconduct
Five Steps in SAFER Model
Step in when you observe behavior that does not align with Mayo Clinic values.
Address (the inappropriate) behavior with the patient or visitor.
Focus on Mayo Clinic values (such as respect and healing).
Explain Mayo's expectations and set boundaries with patients and visitors.
Report the incident to your supervisor and document the event using the Patient Misconduct form.

Melanin in Medicine’s goal is to celebrate diversity and inclusion in health care, science, and public health by highlighting the work of people from URM backgrounds to inspire the next generation of diverse educators, healers, public health practitioners, researchers, scientists, and agents of change. Visit the organization at: <https://www.melanininmedicine.org>.



SUPPORT, MENTOR, & SPONSOR URM RESIDENTS

Breaking Down Barriers for Women Physicians of Color

[The Greenlining Institute and the Artemis Medical Society interviewed 20 women physicians of color to understand their experiences and barriers they face](#). Interviewees described lack of support during high school and college, lack of seeing a physician of their race, and barriers to entry into medicine including expense of the medical school application process, repeated tokenization, and lack of diversity among medical school faculty. Recommendations discussed include supporting health career pipelines, increasing diversity in medical student admissions and faculty, developing robust mentorship and support networks, adopting specific training in cultural competence and racism in medical schools and residency, and addressing financial and structural barriers, including gender pay inequity and unfair maternity leave policies.

EDUCATE & TRAIN ON DIVERSITY & INCLUSION

The University of Virginia College of Medicine sought to recognize how its institution’s history impacted its relationship with the community and with diverse populations. The institution developed a multi-faceted diversity and inclusion initiative related to GME programs, including:

- Development of a Housestaff Council on Diversity and Inclusion, of which the founding secretary and president were surgery residents. This council developed and organizes an annual weekend conference on diversity and inclusion: <https://med.virginia.edu/gme/diversityandinclusion/tdiconference/>
“The GME department works closely with UVA faculty and the Housestaff Council for Diversity and Inclusion to stimulate meaningful conversations about race, privilege and representation in our community. Our goal is to ensure that all residents, no matter their race, sexuality, country of origin, gender, religion or able-bodiedness, feel included at UVA.”
- Creation of a Task Force on Diversity and Inclusion for the Department of Surgery, led by the Vice Chair, which is open to any resident or faculty who wishes to participate.
- Promotion of Grand Rounds exploring history of UVA Medical Center with respect to issues of race.

Additional resources follow that can be used to promote institutional diversity training and education.



Gender & Sexual Harrassment Resources



AWS Pocket Mentor for Surgeons-in-Training & Medical Students

Provides helpful advice for all medical students and residents on clinical expectations, clinical and operative experiences, championing your education, problems and pitfalls (including substance abuse, relationships, discrimination, harassment, and poor patient outcome), self-care, and planning for the future.



AAMC Gender & Sexual Harrassment Resources

Based on the findings and recommendations in *Sexual Harrassment of Women: Climate, Culture, and Consequences in Academic Sciences, Engineering, and Medicine* (2018). Includes presentations on sexual harassment and its impact on professional outcomes, pervasiveness of sexual harassment in academic medicine, and infographics and handouts on the problem and how to overcome it.



AAMC Sexual Harrassment Foundation Presentation & Discussion Questions

Presentation that can serve as a foundational primer to help institutions and leaders initiate conversations on their campuses regarding sexual harassment. Defines how to create a safe environment, types of sexual harassment, key terms, institutional barriers, and keys to prevention through allyship and bystander intervention.

Recognizing & Responding to Microaggressions



MTV’s 2015 “Look Different” Campaign

These short videos demonstrate common microaggressions: “I can’t tell Asians apart;” “You’re different for a Black guy;” “How’d you get into that school?;” “You’re pretty for a dark girl;” “What up, Bin Laden?;” “You don’t look Jewish;” “Your English is so good.” (videos, 20-40 seconds)

EXAMPLES OF DIFFERENT FORMS OF MICROAGGRESSIONS

Microinsult	<p>A Black male college student at a highly selective university is asked what sport he plays, with the underlying assumption that he did not gain admission based on his academic credentials, but rather his athletic ability.</p> <p>A Latina administrator is described as “spicy,” which culturally and sexually objectifies her while diminishing her effectiveness as a leader.</p>
Microinvalidation	<p>An Asian American professor is asked where she is from, and when she replies, “Kansas,” her student responds with, “No seriously, what country are you from?,” suggesting she was not born in the US.</p>
Microassault	<p>A Muslim student sits in a class where a professor makes Islamophobic comments during his lecture.</p>

Adapted from: <https://www.higheredtoday.org/2016/07/27/understanding-and-combatting-microaggressions-in-postsecondary-education/>

Understanding & Responding to Microaggressions as a Recipient

Microaggressions: brief and often commonplace verbal, behavioral, or environmental indignities (whether intentional or unintentional) that cause members of social groups to feel stigmatized

Link Evidence & Experience

Data is important, but often not enough to drive change without a personal narrative

Educate Rather Than Excuse

Microaggressions are often unintended, but they shouldn't be ignored

Prepare Response Strategies

Direct Question: What do you mean by that?

Assume Good Intent: I'm sure you didn't mean to suggest [x]"

Call someone in: Can we talk about what just happened?

Acknowledge Emotion: I didn't feel great about how this went

EAST Equity, Quality and Inclusion in Trauma Surgery Practice Ad Hoc Task Force

Visual abstract by @CAHarrisMD #EAST4ALL <http://bit.ly/EAST4ALL>

Eastern Association for the Surgery of Trauma
Advancing Science, Fostering Relationships, and Building Careers

Understanding & Responding to Microaggressions as an Ally

Microassault: overt discrimination
“We don’t want [religious group] here.”

Call-In rather than Call-Out

Emphasize that everyone makes mistakes; we all learn & lead with empathy

Create Departmental Policy

Clearly delineate steps for reporting events and consequences for repeat offenders

Microinsult: subtle snubs, often unknown to the perpetrator
“You’re smart for a girl!”

Identify and Behave as an Ally

Verbal commitment must be backed with enforcement in public and private

Listen and Ask for Feedback

Take colleagues’ experiences seriously and ask if you’re doing enough to help

Microinvalidation: devaluing or exclusionary events
“I don’t see color; the most qualified person got the job.”

EAST Equity, Quality and Inclusion in Trauma Surgery Practice Ad Hoc Task Force

Visual abstract by @CAHarrisMD #EAST4ALL <http://bit.ly/EAST4ALL>

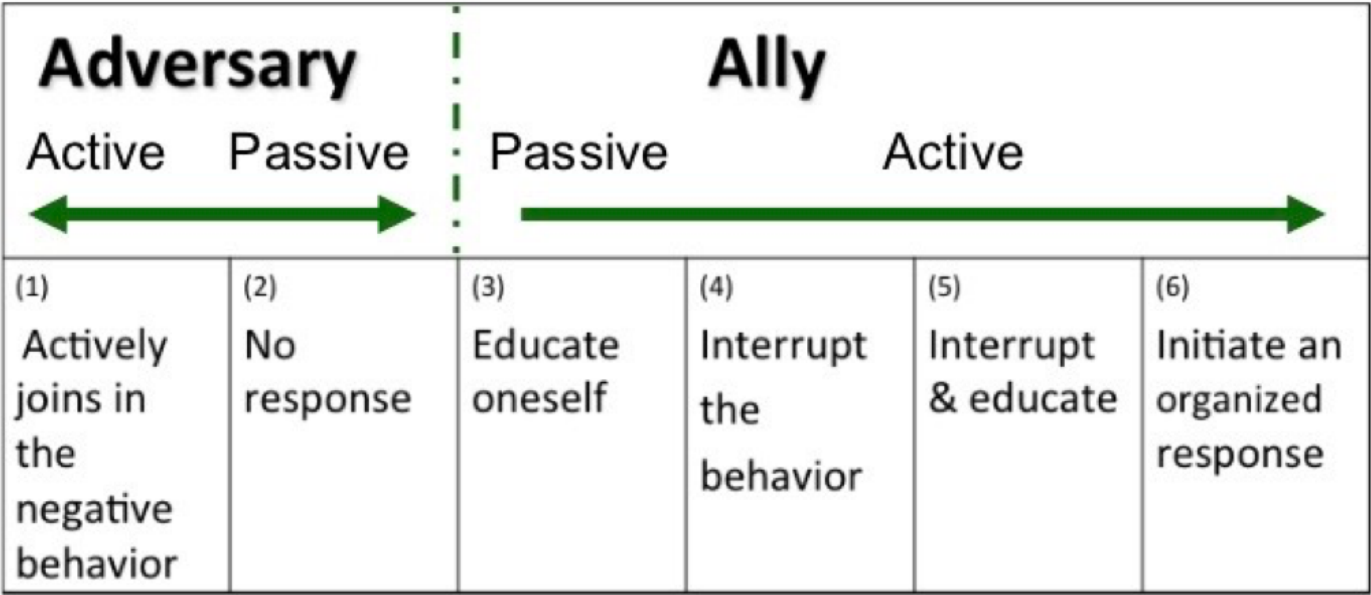
Eastern Association for the Surgery of Trauma
Advancing Science, Fostering Relationships, and Building Careers

Training Allies

“ To be an ally is to take on the struggle as your own; stand up, even when you feel scared; transfer the benefits of your privilege to those who lack it; acknowledge that while you, too, feel pain, the conversation is not about you.”
-from GUIDE TO ALLYSHIP

ALLY TRAINING (Sunny Nakae, MSW, PhD; ACGME 2020)		
CONCERN	TYPICAL RESPONSE	ALLY RESPONSE
The security guards racially profile me.	What? They're so nice to me!	I'm sorry to hear that. Tell me more.
I'm having a hard time with my attending.	Don't worry about it; she's like that to everyone.	That sounds really difficult. How can I help?
I feel so disrespected when he talks to me like that.	Don't take it personally. Just move on.	That's upsetting. How can I be supportive when that happens?
I can't believe he said...!	He's old school. He doesn't mean any harm.	That's unacceptable. I will do my best to personally address this.

Use this MedEd Portal toolkit with all the resources for a 2-hour workshop training pre-medical and pre-dental students to recognize microaggressions in clinical practice:
<https://www.mededportal.org/publication/10893/>.²⁴



From *Teaching for Diversity and Social Justice* (Maurianne Adams, Routledge 2016): <https://www.amazon.com/Teaching-Diversity-Social-Justice-Maurianne/dp/1138023345>.

Simple Switches: Transforming Daily Interactions to Become Inclusive



Tool: Recognizing Microaggressions and the Messages They Send

Microaggressions are the everyday verbal, nonverbal, and environmental slights, snubs, or insults, whether intentional or unintentional, that communicate hostile, derogatory, or negative messages to target persons based solely upon their marginalized group membership (from *Diversity in the Classroom*, UCLA Diversity & Faculty Development, 2014). The first step in addressing microaggressions is to recognize when a microaggression has occurred and what message it may be sending. The context of the relationship and situation is critical. Below are common themes to which microaggressions attach.

THEMES	MICROAGGRESSION EXAMPLES	MESSAGE
Alien in One's Own Land When Asian Americans, Latino Americans and others who look different or are named differently from the dominant culture are assumed to be foreign-born	<ul style="list-style-type: none">"Where are you from or where were you born?""You speak English very well.""What are you? You're so interesting looking!"A person asking an Asian American or Latino American to teach them words in their native language.Continuing to mispronounce the names of students after students have corrected the person time and time again. Not willing to listen closely and learn the pronunciation of a non-English based name.	<p>You are not a true American.</p> <p>You are a perpetual foreigner in your own country.</p> <p>Your ethnic/racial identity makes you exotic.</p>
Ascription of Intelligence Assigning intelligence to a person of color or a woman based on his/her race/gender	<ul style="list-style-type: none">"You are a credit to your race.""Wow! How did you become so good in math?"To an Asian person, "You must be good in math, can you help me with this problem?"To a woman of color: "I would have never guessed that you were a scientist."	<p>People of color are generally not as intelligent as Whites.</p> <p>All Asians are intelligent and good in math/science.</p> <p>It is unusual for a woman to have strong mathematical skills.</p>
Color Blindness Statements that indicate that a White person does not want to or need to acknowledge race.	<ul style="list-style-type: none">"When I look at you, I don't see color.""There is only one race, the human race.""America is a melting pot.""I don't believe in race."Denying the experiences of students by questioning the credibility /validity of their stories.	<p>Assimilate to the dominant culture.</p> <p>Denying the significance of a person of color's racial/ethnic experience and history.</p> <p>Denying the individual as a racial/cultural being.</p>
Criminality/Assumption of Criminal Status A person of color is presumed to be dangerous, criminal, or deviant based on his/her race.	<ul style="list-style-type: none">A White man or woman clutches his/her purse or checks wallet as a Black or Latino person approaches.A store owner following a customer of color around the store.Someone crosses to the other side of the street to avoid a person of color.While walking through the halls of the Chemistry building, a professor approaches a post-doctoral student of color to ask if she/he is lost, making the assumption that the person is trying to break into one of the labs.	<p>You are a criminal.</p> <p>You are going to steal/you are poor, you do not belong.</p> <p>You are dangerous.</p>
Denial of Individual Racism/Sexism/Heterosexism A statement made when bias is denied.	<ul style="list-style-type: none">"I'm not racist. I have several Black friends.""As a woman, I know what you go through as a racial minority."To a person of color: "Are you sure you were being followed in the store? I can't believe it."	<p>I could never be racist because I have friends of color.</p> <p>Your racial oppression is no different than my gender oppression. I can't be a racist. I'm like you.</p> <p>Denying the personal experience of individuals who experience bias.</p>
Myth of Meritocracy Statements which assert that race or gender does not play a role in life successes, for example in issues like faculty demographics.	<ul style="list-style-type: none">"I believe the most qualified person should get the job.""Of course he'll get tenure, even though he hasn't published much—he's Black!""Men and women have equal opportunities for achievement.""Gender plays no part in who we hire.""America is the land of opportunity.""Everyone can succeed in this society, if they work hard enough.""Affirmative action is racist."	<p>People of color are given extra unfair benefits because of their race.</p> <p>The playing field is even so if women cannot make it, the problem is with them.</p> <p>People of color are lazy and/or incompetent and need to work harder.</p>

Adapted from Sue, Derald Wing, *Microaggressions in Everyday Life: Race, Gender and Sexual Orientation*. Wiley & Sons, 2010.

Source: <https://sites.google.com/site/cacmnow/university-of-california-microaggression-lisy>

Sexual & Gender Diversity

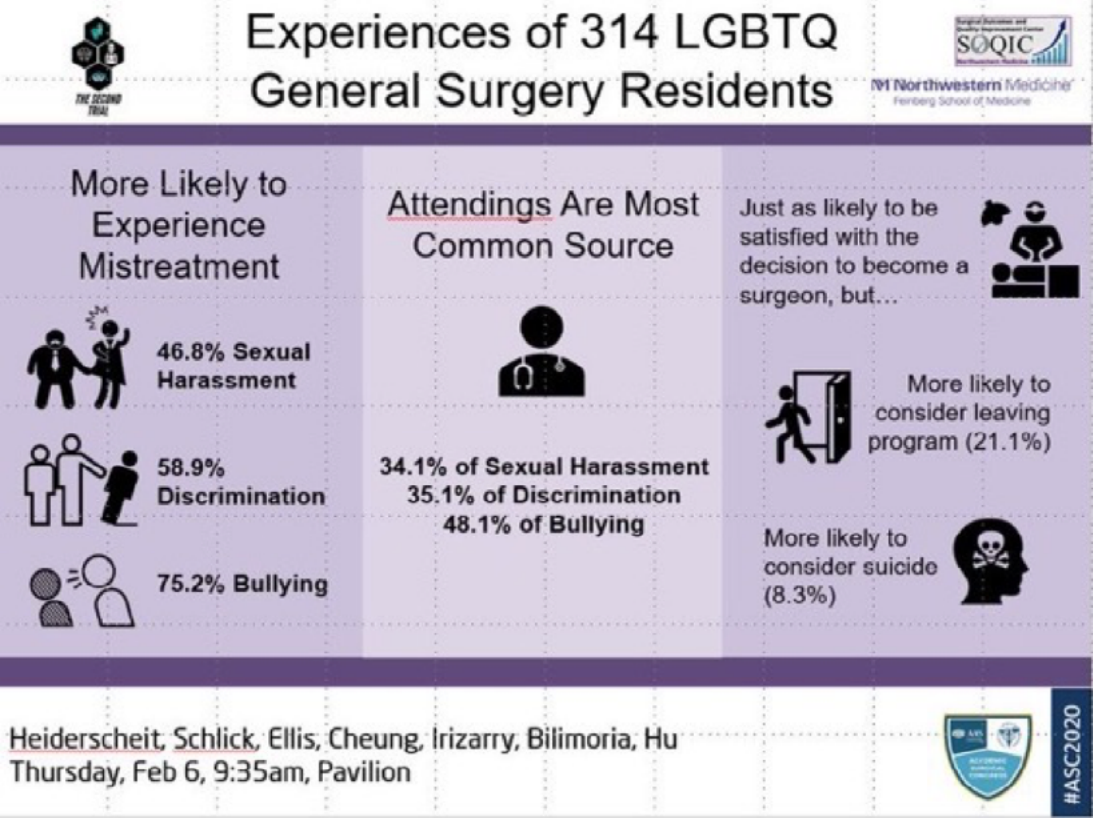
A recent Associated Press article shed some light on the “awkwardness” some LGBTQ+ patients face during doctor visits. “When being heterosexual is presumed even in doctors’ offices, those who identify otherwise can feel marginalized and less likely to seek medical care.” To combat this trend, medical schools are increasingly requiring LGBTQ+ health issues be taught within their curriculula. For example, Harvard Medical School is actively recruiting LGBTQ+ students given research showing that patients receive better care when cared for by doctors who identify like them. Not coincidentally, Harvard’s recent entering medical school class was 15% LGBTQ+.

Experiences of Surgery Residents Who Identify as LGBTQ+

In a 2014 survey of 388 general surgery residents, 11% (43) identified as LGBT.²⁵ Of these LGBT residents:

- 30% did not reveal their sexual orientation when applying owing to fear of not being accepted. Over 50% actively concealed their sexual orientation from fellow residents and attendings.
- 54% witnessed homophobic remarks by nurses and residents and 30% by surgical attending physicians.
- 21% experienced targeted homophobic remarks by fellow residents and 12% by attendings. None reported these events.

26



These data have called on various organizations to take action. [The Medical Student Pride Alliance \(MSPA\)](#) is quickly recruiting followers and has called for a petition to add a section within the Electronic Residency Application Service (ERAS) to list sexual orientation, gender identity, or pronouns, a step towards a more inclusive community and diverse physician workforce. You can sign the petition by following the link: <https://www.medpride.org/eras-petition>.

Microaggressions Specific to LGBTQ+ Trainees

Welcoming LGBTQ+ trainees involves recognizing specific microaggressions that may be hurtful or harmful to their comfort in a specific training environment. Examples of specific microaggressions and tips on ways to be an LGBTQ+ ally are below.

- 1. Using heterosexist terminology – “That’s so gay!” – implies that being gay is somehow “bad.” **ALLY:** Avoid using these terms and question others when they do.
- 2. Being heteronormative in daily conversation – “Come on Joe, don’t be a sissy” or assuming sexual orientation (e.g., asking a gay man about his partner: “What does she do?”). **ALLY:** Use the pronoun “they”; it will show you’ve put some thought into LGBTQ+ culture.
- 3. Stereotyping – All gay men like “shiny things” or are “dramatic.”
- 4. Denying claims of “different treatment” by LGBTQ+ trainees when they disclose their feelings. Minority groups can sense when someone is being awkward toward them due to discomfort with their sexuality or race.
- 5. Assuming sexual pathology in question stems: “A 30-year-old gay man with a past medical history of HIV...” Why does the man have to be gay? This is being addressed nationally in USMLE question stems.
- 6. Asking an LGBTQ+ trainee why they post about LGBTQ+ issues on social media frequently. **ALLY:** If you think they are posting too much it’s likely because you’re biased.

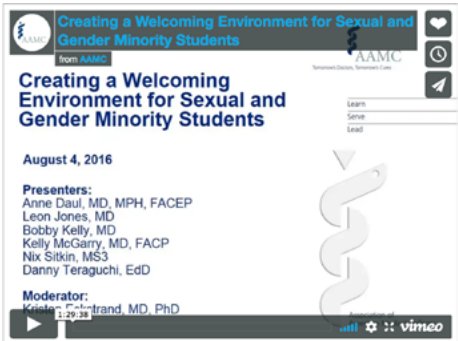
An ally, straight ally, or heterosexual ally is a heterosexual and cisgender person who supports equal civil rights, gender equality, and LGBTQ+ social movements and challenges homophobia, biphobia, and transphobia.

Sexual Diversity Resources



LGBTQIA+ GLOSSARY OF TERMS FOR HEALTH CARE TEAMS

From the National LGBT Health Education Center (<https://www.lgbthealtheducation.org>), this resource has a comprehensive glossary of terms including a chart listing “Outdated and Insensitive Terms to Replace” and alternative, appropriate modern terminology.



WEBINAR FROM AAMC ADVISORY COMMITTEE ON SEXUAL ORIENTATION, GENDER IDENTITY, AND SEX DEVELOPMENT

Medical schools face a variety of challenges in creating safe, welcoming and nurturing environments for sexual and gender minority students, including those who identify as lesbian, gay, bisexual, transgender, or gender nonconforming. Realizing that each institution’s context is unique, this webinar will provide an overview of methods and resources institutional leaders can use to improve the climate at their institution for students of diverse sexual orientations, gender identities, and forms of gender expression.



“SAFE ZONE” TRAINING

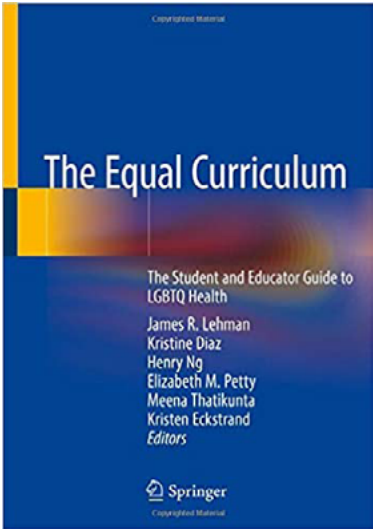
The Safe Zone Project (<https://thesafezoneproject.com/>) offers a free online resource for powerful, effective LGBTQ+ awareness and ally training workshops.

CULTURALLY COMPETENT CARE FOR LGBTQ+ PATIENTS

Also from the national LGBT Health Education Center, learning modules for providing culturally competent care for LGBTQ+ patients.



UCSF LGBTQ+ TRAINEES SPEAK OUT
In this video, LGBTQ+ medical students and a resident at the University of California San Francisco speak out about their experiences.



THE EQUAL CURRICULUM: THE STUDENT & EDUCATOR GUIDE TO LGBTQ+ HEALTH (LEHMAN, ET. AL., SPRINGER 2020)
This book is aimed at educating doctors and medical students to effectively work with and treat members of the LGBTQ+ community. To help close the health care gaps for sexual and gender minorities, the book offers an explanation of terms related to sexual and gender identity and history of the LGBTQ+ community as it relates to medicine. Chapters include: LGBTQ+ Health Disparities, LGBTQ+ Friendly Clinic Encounter, Child and Adolescent Medicine, Adult Primary Care, Sexual Health, Transgender Health, Emergency Medicine, HIV/AIDS, Psychiatry and Neurology, amongst others.



10 WAYS TO BE AN LGBTQ+ ALLY & FRIEND (FROM GLAAD)

- 1. Be a listener.
- 2. Be open-minded.
- 3. Be willing to talk.
- 4. Be inclusive and invite LGBTQ+ friends to hang out with your friends and family.
- 5. Don't assume that all your friends and co-workers are straight. Someone close to you could be looking for support in their coming-out process. Not making assumptions will give them the space they need.
- 6. Anti-LGBTQ+ comments and jokes are harmful. Let your friends, family and co-workers know that you find them offensive.
- 7. Confront your own prejudices and bias, even if it is uncomfortable to do so.
- 8. Defend your LGBTQ+ friends against discrimination.
- 9. Believe that all people, regardless of gender identity and sexual orientation, should be treated with dignity and respect.
- 10. If you see LGBTQ+ people being misrepresented in the media, contact us at [glaad.org](https://www.glaad.org).



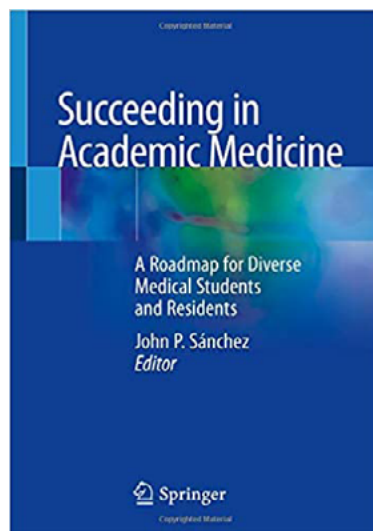
SIX PRONOUN PRACTICES TO BUILD TRANS-AFFIRMING WORKPLACES & WHY THEY MATTER
Using the right pronouns correctly is an important first step for building a trans-affirming workplace. This guide from Eli Green of the [Transgender Training Institute](https://www.transgendertraininginstitute.com) covers what you need to know as far as pronouns go.



GENDER NEUTRAL PRONOUN PRACTICE

A part of the Show Your Love campaign from Preconception Health, a guide for how to practice using gender neutral pronouns and how to adapt to a person's preferred pronouns.

General Diversity Resources



“Succeeding in Academic Medicine: A Roadmap for Diverse Medical Students and Residents” (John P. Sánchez, Springer 2020)

This first-of-its-kind book for underrepresented racial and ethnic minorities, women, and sexual and gender minorities in medicine offers the core knowledge and skills needed to achieve a well-planned, fulfilling career in academic medicine. In 12 chapters and with a unique focus on a practical approach to increasing diversity and inclusion in academic medicine, this book demystifies the often-insular world of academic medicine. It comprehensively outlines career opportunities and associated responsibilities, how to transform academic-related work to scholarship, and offers a clear and transparent look into the academic appointment and promotion process. By focusing on the practical steps described in this book, students and residents can develop a strong foundation for an academic medicine career and succeed in becoming the next generation of diverse faculty and administrators.



“The Common Thread” – The 4 Essential Modules of Cultural Inclusion: Building Belonging, Understanding Bias, Cultural Competency, and Conflict Resolution

These short videos, put together by the University of Alabama at Birmingham, offer insight into how to develop cultural competency and find “the common thread” between yourself and others from various backgrounds.

Perspectives: The Role That Graduate Medical Education Must Play in Ensuring Health Equity and Eliminating Health Care Disparities²⁷

Health care disparities still exist. The ACGME places strong emphasis on GME's role in eliminating health care disparities by asking medical educators to objectively evaluate and report on their trainees' ability to practice patient-centered, culturally competent care including collecting data on outcomes by patient race, cultural identification, and language. Moreover, training programs and institutional leadership need to collaborate on ensuring data collection on patient satisfaction, outcomes, and quality measures that are broken down by patient race, cultural identification, and language. A diverse physician workforce is another strategy for mitigating health care disparities and using strategies to enhance faculty diversity should also be a priority of graduate medical education.

PERSPECTIVES

The Role That Graduate Medical Education Must Play in Ensuring Health Equity and Eliminating Health Care Disparities

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Abstract
Despite the 2015 Institute of Medicine report that described the need and financial impact of health care disparities and the need to address them, it is unclear that health care disparities exist. Recommendations for addressing disparities include collecting and reporting data on patient race and ethnicity, improving language interpretation services, increasing awareness of health care disparities through education, improving cultural competency training for all health care professionals, and increasing diversity among health care professionals. The Accreditation Council on Graduate Medical Education places strong emphasis on graduate medical education's role in eliminating health care disparities by asking medical educators to objectively evaluate and report on their trainees' ability to practice patient-centered, culturally competent care. Moreover, one of the objectives of the Accreditation Council on Graduate Medical Education Chief of Learning Development Report is to identify how sponsoring institutions engage residents and fellows in the need to improve systems of care, reduce health care disparities, and improve patient outcomes. Resident and fellowship programs should ensure the delivery of meaningful curricula on cultural competency and health care disparities, which does not minimize awareness, and ensure resident awareness of culturally competent care. Moreover, training programs and institutional leadership need to collaborate on ensuring data collection on patient satisfaction, outcomes, and quality measures that are broken down by patient race, cultural identification, and language. A diverse physician workforce is another strategy for mitigating health care disparities and using strategies to enhance faculty diversity should also be a priority of graduate medical education. Training programs and institutional leadership should be provided to interested medical students, residents, and faculty. Graduate medical education has a clear charge to ensure that all patients receive high-quality health care and that all patients receive high-quality health care.

Keywords: graduate medical education; health care disparities; cultural competency; health equity

Despite the seminal report, “Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care,” released in 2002 by the Institute of Medicine, which concluded “though the quality of care is improving, disparities in health care are still a major public health problem,” the Institute of Medicine's report suggests that the health care system is not doing enough to address disparities in health care. The report also states that the health care system is not doing enough to address disparities in health care. The report also states that the health care system is not doing enough to address disparities in health care.

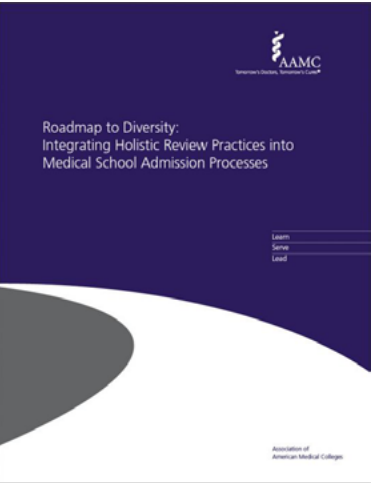
Perspectives

603



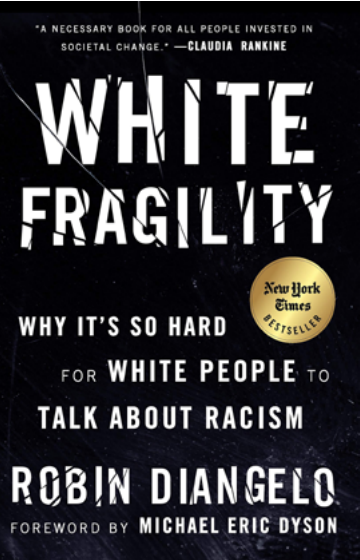
Building High-Performing Teams in Academic Surgery: The Opportunities and Challenges of Inclusive Recruitment Strategies

Based on research conducted by the University of Michigan Department of Surgery, this publication outlines the challenges associated with diverse recruitment and outlines approaches to solve these challenges.



AAMC Roadmap to Diversity: Integrating Holistic Review Practices into Medical School Admission Processes

This publication offers schools the tools and knowledge to help align admission policies to ensure proper diversity. This publication provides schools with the tools to align admission policies, processes, and criteria with institution-specific missions and goals. It also helps establish ground rules for sustaining the benefits of medical student diversity to support its overall mission and goals.



“White Fragility: Why It’s So Hard for White People to Talk about Racism” (Robin DiAngelo, Beacon Press, Boston, MA, 2018)

This book challenges racism by working against and understanding what the author terms “White fragility,” a reaction in which White people feel attacked or offended when the topic of racism arises. DiAngelo stresses that all White people play a role in perpetuating White supremacy – willing to examine how underlying assumptions influence their behavior. When White people’s racial comfort is challenged, they feel a range of defensive emotions, which they externalize through negative actions and behaviors. To combat White fragility, White people must first become more aware of their internalized convictions, and then actively teach themselves to respond differently in the moment.



Inclusion and Mutual Respect of Women in the Orthopedic Surgery Workplace

Created by surgeons in the American Association of Hip and Knee Surgeons, this powerful video promotes diversity and inclusion for women in the orthopedic surgery workplace.



Altering the Course Black Males in Medicine (AAMC)

This resource provides background on systematic factors that have led to lack of Black men in medicine and ways academic medicine may influence current trends.



Diversity in the Workplace: Eye-Opening Interviews to Jumpstart Conversations about Identity, Privilege, and Bias (Bärí A. Williams, Esq.)

If you want to create an inclusive working environment, understanding the experiences of marginalized employees is key. *Diversity in the Workplace* is a guided tour of what it means to be a minority in today’s labor force.

Through 25 trailblazing interviews, you’ll get a deeper sense of the systemic inequality that exists in workplaces everywhere. Learn about how the interconnection of multiple identities – race, gender, LGBTQ+, age, ability, religion, and culture – can shape disparity at work. Find tips on how to have meaningful conversations with colleagues and build awareness with key terms, such as *unconscious bias*.



Georgetown University National Center for Cultural Competence

The mission of the NCCC is to increase the capacity of health care and mental health care programs to design, implement, and evaluate culturally and linguistically competent service delivery systems to address growing diversity, persistent disparities, and to promote health and mental health equity.



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