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My Thoughts / My Surgical Practice

Society of Black Academic Surgeons (SBAS) diversity, equity, and inclusion series: Microaggressions - Lessons Learned from Black Academic Surgeons

Introduction

Dr. Steven Wexner: I would like to welcome everyone to this month's episode of the Diversity, Equity, and Inclusion series, in alliance with the American College of Surgeons, proceedings From the Advances in Surgery (AIS) Channel's Diversity, Equity, and Inclusion Series: Microaggressions: Lessons Learned from Black Academic Surgeons.[1] I am very gratified that each of these broadcasts during the last several months have attracted over 30,000 surgeons from over 100 countries.

Today's program is going to be absolutely first rate and spectacular, and I know everyone who is tuned in is going to be very gratified to be here today to participate. Please also participate in the chat and send questions to the faculty moderators and the speakers – they are very keen to answer your questions. Any questions that do not get answered today will be answered after the program online so you will be able to find the answers to your questions later on. We really appreciate your being interactive, not only taking the time today but to actually be active rather than passive participants and think of and ask questions.

Without further ado, I would like to introduce today's host, Dr. Carla Pugh. She is here today in her role as President of the Society of Black Academic Surgeons who put on this absolutely tremendous first-rate program. Dr. Pugh, with pleasure, I am turning it over to you.

Dr. Carla Pugh: Thank you Dr Wexner for hosting the Society of Black Academic Surgeons in a conversation on microaggressions in the surgical workplace. It is such an important topic, and I am ecstatic to have my esteemed colleagues Dr. Daniel Dent and Dr. Nancy Gantt to share in this endeavor as our moderators. Drs. Dent and Gantt have dedicated their lives to the surgical profession and have held high posts at the College and the American Board of Surgery. We are delighted to have them partner with us in a conversation around microaggressions in the surgical workplace.

Our first speaker is Dr. Yewande Alimi, who will be presenting on microaggressions in surgical training. Our second speaker will be Dr. Fabian Johnston, who will speak about microaggressions in the black male physician. Our third speaker is Dr. Lola Fayanju, who will be speaking about microaggressions and the black female surgeon. I am the fourth speaker and will share a few words on microaggressions in the surgical workplace. Our last speaker will be Dr. Paris Butler who will talk on allyship, policies, and real solutions.

Part 1. microaggressions and implicit bias in surgical training: An Undocumented but pervasive phenomenon

Yewande Alimi, MD, MHS, FACS

Thank you for the opportunity to present our work today and discuss "Microaggressions and implicit bias in surgical training: An Undocumented but Pervasive Phenomena".[2] My co-authors are Dr. Lisa Bevilacqua, Dr. Rebecca Snyder, Dr. Danielle Walsh, Dr. Patrick Watson, Dr. Eric DeMaria, Dr. J.E. Tuttle-Newhall, and Dr. Maria Altieri. I am a heterosexual, cisgendered, African American woman who has experienced a multitude of microaggressions during her surgical training and it is from this framework that I come to this work.

Implicit bias is defined as a reflection of unconscious attitudes or stereotypes that affect individual's decisions and actions. Racial microaggressions were defined by Chester Pierce in 1978 as subtle, stunning yet often automatic and non-verbal exchanges which are put downs of blacks or persons of color by offenders.[3] Microaggressions are often brief, commonplace, daily verbal, behavioral, or environmental indignities whether unintentional or intentional that communicate hostile, derogatory or negative racial slights and insults towards people of color.

Microaggressions can target individuals based on a variety of differences and these can include sexual orientation, nationality, gender, or personal traits. They are often disruptors in the healthcare setting, and they can undermine the physician-patient relationship due to disparities in the gender, racial, and sexual orientation demographics better represented in the surgical professional workforce, the surgical disciplines are particularly susceptible to these phenomena. Establishing a workplace environment that minimizes psychological stressors outside of the demands of clinical practice is a goal of many residency programs and, with this in mind for surgical trainees, the magnitude of clinical knowledge that one must acquire, and the demands of a busy clinical workload can ultimately be very stressful. This stress is compounded with a trainee who is treated differently based on his or her gender, race, age, sexual orientation, religion, or personal characteristics and can be very detrimental.

Experiences with microaggressions and implicit bias have a pronounced impact on individual's mental health, and they undermine one's ability to participate in cognitive tasks, and this has been previously demonstrated. Microaggressions undermine the credibility of knowers and it results in marginalization and depersonalization and diminishes an individual's ability to participate in the cognitive tasks in which they are meant to engage.

Thus, the aim of our study was to report the trainees' experiences with implicit bias and microaggressions as it pertained to racial, ethnic, gender, sexual orientation, and religious minorities to accurately capture current experiences among surgical residents. The secondary aim of this study was to report differences in microaggressions experience by

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gender. We conducted this by performing a 46-item voluntary skip pattern survey that was a modification of the racial microaggression scale and pre-testing was done with a cohort of 10 surgical residents. The residents were asked to identify personal as well as witnessing experiences of microaggression as well as the sources of the microaggressions, whether or not they came from patients, staff, other residents, or attendings and then whether or not they reported microaggressions and if they felt retaliation was experienced. The study was approved by the Association of Program Directors for distribution and was distributed by email as well as social media.

Responses from the residents

We had a total of 1624 residents and these were pretty equally distributed between male and female. The racial distribution is reflective of the surgical training population with a predominance of Caucasian non-Hispanic whites at 69.6% and about 6% of the residents were black and about 16.3% of the residents were Asian. If we look at the sexual orientation, this is also pretty reflective of the general population with 92% of residents identifying as heterosexual and the minority of residents identifying as either homosexual, asexual, bisexual, or preferring not to answer.

Now let's dive into the data. During residency have you had a personal experience with microaggressions? When residents were asked this question, 64% said yes and there was a preponderance of this experience with female residents compared to male residents at 74% vs 26%, and this was statistically significant. When asked if residents had personal experiences of microaggressions with attending physicians, only 45% of respondents said yes; however, again, there was a statistically significant difference between females and males at 72% versus 28%. When asked about staff member experienced microaggressions, 58% of residents said yes. Compared male and female, this again was predominantly seen within females at 72%. When we asked if they experienced or witnessed a microaggression of another resident by a patient, this was overwhelmingly yes at 77%. While this was statistically significantly different at 56% female versus 44% male, this notable difference was not as predominant as the other differences. When asked if during residency they have witnessed or experienced microaggressions by an attending physician, 47% of respondents said yes and 53% of males said yes compared to females at 47%; this was a flip in the preponderance as we have noticed in the prior questions. When asked if during residency they witnessed another resident experiencing microaggression by a staff person, 61% of residents said yes and, again, here we see the female predominance ramped up at 60% versus 40% in males.

When we look at the themes of microaggressions, the majority of experiences had to do with invisibility, where invisibility is being dismissed, devalued, or ignored because of one sex, race, ethnicity, gender identity, sexuality, religion or nationality. In addition, 42% noted ascription of intelligence, meaning they were being treated as intellectually inferior or superior based on their race, gender, sexuality, religion, or nationality.

When witnessing microaggressions, only 6% of residents reported these incidents to their staff and, again, here there was a 61% female predominance versus 39% male, but this was not statistically significant. When we look at if residents reported microaggressions to the GME or the institution or to their program directors, 7% of residents said that they did and there was a statistically significant difference in which 82% of females felt more comfortable reporting compared to males. When we asked the question about retaliation or negative consequences following reporting of these microaggressions, we already had a low number of residents who reported, but 31% of the residents responded that they felt that they were retaliated against or had a negative experience and, again there was a female preponderance of 72% compared to 28%.

When we asked residents that because of their sex, race, ethnicity and so on, did they feel that they were evaluated unfairly, 30% said yes and female residents felt that this happened more often than male residents at 75% versus 25%. When we asked the question of whether or not people felt that this had adversely affected their training, 30% of residents again said yes, again with females reporting this more often than males at 76 versus 24%. Finally, when we asked residents if they felt like they would leave residency because of their experiences with microaggressions, 14% of residents said yes, again with more females than males at 77% versus 23%. This is a shockingly high number.

To summarize the results, 84.4% of trainees believed that microaggressions could negatively impact patient care and almost 50% of the participants reported reacting emotionally when these microaggressions occurred, but only 53% of respondents felt that they had some sort of formal training or didactics on explicit or implicit bias or microaggressions.

When reviewing all of this data, we found that we need more training on how residents could respond to microaggressions when they happened. Female trainees felt as though they were perceived as not serious, that they must create a more docile tone to be liked. As a female I'm judged differently, or my responses are characterized as aggressive or mean rather than decisive or definitive.

Attendings and administrators need to be more proactive in communicating with patients that this is unacceptable behavior rather than letting it go out of fear of bad satisfaction survey results or that the patient is also right, or always right mentality. More than half of respondents reported experiencing some sort of microaggression and that a majority of these experiences actually occurred during interactions with patients. Only 53% had had implicit or explicit bias training where only 30% of the respondents noted undergoing the training to respond to or manage microaggressions, which is different than just learning about what implicit and explicit bias is.

While there was a high occurrence of microaggressions overall, there was very low reporting at 7.1%, and many that reported felt that they were retaliated against. Therefore, it is critical that faculty physicians who are bystanders when these microaggressions occur exert and stand by their trainees through allyship or reaction of support and solidarity. The act of upstanding or taking action when witnessing a form of bullying when colleagues experience microaggressions is critical and educating our residents, our faculty, and students on how to do this prior to them engaging or interacting or experiencing microaggressions is really important.

While this data was not reported here, when we looked at racial differences in regard to microaggressions there were significant differences between those who identified as being non-Hispanic blacks as well as Hispanic and Asians, compared to their white counterparts. So, this is a phenomenon that we see both in racial discrepancies as well as gender discrepancies, and that data will be forthcoming.

HOW do we solve the problem?

So how can we help to fix this? What do we have in terms of resources thus far? The Association of Program Directors in Surgery (APDS) diversity, equity, and inclusion toolbox is a guidebook that emphasizes recruiting a diverse workforce and improving diversity within the surgical pipeline. Most importantly, it educates program directors to examine and recognize their own biases. We need standardized training centered on the prevention of microaggressions as well as key strategies to disarm microaggressions such as making the invisible visible, educating the offender, and seeking external interventions because many of these microaggressions happen from patients and we cannot really choose who walks into our doors.

Appropriately managing microaggressions instigated by patients must be addressed. We have a patient Bill of Rights to receive medical care, free of harassment, and there are some institutions that are starting to institute policies related to patient harassment towards health care workers. This was particularly highlighted during the COVID-19 pandemic.

This survey certainly has limitations because of the nature of it being

a survey. In addition, we could not ascertain all of the ideologies of microaggressions within this study, including appearing younger than stated age or having a family or being a foreign medical graduate.

Part 2: microaggressions and the black male physician

Fabian Johnston, MD, MHS, FACS

I want to thank Dr. Wexner and the AIS channel for giving me the opportunity to speak on my topic today, microaggressions and the black male physician. It is important for us to understand from a systemic racism to economic disadvantage standpoint, black men face numerous obstacles in their path to medicine. This forms the backdrop for our overall evaluation of the conversation that we are going to be having today. In fact, we as a country know that we continue to grow. With that growth has also come diversification of our population, which bring with it all the benefits of diverse cultures that made America great in what it is today.

In addition to this, however, there is an increasing acknowledgement of the benefits of and the subsequent needs to diversify our clinician workforce to provide care for these diverse populations. Layered on top of this is the stark reality that, in medicine, we are predicted to have a physician shortage of between 26,200 and over almost 105,000 physician workforce by 2030. Thus, while there have been many initiatives by both private foundations and medical schools and government entities to focus on increasing diversity in the physician workgroup in the pipeline, it is important to know that one major demographic group has reversed its progress in applying to medical school - and that is the black male.

This all became the reality around 2005 in this landmark report from the AAMC (Association of American Medical Colleges) entitled "Altering the Course: Black Males in Medicine" and within this report it was revealed that black men enrolling in medical school actually has decreased between 1978 and 2004 to the extent that there are less black men in medical school today than there were in 1978.[4] Thus, as we think about this as a backdrop for our conversation today, specifically focusing on black males, it is important to know where we actually are.

There is really no silver lining to this. There is one thing that may have some positivity in that in academic medicine, at least black men, tend to be retained and while the progression is slow in terms of promotion with the faculty, this persists. Having said that, this is only the hallowed halls of academia and there is a larger issue.

Defining the environment

When I thought about what I wanted to say today, it became clear to me that I did not really want to focus specifically on microaggressions because to do so would give more credence to the microaggressions themselves. What we really need to be thinking of, in my opinion, is what are the things that are underlying the microaggressions and then what is the environment in which these things are happening for our African American male colleagues. Thus, it was with that mind that I begin this next section.

For me, it is a little bit of a walk into my life and so for me it was Dr. David Satcher, who was the surgeon general when I was in college and one of the things that he was known to say is that we need leaders who care enough, know enough, do enough, and will persist until the job is done. This is something that is carried on and thought of by most of my colleagues, or rather all of my colleagues, today and [specifically] many that are in the African American physician workforce today.

It is important to recognize that this is in the backdrop of experiences that we have had in our lives, both in our backgrounds and in the experiences we have academically and socially. So, this is Charity Hospital, which is no longer in use but is where I started my residency at Louisiana State University (LSU) Hospital. In working in this indigent care hospital, I saw the totality of what economic, social, and financial health care disparities played on the populace, especially the black populace of the city of New Orleans, which is a majority black city. After initially seeing this, and then Hurricane Katrina came, it really laid to bear the wide gap for our poor populations and what they experience.

If we then take that lived experience in a short term, such as the Katrina incident, we focus on the longer term looking at life expectancy, depending on where you live. This is St. Louis, where I finished my residency training at Washington University, after I left LSU following Hurricane Katrina. Then here is the city of Baltimore - I live in the green areas right now, but the majority of the black population in Baltimore lives in these higher colored areas where life expectancy is lower. This is largely driven by political and social segregation policy decisions that allow these things to persist.

When we think about that as the backdrop of things that may be lived experience that may be in the front of mind or back of mind for many of African American men, they think about their own experience and seeing people that look like them from varied backgrounds and what happened to them. There is Amadou Diallo who was shot by police 41 times when I was growing up in New York City. There is Mike Brown who was shot by police in Ferguson, Missouri, a suburb of St. Louis where my wife worked in the school system. The world knows exactly what happened to George Floyd, the most recent example of how black males may be perceived as a threat - and this is coming from outside the hospital and within the hospital in our lived experiences.

For those of us in healthcare, we often talk about these microaggressions as a death by 1000 cuts, so imagine if you are on anticoagulation. Thus, it does not take as much of a cut to bleed, and we are bandaged. We have to bind ourselves to control and allow our ourselves to be as healthy as possible. For our trainees, this relates to the level of discrimination they experienced.

A study by Karl Bilimoria and colleagues showed levels microaggressions and discrimination that were reported.[5] If we know anything about reporting, it is likely that is an under-representation of the actual percentage of experiences. When we also look at racial and ethnic discrimination, we see the level of discrimination that occurs and we also focus on when it occurs at all levels and experiences.

So, your lived experience. The majority of us live in the hospitals rather than in our homes, this is what our trainees are experiencing. As we think about how we move forward, I think it is important for us to focus on the "isms". In this specific situation, antiracism is an "ism" that we need to focus on. If there is going to be a takeaway message, I think it is to access a great publication entitled "Toward an equitable society; building a culture of anti-racism in health care" by my colleague and friend, Dr. Paris Butler, who you will hear from later, and his coauthors Dr. Merchant and Dr. Eugenia South, and read it front to back and do it twice or three times.[6]

Implementing anti-racism training

If I wanted to give some takeaways from this, I think that one of the things that can be done to address these microaggressions is deliberate implementation of diversity, equity, inclusion, and antiracism (DEIA) training.[7] I think this is going to be incorporated into how we train our trainees from all levels, undergraduates, medical students, residents, faculty, and advanced practice provider trainees. Let's utilize the tools that we have, and when we see microaggressions occur take these as learning moments and not just brush them under the rug. Let's take an idea of having an accountability system just as we have a system in our hospital for recording adverse events. I think these are also major adverse events that play a role in how our patients and our providers encounter the health system. Let's report them. What can people do? Be mentors, be sponsors. You have power, so support these people that are having these experiences. Find them, network with them, create affinity groups, be an upstander not a bystander, and call out these microaggressions when you see them occur. Apologize when you know that you have been the person perpetrating. Do not be colorblind. Be

intentional about what you do and establish a system of accountability. Lastly, focus on checking in with our trainees and faculty.

In summary, we want folks to focus on being transformative in what they do and not focus on tokenism and one-offs and caring about microaggressions for the black male.

Part 3: microaggressions and the black female surgeon

Oluwadamilola "Lola" Fayanju, MD, MA, MPHS, FACS

I am very pleased to be discussing microaggressions and the black female surgeon. I had the privilege early in my career of presenting at the American Surgical Association, often regarded as the most prestigious and certainly the oldest national surgical association in the United States. It was my first time at the annual meeting for this society, whose members include many of the best, brightest, and indeed oldest members of our profession, and so I was not quite sure where to sit as a presenter. I was eventually directed to the appropriate place for presenters and had the opportunity to see my fellow presenters go before me.

One of the individuals presenting was the son of a very prominent surgeon, and when he concluded his talk the moderator for the session literally said, "we would expect nothing less of the son of "X" that he should be perfectly on time." I thought to myself that this young man had probably attended this meeting before, perhaps as a resident or even as a child, but certainly not like me as a full faculty member for the first time at this, again, very prestigious meeting. It made me think about the fact that, when we assume the best of some, as the moderators had of him, what by default are we assuming of others? This brings us to the insidious issue of microaggressions.

"Micro" is not "small"

Microaggressions, as evidenced by the first part of that word "micro", can appear small but they contribute to a death by 1000 cuts. In medicine and in surgery, that can look like hypercriticism of how you suture, care for patients, communicate a patient's story, and that patient story in a medical record. It can also consist of low expectations, where very little is expected of you and, as a result, very little is demanded of you. Furthermore, those low expectations can lead to people being insufficiently interested in your improvement and your ultimate success. If you are getting too few criticisms and too little coaching, that is as detrimental to you and as much a microaggression as is the hypercriticism experienced by others. Finally, what microaggressions really come down to is that the person putting them forward is assuming things about the person in front of him or her, based on the very few members of that intersectional dynamic that he or she has known before. Again, it can contribute to a death by 1000 cuts.

The effects of microaggressions, and indeed macroaggressions, on the lives of people in surgery have now been well documented. An important survey that was conducted after the 2019 ABSITE, which is the in-service training exam that we all take in the United States, was very revelatory with regards to the extent that bullying behaviors both big and small are a routine part of surgical education.[8] The study reported that a significant proportion of people who responded had experienced at least one episode of bullying behavior and, most egregiously, that this behavior was permitted and even perpetuated by attending physicians. Importantly, of the 18% who reported frequent bullying, women and people who belong to racial/ethnic minority groups were most likely to experience frequent bullying. Notably, there is no data reported on the intersectional identity of those groups. That is, we might assume but we do not know whether people who are both racial/ethnic minorities as well as women are all the more vulnerable to this type of bullying and aggression.

More disturbing still, we know that the consequences of this type of aggression are not simply psychological but ultimately can lead to physical harm, as one in 30 of those who reported serious bullying were thinking of suicide. That rate was even as high as one in ten of those who were significantly bullied.

What does this mean and why do we need to do something about it? I think that we, as surgeons, are uniquely in a place to deal with microaggressions both within and beyond our profession. We are committed to truth telling. In the end, what we see with our naked eye belies whatever is seen by an image or by an X ray or by reports. We see disease in the work that we do every day, and that unique opportunity to see the inside of people really gives us the opportunity to be honest with ourselves – what we do well, what we do wrong, what we can and cannot change.

Dynamism defines us. We are used to working in situations where the landscape changes before our very eyes, and we are used to the idea of needing to adapt to respond to those changes.

Finally, I fundamentally believe that we as surgeons are drawn to doing things that are hard as well as being drawn to doing things that are right. It is precisely because we are often grappling with *micro*-aggressions. That is, not the kind of flagrant prejudice we associate with wearing Ku Klux Klan hoods or shouting anti-Semitic slurs or treating people in ways that are egregiously related to their race or gender, but rather the gentle but insidious actions that can contribute to the harm of the individuals who suffer from them. These offenses are harder to target, harder to identify, and harder to eliminate. However, I do think that we as surgeons have an opportunity to do all of those things.

Intersectionality

A few years ago, I had the privilege of having a piece published in the Journal of the American Medical Association (JAMA) on my experience as a black woman operating in the world, not only as a surgeon but also as someone who is frequently ignored by the people who see me.[9] I wrote this paper right after having attended a meeting in which I was specifically honored as one of the best and brightest in the United States and a future leader in health care. Unfortunately, that particular accolade did not protect me from being ignored on the plane, being overlooked during the meeting, or being treated as "less than" throughout … Much in the same way that many of my black female patients are *all of the time* and in contrast to how I am treated when I have the benefit of a white coat on and a stethoscope around my neck.

Our world has been forever changed by forces both viral and social, which places us at a unique moment to address the most insidious and yet ultimately most harmful aspects of the ways in which we treat each other, particularly the way we treat those who have the least say and the most opportunity to be vulnerable. As a black woman in surgery, I have faith that our profession can ultimately deal with the microaggressions that I and many others will experience. My faith is a reflection of what I believe is best about surgery, namely our commitment to always make whatever is *worst* in surgery at any given moment better. We are our choices.

With regards to microaggressions, the truth of the matter is that we may not be able to choose what comes out of our mouth in a thoughtless moment, but we can choose to do something about the greater structure that feeds that instinct into all of us and causes us to sometimes be less than thoughtful and even deliberately hurtful. Those of us who come from minoritized backgrounds have often had fewer choices. When we find ourselves in an opportune circumstance, I hope those from more privileged stances recognize that they have often had choices that were not available to the rest of us. I hope they use the privilege of choice in order to make the world of surgery a more equitable and hospitable place for people like me.

Part 4: microaggressions and the surgical workplace

Carla Pugh, MD, PhD, FACS

I am Carla M. Pugh, and my talk relates more broadly to microaggressions and the surgical workplace. When we think about the surgical workplace, what we know is that this space requires rapid processing of a wide variety of data and information from multiple sources. Teams depend on information exchange, pattern recognition, cohesion, mutual respect and trust of fellow team members to execute complex surgical decisions. When we step back and think about microaggressions in the surgical workplace, many times we can see them as very common everyday occurrences. Physicians mistaken for nurses, comments regarding how well you speak or your level of English excellence, or other remarks that pretty much can make people feel uninvited in the workplace or unseen. When you look around the hallways in your workplace or campus - you do not necessarily need someone verbally to say something to remind you that you don't belong. The surroundings can make it clear that, from a historical perspective, you have not belonged for quite some time.

What we do know from the business literature is that a single incidence of micro-exclusion can lead to an immediate 25% decline in an individual's performance on the team project. On the other hand, workplace belonging, which we are all striving for, can lead to a greater than 50% increase in job performance, 50% reduction in turnover risk, and 75% decrease in employee sick days. This is real data from the business sector. We do not have this data widely used in health care. It is not clear to me that we have even collected the data, but there is a real opportunity here.

Intent versus impact

What you will hear from some of my colleagues are data regarding patients and microaggressions, but at a high level just looking from the legal perspective, organizations that make race-based staffing decisions that accede to a patient's request for reassignment based on the worker's race may violate title seven from the 1964 Civil Rights Act. What we also know is that nurses and nursing assistants have successfully sued employers who require employees to accommodate such demands by patients. This is something that is interesting from a legal and historical perspective, but the reality is that all of this can be prevented if we took the laws that were enacted in the 1960s and made them relevant in our current healthcare system.

When we step back and think about microaggressions and the work that has been done locally, many of us work in hospitals where there are posters, signs, and early level policies that make it clear that there's no excuse for verbal or physical abuse against healthcare workers. When you look in depth at the volume of work and effort on behalf of nurses in the healthcare environment, they have been at this for 30 years. There are journal articles from Canada and worldwide in the health sector regarding the amazing amount of work that nurses have done and, despite their efforts, many of them say we still have not made headway. I think there is a reason for that.

One of the things is that we really have not taken full toll of intent versus impact. The following is a statement from a senior level nurse that puts things into perspective, "After 30 years I have seen this rampant change towards more expected and tolerated abuse to health care workers. I am done living in fear. It's time to get out. I can only protect myself. To those supervisors that told me that the patient is just delirious. It's not his fault. Well, you can take my place now." Intent versus impact. We understand the position of a patient – they are ill, they are sick, and we are there to help them. But there has to be a balance in creating a safe place for the providers. I'll just pause here.

When we think about nurses, the majority are women. This fits in the realm of microaggressions and a system that has not always protected women and people of color and other underrepresented groups in healthcare. One of the other articles that I found recently in The Varsity, in 2020, states that it is not people of color's responsibility to solve microaggressions in the workplace.[10] I would say the same for nurses. It was never their responsibility to solve this issue. It needed to happen collectively. We all have to work together. When we look at it holistically, the nurses have worked for 30 years, and they have not solved it on their own. We should not create the same mistake for those who are underrepresented in medicine. It should not take another 30 years to come to this realization that this needs to be a holistic effort.

HOW do we move forward?

So how do we move forward? As I mentioned, this has to be built into the very cogs and wheels that run the local health systems in terms of policy and, in fact, at the highest level – the federal level. This is a public health issue, and we need public health policies to protect health care workers. One of the things that has helped me really peel back the layers of this is Isabel Wilkerson's book, *Caste: The Origin of our Discontent*.[11] I think that when we talk about race, it immediately becomes such a volatile political issue, and it allows us not to be able to have a clear lens on how to address things that are happening in front of us on a daily basis. As a researcher myself, Isabel Wilkerson's book has provided a learning framework. It uses the framework of the caste system from India, the Brahmin system. In the book, she layers on the concept of the untouchables and tells a story about Martin Luther King, Jr. And others that have visited other countries and realized that they felt similar to the untouchables, the Dalits. And when they have had conversations with the Dalits the treatment and place in society feels the same. When you look at our health system, if we do not pay attention to external factors that affect how we interact with one another, our patients and our coworkers, it will prevent us from really seeing ourselves.

I have to say, as an underrepresented person in the healthcare system, I am subject to microaggressions and biases every day. I have also imposed them on my colleagues. We have to unfold this - it is not just one person; it is all of us and we do this unconsciously or consciously on a regular basis. I think we just need to see this as a learning framework and then adjust and make policies that affect our workplace, then we can enact our new learning around the policy. I think trying to change individuals one by one is a tall order and a tough task, but if we adjust the system then we as learners can come in and see ourselves and change within a system that has upheld the highest standards. In essence, when the health system seeks to provide care within a social ecosystem that unknowingly embodies the caste infrastructure, then the result is a significant weakness in the delivery of high-quality care because we are operating on shaky ground.

When we consider the untouchables in Isabel Wilkerson's book, there is a level of dehumanization that we have seen before. This may seem like a harsh word but when you look at history, for example, during the civil rights movement, we have made some advances. But I think when you look at things that are happening in our current day events, there is a group of people that just do not belong, that are outcast, that are dehumanized. In fact, the CAREN (Caution Against Racially Exploitative Non-Emergencies) Act that just was implemented in 2020 is one example of the work ahead that we need to do. I think it is a very basic concept in reshaping that we are all capable of issuing microaggressions.

When we look at USMLE (United States Medical Licensing Examination) scores and we compare the scores, our work to address this is to offer more training to Blacks and Hispanics who tend to score lower. We do not pay attention to poverty levels, for example, and this prevents us from being holistic. How many people in certain demographics have the money to pay for courses? Ironically, when I look at these scores I am thinking, "Wow, if Blacks and Hispanics were inherently unintelligent, I would think that the difference in the scores would be greater than 10 points". So, I believe that we have to look at this holistically - the path traveled, the level of support, the historical support. We also have to look at the other side - how much of the scores are related to wealth and the ability to pay for access to certain levels of help and facilitation.

Again, we have to look at this holistically. If we just sit and ascribe intelligence, we allow ourselves to feel sorry for a certain group, then we

are not being holistic. That prevents us from understanding why we should enact policies. Again, it is not for one group to make change, forging a new and successful path requires allyship. When we look at the new surge in pipeline work, a lot of surgeons are rushing to get more students and undergraduates interested in medical school. The pipeline programs have been working for years, of course they can be improved, but the data show a steady increase in underrepresented groups applying and getting accepted to medical school.

Implementing policies

The most important pipeline work to be done is to implement policies in the workplace. We are past due in implementing public health policies to address this bigger issue of gender. The nurses have worked at this for 30 years. It is my hypothesis that if we address the later part of the pipeline, you will see a significant change in the level of dismissals of black and brown residents and faculty. Black and Hispanic residents are 4–12 times more likely to be dismissed in every single specialty healthcare. I believe that if we addressed the microaggressions in the workplace we would see a difference in this. We would see a difference in the end of the pipeline in terms of the small numbers of women who become full professors. Take a look at the AAMC (Association of American Medical Colleges) statistics. One black female orthopedic professor surgery and two Hispanics, 15 black female professors of surgery and 12 Hispanic Females. These are the persons who should be mentors for the pipeline that we seek to bring into healthcare. We need to address the other end of the pipeline. This encompasses the tireless work that the Society of Black Academic Surgeons has been committed to, along with all of the other identity-based surgical societies. There is a lot of work to be done and allyship is a significant portion of the work ahead.

Part 5: allyship, policies, and real solution

Paris Butler, MD, MPH, FACS

I would like to commend the College and the Society of Black Academic Surgeons for taking on this diversity, equity, and inclusion series focused on microaggressions. I am fortunate to be able to participate by speaking about allyship, policies, and real solutions.

There is an overwhelming consensus that in order to alleviate healthcare disparities in this country, it is going to require a multifaceted approach - improving access to care; improving cultural competency, actually I prefer the terminology cultural humility, among providers; improving and increasing more targeted research on minority-specific issues; increasing public health funding on minority-specific challenges; and increasing diversity, equity, and inclusion of the health care workforce. This is the focus of our series.

Definitions and goals

The terminology diversity, equity, and inclusion has received a lot of press of late. It is on the tip of most people's tongue in this current day and age. However, I think it is worthwhile to have a brief conversation about the fact that these terms, although used in continuity, are not synonymous. I think that taking just a brief moment to look individually at the definitions and how they interplay is of value. The terminology "diversity" is ensuring that multiple identities and perspectives are represented, followed by "equity" which is the fair treatment of all people to ensure full participation and advancement, and then inclusion, separately, perspectives ideas and thoughts of all individuals are honored. The goal of diversity, equity, and inclusion efforts in my opinion, and thankfully those of many others, is this idea of creating belonging. We want to have this engagement of the full potential of the individual where innovation thrives and views, beliefs, and values are integrated. We want to create this new culture of diversity, equity, inclusion and, in my opinion, belonging. As it pertains to allyship, as it pertains to moving the needle forward in this space from a big picture perspective, I just want to comment on a couple of things.

We know that minority patients experience worse outcomes after procedures ranging from bariatric surgery to cardiac bypass. There remains an alarming deficit of ethically UIM (underrepresented in medicine) faculty and particularly UIM women across all surgical specialties. The terminology "underrepresented in medicine" was coined by the AAMC (Association of American Medical Colleges) about 15 years ago, which basically defines the fact that not all minority groups are underrepresented. Those specifically that are truly underrepresented in medicine are those that are African American, Latino or those that come from indigenous backgrounds such as our American Indian, Alaskan natives, and our native Hawaiian and Pacific Islanders.

Next, with an overwhelming majority white physician workforce it becomes increasingly evident that efforts to uproot racial inequities in surgery cannot fall on the shoulders of ethnic minority surgeons alone. Attempts at this have been relatively unsuccessful in the past and it is going to require a big lift on all fronts, agnostic of race or ethnicity. This is especially true given the preponderance of leadership positions held by white physicians, providing them with institutional leverage that may not be accessible to all other faculty. Those who have heard me present in the past know that I follow the numbers closely, particularly when it comes to surgical leadership. In the 154 departments of surgery that are acknowledged by the AAMC, currently only eight are led [chaired] by African American surgeons.

Allyship

Herein lies the concept of allyship. Although some prefer the expression champion or upstander, these terms are used for the most part synonymously. Allyship is defined by Webster and several others. I used the Forbes definition here because it has a great infographic depiction of allyship, as a lifelong process of building relationships based on trust, consistency, and accountability with marginalized individuals and/or groups of people.

Several of my colleagues and I, and this is relatively hot off the press as I believe this article actually goes live next month in the Journal of the American College of Surgeons (JACS), looked at how we could embrace allyship in academic surgery.[12] We titled it as such and suggest how all surgeons can become effective champions of change. We describe three steps towards surgical allyship: learning, speaking, and acting. I am going to dive a little bit more granularly into each.

So, what does learning mean? It means to listen to your marginalized colleagues when they choose to share, setting aside preconceived notions or political beliefs means becoming better acquainted with the terminology of diversity and inclusion, becoming better acquainted with the history of racism and sexism in surgery, and the evidence of disparities and discrimination within one specialty. It means owning up to one's own potential privileges within historical surgical culture and examining and self-reflecting upon one's own potential unconscious and conscious biases. It also entails being receptive to and welcoming constructive criticism even when it comes from those that are peers or have less surgical training or clinical experience than oneself.

Next is speaking up. Actively using words like racism, privilege, and discrimination. It means that one will not shy away from diversity-related conversations even if it makes that person feel uncomfortable. It means not using or tolerating derogatory jokes or language in the operating room or inferring that they should be avoided to "not be reported". Just making a complete culture change. Do not justify inappropriate remarks from colleagues as part of the culture of surgery, that is antiquated. Being consistent, do not make offhanded comments or jokes about diversity in surgery and casual conversation with friends or peers.

Finally, embracing your role as an upstander and by enacting the 5Ds in interactions with patients and peers who display discriminatory

language or behavior. I am going to dive deeper into the 5Ds later. Now acting, join diversity-related committees. Do not relegate all diversity initiatives to women or ethnically underrepresented medicine colleagues as I previously stated. Speaking of and prioritizing diversity at all levels of recruitment including students, residents, faculty, and leadership. Do not have or be accepting of all white or all male status quo. Actively mentoring and supporting ethnically underrepresented medicine physicians within the field. Avoiding the use of different phrasing or terms and evaluations or letters for ethnically underrepresented in medicine mentees. Focusing on the objective of their skills and leadership potential. Not covering up or dismissing any reports of discrimination or harassment in one department. Embracing clinical policies focused on improving patient care in the minority and underserved communities. We believe that these three steps, if put into place, can really move the needle towards achieving surgical allyship.

The 5Ds of upstanding intervention

When conflicts arise, the question I get frequently is what to do in real time. We have incorporated and adapted to surgery what we call the 5Ds of upstanding intervention. The 5Ds are not novel to us as I believe it was first described by the Southern Poverty Law Center. Once again, we wanted to adapt this concept to surgery.

The first "D" is Direct: directly addressing the inappropriate behavior. The second is Distract/Delay: creating a distraction that will diffuse the situation. The third is Documenting: recording and making sure to ensure that one has consent before sharing. The fourth is Delegating: asking someone to help. The fifth is Digesting/Reconnect: taking time to process the incident and check in with the targeted person. In our paper we provide a few vignettes. I will go over one briefly. This vignette is aimed at equipping an attending physician when in their presence a patient has used a derogatory phrase or language when talking to one of their residents. The first "D" would be to comment to the patient, "I understand that you are scared, but you cannot use this language when talking to my colleague." The next "D", Distract/Delay, would be, "We have some other patients we need to see, but we will come back shortly." The third "D", Documenting, with consent of the assailed colleague both verbally and via email, relate this experience to the other faculty and staff that are treating this patient. The next "D", Delegating, elicit the support of other attendees treating the patient and other residents and staff. The next "D", Digest and Reconnect, circling back with their resident colleague to inquire about their well-being and offer to listen to how they are processing the experience. There are other similar vignettes, however in the interest of time I will move on.

Polices and solutions

How about policy and broader solutions? What are some tangible ways that our allies can help move the needle pertaining to diversity, equity, and inclusion initiatives? The week of May 25, 2020 stands out to me. I was an attending at the University of Pennsylvania and that week will stand in infamy probably for the entire country, but particularly those of us that come from the black and brown community. It was the week that Ahmaud Arbery's recorded killing hit the social media pages. It was the week that Brianna Taylor's telephonic recording of her murder became available to the national press. It was the week of Christian Cooper's YouTube video of him being in Central Park in New York City asking a woman to put her dog on a leash and having this Caucasian woman weaponized her tears and call the police on him saying that he was assaulting her. Then, unfortunately, it was the same week that the recorded murder of George Floyd occurred. So along with my black and brown colleagues and all of my colleagues agnostic of race or ethnicity at the University of Pennsylvania, we banded together and did a white coats for black lives demonstration on our famed Franklin Field.

Beyond just demonstrating, we wanted to put something into action, so with four of my colleagues, we documented how we felt that the University of Pennsylvania could truly embrace diversity, equity, inclusion, and antiracism and gave 17 actionable recommendations to our leaders. We very intentionally sent it to five individuals: our Dean, Larry Jamison, our CEO (Chief Executive Officer), Kevin Mahoney, our CMO (Chief Medical Officer), P.J. Brennan, our DIO (Designated Institutional Officer), Jeff Berns, and our Vice Dean of Inclusion, Diversity, and Equity, Eve Higginbotham. Four of the five individuals come from the majority community, but recognizing their privilege, their station, and their power, in rather short order at the University of Pennsylvania, we have had this level of success and progress in diversity, equity, and inclusion since July 1 of 2020.

We now have mandated unconscious bias training for all faculty. There is now a Vice Chair for Diversity, Equity, and Inclusion in each and every department throughout the entire health system. There is a Martin Luther King Jr. (MLK) day that is honored like a federal holiday. Previously we had MLK day on the calendar, but it is now truly treated like a federal holiday, similar to Labor Day or Memorial Day with no elective procedures and no elective patient care. The University of Pennsylvania committed giving Philadelphia public schools $100 billion over 10 years and $10 million in support of the five new CPUP (Clinical Practices of the University of Pennsylvania) Presidential Professorships and the creation of a new CPUP Faculty Impact Fund were created. In short, and once again out of respect for time, I would just like to end by saying that allyship and tangible commitment to diversity, equity, and inclusion by all, can yield significant results.

Part 6: Debate/Panel Discussion

Dr. Daniel Dent, Dr. Nancy Gantt, Dr. Carla Pugh, Dr. Paris Butler, Dr. Yewande Alimi, Dr. Lola Fayanju, and Dr. Fabian Johnston

Dr. Nancy Gantt: Panelists, thank you for your terrific presentations that were so encompassing of the issues that we face in this area. Dr. Pugh, I believe women in the health professions are often mistaken for nurses. Nurses are an essential part of our training. I would not be the surgeon I am today if it were not for the surgical Intensive Care Unit nurses at Presbyterian University Hospital in Pittsburgh. But how can nurses assist us? How can they be allies when they witness these types of microaggressions?

Dr. Carla Pugh: I think that is a really great question and I have often raised that question and that is what led me to take a deep dive into the situationality, if you will, of nurses and the health system and that was my epiphany. Nurses have been experiencing microaggressions themselves and fighting vigorously to get policies put into place to protect them for over 30 years. They feel they have failed. So, when they are in the room and it is happening to us, it would not be a surprise if some of them are thinking, "Welcome to the club!". Some of them speak up, but I was just amazed by the literature that I found in USA, Canada, Australia and the UK that they have been talking about this at conferences for 30 years. Obviously, we can look to them as allies because they have tried to push the micro- and macroaggression boulder uphill for many, many years. We can learn from the roadblocks that they have experienced, but it is not up to them to lead the way for us. We must partner together, and we have to have leaders in the healthcare system, the Chief Executive Officers (CEOs) and the Chief Medical Officers (CMOs), to realize that this is a global problem that has largely been ignored for over 30 years and it will not help now that we have a platform for the underrepresented in medicine to speak up about what they're experiencing. We don't have 30 years to do the same thing.

Dr. Daniel Dent: Thank you Dr. Pugh. Dr. Johnston, yesterday I actually met with an African American male who's a preclinical medical student who wanted to learn more about the path to becoming a surgeon. As we chatted, I did the things I usually do for any first or second year medical student in this setting, I talked to him about how to succeed in medical school so he could become a competitive applicant, I got him

plugged in for some clinical experience in our trauma ER that we offer to our preclinical students, and I told him to consider this the start of an ongoing relationship and that my door is always open to him. That is something I try to do with any preclinical student who reaches out to me. What I did not do was ask about any challenges or issues he might be having because of his race to see if I might be able to provide support or assistance relative to some of these issues. I am wondering, did I do the right thing? Is this a first date conversation or is this something that maybe I talk about as we develop a relationship? Or is this something I should not bring up unless he does as we become comfortable with each other?

Dr. Fabian Johnston: Thank you so much for that Dr. Dent. I love how you put it, is this a first date or not. All of these things that we do in medicine are either outside or building relationships, and the fact that you are even thinking about this is a positive sign. We would hope that others think about this as well. What kind of discussions do you want to have? We have to think holistically. Right now, we are talking about microaggressions, we are talking about race, but there are whole people coming to you with whole lives that they are experiencing, and with nothing the pandemic has done is brought to bear the burden of the lives that we have outside of the hospital. While we spend the majority of our time in the hospital, you know there are so many things that we have forgone and missed in our lives to be able to partake in this thing called medicine, because it is a calling it is not just a vocation or a job. If we start with that, that there are more than just the things that occur when we step into the hospital and we want to think of these folks as whole people, then you start to say okay well after we do those initial things as it pertains to their position or where they want to go and where we are trying to mentor them, let's try to get to know people more holistically.

To answer your question more pointedly, I think some of it depends on comfort and that goes for both sides. First meeting, it may take me aback, it may be something that I'm fine with, we don't know. I think it is important for you to get to know that person and understand where they are coming from and then where your comfort is and then, in time, start asking those questions. It may not necessarily need to be a pointed question. You can ask about their experiences, how are things for you so far in medical school? It then becomes an organic discussion and, again, shows that this person is really trying to get to know me. Tell me a little bit about your family, about your experiences, and if you do that you start hearing more and more and it becomes more comfortable. So, if you ask it at the first go around, you may get a very generic answer because that person thinks, I do not know you well enough yet. We have had enough blowbacks by being vulnerable, and some people who may seem to be allies may not necessarily be an ally in the long run. So, building those relationships, I think, will go a very long way. If we center that, it is going to transfer not only to that black male or that UIM resident, but it is also going to transfer to all of our relationships in medicine and I think will pay dividends in the long run.

Dr. Carla Pugh: Dr. Johnston you are on point with it and the entire time you were

talking about this I kept saying, trust, trust, trust. I am thinking, yes it has to be part of the mentor/mentee contract that this comes up. However, the only way it is going to work is if the leadership brings all of the UIM residents together and the faculty and says, "Yes, we are committed, and this is our plan." This is the structure that we must have in place to try and make sure that we address residents and faculty as holistic beings. This includes knowing their experience in the hospital. Also, department leaders must seek feedback because each group is going to be different, the UIM cohorts are all having different experiences, and they have different backgrounds. When you have met one underrepresented person in medicine, you've met one. You do not know where they come from, their family history or, where they grew up. We are not all the same. Having a global commitment as a department, also helps when you're meeting with a UIM resident or faculty member one on one. Once the mentee knows that a specific type of question is coming based on a foundation that the entire department is behind, it helps. I am not saying it is going to be the perfect solution, but I do not think that one mentor asking the question of the mentee and the mentee does not know if everybody else is getting that question, there will be some lack of trust because nobody wants to be singled out by answering a sensitive or personal question from their mentor. The residents frequently comment that they are here for five years and are trying to keep their head down and get through the training program so that they can get on to the next job. They do not want to be singled out.

Dr. Yewande Alimi: Just to jump off of that, as you're establishing that relationship, and I think that this is something that is often lost when we sort of rise in our bridges, I think that you have to be very intentional with that person. You set up the next meeting, that it is coming from you and that it is not put on them because I really feel that when a preclinical student or a PGY1 (Post Graduate Year −1) walks into the office of a chair or division chief, they do not necessarily feel like that invitation is true, that they want to continue having these conversations. I feel as though when chiefs and chairs say they want to be intentional about building a relationship with you and say let's put a date on the calendar for that next meeting, that tells the preclinical student or that young buck that this guy is actually invested he is not putting all the work on me, or this woman is really invested in us developing this relationship. So, I think that even if you do not have that conversation during your first date, if you set up that second date in very short order in the time that you have interacted with that person, they are really going think that this person is actually invested in me and they did not put all the legwork on me. You are doing that first step of setting up that follow-up meeting can be really impactful.

Dr. Paris Butler: I am just going to follow up on what Dr. Alimi said at the end, because I believe this a very important discussion point. I frequently have conversations with my black and brown mentees, in particular, pertaining to how they should best navigate the waters when the overwhelming majority of their colleagues, chairs, and program directors come from the majority community. I express how I have benefited from many majority colleagues that have both mentored and sponsored me. I heard this quote from Dr. Wayne Frederick regarding the receipt of mentorship from nonracially concordant individuals and he poetically stated that "A mentor does not necessarily need to look like you, they just have to share your mission". So in short, that trust will need to go in both directions. There is an understanding that there is some trepidation to trust people who do not look like me and that do not have the same shared lived experience, but the reality is that with the current demographics in the academic surgical workforce, minority physicians will need to enable and feel empowered to let majority physicians assist us in various ways. I just think that a two-way relationship is really important, and that trusting on both sides is absolutely imperative.

Dr. Fabian Johnston: One last statement, one thing that I do not want to escape is that we are talking about this two-way street and what the mentee may do. We want to be really careful. Your mentee is not there to teach you how to do X, how to be X. Many people have been like tell me and show me and do this. That is not their job. That is a burden that they should not have to face. In the last two years, the number of medical students and or early career residents have been asked to give grand rounds and talk about things. That is not fair to them. That needs to come out and be heard - that it is not their job and not their burden to carry.

Dr. Nancy Gantt: Completely agree. All the points were fantastic. Dr. Butler, going forward, I really want to commend you on all the effective programs you have initiated at Penn. When we talk about white physicians having the majority of the institutional leverage, how do we introduce the 5Ds to other surgery programs? What resources do we need to mobilize to improve the learning and working environment for our underrepresented colleagues? What are the tangible and intangible resources that a department would need to accomplish this?

Dr. Paris Butler: Thank you Dr. Gantt for the question. Honestly, we do not know yet. We are doing our best to establish toolkits and best

practices because this is, thankfully, new to all of us but something that we are embracing as academic surgery. I know that Dr. Pugh being President of the Society of Black Academic Surgeons is really pushing for an allyship curriculum and I think this is something that we can take to scale and hopefully this will be embraced and adopted throughout the country. I think we need to continue to use our words and our written words to write down our experiences. I am documenting what has been working and what has not been working because every idea that we come up with is not always going to be successful and maybe we can help other programs avoid some of these potholes or that time suck of putting resources and time into things that are not all that effective. So, I wish I had a better answer for you and that I can point you exactly to a curriculum that has already been established, but I cannot. Through the College I know that Dr. Patricia Turner, the Executive Director, and her team have really been putting forth some intentional efforts toward this endeavor. They have recently hired Dr. Cie Armstead and Dr. Bonnie Simpson Mason, their first Director and Medical Director of Diversity, Equity, and Inclusion, respectively, who will be leading these efforts to help align and collaborate DEI efforts across American surgery. One of my concerns right now is that a lot of people are very excited about the work, but we are kind of fragmented. We need to do everything in our power to get things aligned, and I think the College is actually positioned quite nicely to help us accomplish that.

Dr. Nancy Gantt: The College is certainly aligning its efforts in DEI. Dr. Mason and Ms. Armstead have a big task ahead, but their number one mission is coordinating the efforts across all the areas of the College so that we, as the House of Surgery, can develop the toolkits and templates exactly like you're talking about and make them shareable across all of our institutions.

Dr. Daniel Dent: Dr. Fayanju, I found your talk very thought provoking. Our department and much of our school has been educated about microaggressions. We watched a video that many people have seen on the internet where people ask, "Where are you from?" and it is not done with optimal intent. I have actually heard some faculty say, "Well I guess I just won't say anything." That, in itself, is a microaggression as you pointed out because you are ignoring the person instead of paying attention to them, and especially because this is more likely to happen to those from underrepresented backgrounds. So, my question is, how can I guide my faculty colleagues to even just start the relationship when they encounter a medical student in the operating room or in the clinical setting somewhere? Is it okay to ask, "Where are you from?" as long as one follows it up with more questions to demonstrate a true interest in the learner so that you can then guide their education? "Where are you from? What are you interested in as a career? I want to tailor how I educate you to your background and your interests." Or are there better ways to get to know some of these students to develop the relationship to create the educational bond that needs to be created?

Dr. Lola Fayanju: I think that when encountering a new learner, if that person is from the underrepresented background or appears to have a non-western or foreign sounding name, before you ask a question as part of trying to get to know them, you should probably ask yourself would ask that of someone who belongs in the majority or has a very westernized name. If your inclination is to do something different, then you should probably hold back because if you would not ask John Smith, where are you really from, then you probably should not ask me. I think that one of the things that is really amazing about surgery is that during residency and beyond, we grow up together. The intimacy that develops in the operating room, across table. I would say that the amount of time we spend with each other, especially in training, is really incomparable to almost any other profession. So, there is a natural familiarity and intimacy that grows from being forged in the same crucible. There is a natural tendency to want to get to know people, but it cannot be all at once and it needs to be in a way that, again, engenders a trust that everyone else has discussed. The way that I approach interacting with new students is I kind of ask, what is your origin story? That is a very general way of asking what brought you to this moment in time, and I ask it of everyone no matter where they are from. It gives me a sense of whether or not this is a brand-new world for them, if this is their first time in an operating room or their first time holding a scalpel or was their grandfather a surgeon and so they have been tying knots on their stuffed animals since they were children. It is just really interesting, I think, as part of the general conversation. I also ask it of our team, our scrub nurses and our circulators, and in that way, everyone feels like they are part of a team and getting to know each other. I also volunteer information about myself because I think that, not infrequently, our trainees want to know what our origin story is and what brought us to that moment in the operating room across table from them. Again, I think it needs to be organic and it needs to be very carefully thought out such that you would not be privileging some individuals with questions that you would not ask of others or vice versa.

Dr. Nancy Gantt: That is a terrific way of putting it. I think those of us who love to travel and love to see other parts of the world and are so interested in other cultures find ourselves falling into that if there is someone with a different sounding last name or accented speech. I have medical students from all over, so an opening question is, what school are you from? How did you end up at that school? Where does your family live? I love your origins story because that really does sum it all up. How did we get to the point where we are at this moment?

Dr. Lola Fayanju: Sorry to interrupt, but I will say that we should also give people the grace of declining to share that information. I am very aware of the fact that the operating room is both a private and a public space, and that what is said there often is passed along to other individuals. Some individuals are very private and even things that seem innocuous like asking where you like to travel, you may be talking to someone who is undocumented and therefore cannot leave the country, or someone whose parents would never have been able to afford to send them anywhere, or someone who frankly does not go to nice restaurants because it is too expensive. Just be able to sense that, even conversation topics that seem very innocuous and kind of open for anyone to answer, will not actually be equally accessible to everyone. So, we all have to develop the kind of emotional intelligence to gauge that and also not come across as a tone-deaf privileged surgeon.

There is a great little skit recently that many of you may have seen by Dr. Glaucomflecken about the "easy-going surgeon." It is a very funny skit because it rings really true in terms of this surgeon imagining himself as very laid back and very egalitarian, but he slips into all these classic tropes of self-referencing his own wealth, speaking as to why his values have changed overtime because he has more money, and I think all of us are guilty of that particular lack of self-awareness. So even when we think we are being, "Hey, I talk to everyone the same! I'm the same, we have been shaped by the training we have had and by the company we now keep occupying the top percentile of income, not necessarily wealth, but income in the United States. As a result, we need to just be very cognizant of the fact that even those of us who may say, hey I'm like you, I was first Gen, or I'm a new American, or I'm a black person, you have been changed. You have been changed by the past several years and that is something you need to bring to your interactions as well.

Dr. Fabian Johnston: Can I just say one thing. Dr. Fayanju said, I speak to everyone the same. Sometimes your conversations are not great. Let's just be honest. You don't know what you don't know, and so it is an opportunity for growth, this process is an opportunity for growth, maybe you can just be a better conversationalist.

Dr. Carla Pugh: It is so interesting because it goes to who your friends are and who do you spend most of your time talking to. So, there is a whole, other layer there and when you were giving that list, I'm thinking wow there you go, that is one thing to add to the allyship competency for those who are now trying to partner with us. Yes, we do need a list of get-to-know-you questions. It is the same way when we are doing our interviews. These are standard interview questions. We had to learn a structure around things you can and cannot ask in a formal interview. We need those steppingstones for those who have tended to

have 90% of their conversations with people who look like them and have their same level of wealth and status. We have to recognize this on both sides. Quite frankly, the same thing for those who are medical students or residents or underrepresented medicine, they also need help because the last thing they need is to be taken aback by a question and not have a strategy or a way out and then you lose the learning opportunity.

Dr. Nancy Gantt: The conversation is not just happening from us. Our scrub techs are so enamored with our medical students, they are pumping them for information to the point where I have to say, can we focus on the case. But you are right, it is almost like you need an elevator speech. What is the right way to approach having a conversation and engendering trust at the same time? Dr. Alimi, you and Dr. Butler brought up a variety of terms such as ally, upstander, and champion. For those of us in this space we have also heard the term co-conspirator that Dr. Dent brought add up, and it describes someone with an even higher level of commitment. They prioritize their DEI work over other work, and they are very proactive in reaching out to underrepresented individuals to advance equity and inclusion and create the belonging that Dr. Butler mentioned. If we are going to try to recruit other white leaders to join us on this journey, we need to pick a term and go with it. Champion, co-conspirator, it does not matter what we call it. What are your thoughts?

Dr. Yewande Alimi: I am not necessarily sure that it matters what we call it. I think that what is core to it all is the theme within whatever words you pick. I think that there are certainly people who think that they are allies but in fact they are just performatively allyshipping and so people might say I'm an ally, but if you are not putting pen to paper or you are not putting your actions to those words, it does not really mean anything at all. So, if you call yourself a co-conspirator, an ally, a bystander or upstander, your actions are what really is important in this realm in space. This is particularly true when we are talking about establishing relationships with residents, junior trainees, and medical students. I like the word allyship when it is not empty and particularly this is when people are experiencing microaggressions or frank macroaggressions and/or racism that people are not being bystanders and that they are actively upstanding. The right word is not necessarily defending. In these situations when these things are happening, we need to make sure that we are either educating the perpetrators that this is not appropriate this, is not something that we think should be happening to our institution and to our trainees and that it is not empty behind those words. A part of that has to do with reporting afterwards. Talking about these things with leadership, hey we're seeing a huge percentage of our patients lately that are coming in and talking very disrespectfully to our residents and what are we doing as an institution about that. There are many places that are now focusing on, as opposed to just the patient Bill of Rights, the employees' rights relative to how they are engaging and interacting with patients, that we are not going to stand for this. While it is important for us to take care of you as a patient, you cannot be disrespectful to our staff. I think that certainly the COVID environment brought this more to light, but folks have been experiencing this for many, many years. So, I think that it has to do with the intentionality behind the action. If you want to call yourself an ally, if you want to call yourself an upstander, that you are truly acting and that it is not performative and it is not passive. Much of the work that needs to be done in supporting our trainees is very active, so it is active before these microaggressions occur, it is active while these microaggressions are occurring, then it is the follow up to these situations - how are we going to change the way that our trainees are interacting with our patients or patients are interacting with our trainees, how our staff are, how our co-residents are. I presented in our data that patients do a lot of this, but so do co-residents, so do the staff in the hospitals, and so we as institutions and as leaders have to be very intentional about what we are putting out there. So, words don't matter. I think that it is really the actions behind the titles of these words.

Dr. Lola Fayanju: I would just like to echo what Dr. Alimi said and to suggest that for those who wish to be allies or upstanders, I would encourage them not to try and crown themselves with those titles, that rather those are the types of titles that are frankly bestowed after you have done the work. I liked her term about how allyship cannot just be an empty term. I think that, in general, to become an ally, to become a true person who is walking side by side with us in this journey, then that is something that you are invited to do, and it is a mantle you are invited to assume not one that you put on for yourself.

Dr. Carla Pugh: It is a marriage, not a trophy.

Dr. Paris Butler: If you don't mind, I would also like to comment on Dr. Alimi's remarks about the vernacular. I believe our vernacular is somewhat important, but the mission is obviously more important than the words that we use. Unfortunately, in this space, much of the terminology like microaggression has been politicized. Having been blessed to be asked to give grand rounds at various institutions, in the midst of audiences where not everybody necessarily believes and thinks the way that I do, I have found the need to be a bit mindful of some of the terms. If I am starting to sense that when I say "microaggression" people get a little uncomfortable, on one hand, yes, I do need to allow them to feel that discomfort, but if I change my language a little bit and instead of using "microaggressions" I say "subtle acts of exclusion", which is the basically the same thing, it allows me to get the same point across while I avoid shutting down the conversation (due to that discomfort). So, if I use the same type of language without the politicized terms, then sometimes it gets a little bit more traction. Similarly, the term "structural racism" is often politicized. Alternatively, if I say, "cumulative career advantage", that kind of phrasing for some reason tends to gain better traction. So, understanding your audience and who you are chatting with is important. I do not want to shut down these conversations that are really important. It took us a long time to get to a place where the majority of us feel comfortable to have them. As you know, it took a long time for academic medicine to really embrace it. The words and the vernacular that we use, although somewhat important, I think the mission should always take precedence.

Dr. Carla Pugh: I think that deserves some emphasis. Some people have justified anger and sometimes it is what it is, but it does shut down conversations. We have to be committed to starting the conversation over again and helping that person because they are sharing their emotions and their feelings in that moment. I have been in that experience with my colleagues on my team. I have to talk to them afterwards and say thank you for sharing, so we are going to meet again, and this is the goal this time. If it is too much for you, then let's talk about what you are feeling. Let's work on that separate from this meeting. It is very difficult to do both in the same meeting: to share the pain, to share the past, to share the anger and then try and innovate towards action. When you are developing your curriculum, just realize those are two different spaces and they are both important, but they yield two different outcomes.

Dr. Daniel Dent: Great point. Well, that is either a perfect or a terrible lead into my question for potentially each of you, which is when Dr. Butler mentioned creating a sense of belonging, it reminded me of when I heard the third year of medical school described as the year where you go through rotations looking for your tribe as you figure out what specialty you want to practice in medicine. As a tall white guy who cares deeply about patients and enjoys making acute differences in people's lives at all hours of the day and night, I felt immediately comfortable when I got to the surgical rotation because I was around people like me and who shared a similar philosophy and appreciation of that aspect of medical care. I am wondering if one or more of you could tell your story about how the specialty seemed like the right choice but that maybe the people in that culture seemed a little less inviting, so that some of us can hear how this impacted you and work to not have that happen going forward.

Dr. Carla Pugh: I will break the ice on that one. I love the question. I am a surgeon through and through and so initially my framework was kind of maybe sports analogies or if you can't stand the heat get out the

kitchen kind of thing. I remember as a chief resident telling my other residents, "Look, this attending is vile, and he is not going to let you do anything. But guess what, this man does the best "X-operation" I have ever seen. Go in there and watch the operation and come back and I will lift you up. That is just one example of the mindset of surgery and taking that on. The irony is, even in those moments as a trainee, for me as a black female the vilest microaggressions came from black female nurses. So, it is global, it is not just the surgeon, it is not just the OR community. I think that throughout my career I have navigated those experiences differently depending on where I was in my training. So, yes, it is the context, it is the venue, and it relates to relationships that you expect to have and then they fail because you learn something you did not understand. The ones that have been the most hurtful are the ones where I was assuming some level of trust and then that trust was broken. Then it became clear that it was actually never there in the first place. Those have been the most crushing.

Dr. Fabian Johnston: I wanted to be a psychiatrist, I went to medical school, and it was kind of a sea change and I actually said I was never going to be a surgeon. Then I saw some people, they did not look like me, but they were more normal than I thought, and I thought I am kind of normal and they are kind of normal, surgeons can be normal. Now having said this, I went to medical school in Hershey, PA and here are not a lot of people of color in Hershey. To do this, there is already a compartmentalization that does occur to allow you to make a decision on where to go and it is so variable. For instance, when I started my residency career at LSU, I was only one of two black residents in all surgical specialties in the city of New Orleans except for OB/GYN surgery. There were only two of us back then. There were black and brown residents at LSU who were going to go in surgery. They left a majority black city because they felt the environment was not right for them, they were medical students there. To do all this means making a decision and figuring out how this works for me in my specialty. Where can I go? Where can I feel comfortable? Who are the allies? Are there any allies? Finding a way, being alone, and feeling lonely for a prolonged period of time. One of the best things to happen to me to be honest was Hurricane Katrina. I left and, surprisingly, when I went to Washington University, there were all these black and brown residents I was thinking what is going on here in Saint Louis? It was a credit to Mary Klingensmith, the program director, in bringing folks in. There was a comfort there and now I felt like I could be who I was. I wanted to protect the other residents of color because of the experience that I went through and navigating things with nurses and, as you said, other residents and the best we can with attendings. So there is a vulnerability there, but you have to put up a shield, you have to compare compartmentalize and some of us can do it better than others.

Dr. Carla Pugh: This is a perfect opportunity to promote the Society of Black Academic Surgeons. I remember one of the most scathing microaggressions I got when I was a resident. I was so excited that I got a paper accepted at the Society of Black Academic Surgeons meeting and I was telling one attending that I was going to go to the meeting to present this work and he said, "Wait …..Society of Black Academic Surgeons? What does that mean? What is it, like 5 of you in the room talking about one paper?" I remember having some emotions about that. But the remedy, at least that helped me get through it, was when I actually got to the meeting, and I shared the exchange with my colleagues. SBAS is an immediate safe space to unload those experiences. So just to make it clear, I have gotten where I am in my career because of the Society of Black Academic Surgeons. SBAS is the venue where you are able to share the experiences you were having in that hospital when you were isolated. SBAS is also the place where you can find lifelong friends you could call on the phone and expect comfort in being reminded that we are all in this together. This has been my foundation through many of those horrible experiences. Problem.

Dr. Yewande Alimi: I went to medical school at Emory. I have to say that, for me, the push that got me to choose surgery (interestingly I was actually very interested in psychiatry, Dr. Johnson) was walking into patients' rooms at Grady Hospital and them thinking that I was their surgeon. This was part of the tincture that made me feel that this was something that I could do. I had plenty of mentors at Emory who did not look like me and who were pushing me along the way. I think that what helped to seal the deal for me was that these patients at Grady Hospital, a majority black population, did not make the assumption that I was not their doctor. It was just so comforting, and I did not have to experience that level of microaggression from these patients. It made me feel like, well they certainly think that I could be their doctor, they enjoy when I walk into the room, and I feel like I can have these pure true conversations with them and really connect. That was like, well, regardless of the people that I see in the Department of Surgery here or at other places, that pushed me. Then as a PGY1 going to Dr. Lynt Johnson, who was my chairman for a bit starting at Georgetown, it really helped solidify all of that to make me feel that sense of belonging. It is certainly not always organic for people, but I think that having that transition from on my experiences as Grady Hospital as MS-3 (Medical Student year 3) and MS-4 (Medical Student year 4) and then going to be a PGY4 (Post Graduate Year 4) with Dr. Lynt Johnson and I actually had a couple of other African American residents, male and female, in my program, it helped me a lot. So, I think that speaks a lot to the fact that we really do need to diversify our workforce so that people who are coming up can see folks who look like themselves or who have had similar experiences themselves for them to feel that sense of belonging.

Dr. Paris Butler: I am happy to go next. I did not want to be a psychiatrist, I wanted to be a pediatrician. I think that stems from the fact that the only black or brown physician that I ever saw growing up was my pediatrician. I went to medical school at the University of Virginia, and I am a very proud plastic and reconstructive surgeon, but my training paradigm was 12 years. I tell my mentees no one should train for 12 years. I landed at the University of Virginia where I felt quite isolated. I think I was one of maybe two African American residents, but one of the commonalities that I quickly identified between myself and several of my majority colleagues and faculty, was a love for basketball. So as a first-year medical student, Dr. Curtis Tribble and Dr. Irving Kron had an organized basketball game every Sunday and that was a common thread for me. I played hoops in college and still loved that and was not trying to give that up as a medical student. So, every Sunday at 10:00 a.m. I would go and play basketball with the faculty and the residents. It was multidisciplinary with colleagues from various department and specialties participating, and we had a great time. Dr. Tribble had invited me into the lab and then that was when I thought, "Surgeons aren't half bad". The team concept kind of fit my lived experience as a college basketball player and then in the lab I started doing well and being productive. Words of affirmation from what I call "made people" are incredibly powerful, so when in my third-year Dr. Tribble says, Paris you can be a surgeon, the light went off and I said, you know what, maybe I should be a surgeon. Fast forward, I started to have an interest because at that time the gateway to plastic surgery was still through general surgery. I interviewed for an opportunity to go to Stanford and join the lab of Dr. Michael Longaker. Once again, this common thread of basketball played a role, as Dr. Longaker played hoops at Michigan State Univ. And literally my initial phone interview from Charlottesville to Palo Alto, 30 of the 45 minutes was about my experience as a college athlete. I decided to go into his lab, he took an interest in me, and his words of affirmation were that "Paris not only should you be a surgeon, but you should be an academic surgeon". Then as I continued on that walk, I ended up getting involved with the Society of Black Academic Surgeons and I met my first African American academic plastic surgeon, Dr. Mark Grevious, who sat me down at the meeting and said this is how you need to navigate the waters of plastic surgery, and I was off and running. This serpentine route for me between my common thread of hoops and these words of affirmation is what made me solidify what I wanted to do with my professional aspirations.

Dr. Lola Fayanju: Like Dr. Johnson and Dr. Alimi, I also considered psychiatry very strongly. I will also say that I know a number of people,

close friends, who were making the same choice between some type of surgical specialty and psychiatry. I think that there is more commonality between those two fields than one might expect. Both have quite a lot of immediate gratification. When you can stabilize someone who is frankly psychotic and help them feel something like normal and, likewise, if you can cure something or fix something in the moment in the operating room, those are both incredibly satisfying approaches to disease. I would say that the intimacy of the surgeon-patient relationship is not unlike the intimacy of the psychiatrist-patient relationship. Patients tell you things that they often do not tell anyone else because they know that you are about to put your hands in their body, and you are about to do something that would be considered a crime if you were not given a medical license and a board certification. I do think that engenders a certain type of communalism, intimacy, candor that is really unusual. In terms of what ultimately brought me to surgery, I came into medical school thinking that I was going to be an OB/GYN, but did not really enjoy it that much, but I did really enjoy psychiatry and surgery. Then, like everyone else mentioned, there were a couple people who said to me, we think you should do this. Those people included Dr. Ira Kodner, a very well-known colorectal surgeon who in his later career pivoted towards looking at ethics in surgery and in helping the underserved, and Dr. Julie Margenthaler who is the recent president of the American Society of Breast Surgeons and was the first breast surgery fellow at Washington University when I was a 3rd year medical student. She reached out to me about doing a project and that was the first time that someone, again, said I think you should do this and let's bring you on board. So having people who see your value early on and make you feel like you can be a part of their tribe, that makes a huge difference. Those people end up being incredibly close friends in addition to being incredibly close mentors. I think surgery is a field where that kind of relationship can really develop because you are training for such a long time and in such intimate circumstances. I felt very lifted up at Washington University, which is where Fabian actually came and joined our program when I was a resident. We had wonderful support not only from Mary Klingensmith but also from the program directors Dr. Michael Awad, Dr. Paul Wise, and our chair Dr. Timothy Eberlein, who I think has been very genuinely committed to trying to diversify surgery and making it a safe welcoming space for all people. Just having a support, for me, not only to go through residency but also to have both of my kids during residency which for many people is not a straightforward path and for many women increasingly is a challenge, was also something that made me feel very lifted up and like, yes, this is my tribe. Even in doing this thing that many people said you should not do, you cannot do, as a trainee I was really lifted up and supported. Finding your tribe is not just about sponsorsis because it depends on the mentors and the space and the environment and if it is not all conducive, then the shift towards psychiatry or pediatrics could happen for anyone even if in retrospect you really have a surgical personality. So, what I would ask people to do is create the space for that natural inclination to take root and to flower. If you do not provide the fertile ground for it to happen, even the most potentially promising surgeon may go somewhere else and do something different.

Dr. Daniel Dent: Thank you for that. All I can say is wow! Thank you all for sharing your stories and your insights and your guidance for those of us who truly are interested in helping walk down this path. I think people that are watching this will have learned a great deal from it.

Dr. Carla Pugh: Thank you Dr. Dent and Dr. Gantt for joining us and thank you to my colleagues for committing to sharing their stories and giving some time for this webinar for the Society of Black Academic Surgeons.

Summary

Daniel Dent, MD, Nancy Gantt, MD, Carla Pugh, MD, Steven D. Wexner, MD

Dr. Carla Pugh: Thanks everyone! Obviously, there are a lot of experiences that contribute to our understanding of microaggressions. We look forward to finding new ways to partner with our allies and continuing the conversation.

Dr. Steven Wexner: Thank you very much Dr. Pugh, and thanks to the entire leadership of the Society of Black Academic Surgeons, of course our moderators and faculty today. I also express our great appreciation to our worldwide audience for your active participation, not only listening but sending questions. When I say active, active I hope in terms of heeding the message that we have learned today and continuously incorporating the critical points discussed today in our behavior. What we all saw and heard today was phenomenally important and very timely. Actions speak louder than words so we must all act in accordance with the material from this program. I also thank of course the technical crew from the AIS Channel, the American College of Surgeons for their alliance with this monthly Diversity, Equity and Inclusion series, and the Johnson and Johnson Institute for funding this AIS Channel program. Stay tuned next month when our Operation Giving Back from the American College of Surgeons is featured in an interesting show involving several of the African surgical societies and we look at another related unique set of challenges in that part of the world with which the American College of Surgeons is very engaged in improving care. Thanks everyone.

Disclosures/conflicts of interest

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