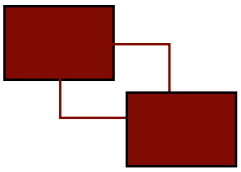
Ensuring Equity, Diversity, and Inclusion in Academic Surgery

Task Force on Equity, Diversity, and Inclusion
American Surgical Association

ISBN 978-0-692-19027-2



Introduction

Brief Description

Surgeons and the discipline of surgery, particularly academic surgery, have a tradition of leadership both within medicine and within society. Currently, we are being challenged to harness our innate curiosity, hard work, and perseverance to address the historically significant deficiencies within our field in the area of diversity, equity, and inclusion. Surgery needs to identify areas for improvement and work iteratively to address and correct past deficiencies. This requires honest and ongoing identification and correction of implicit and explicit biases. More diverse departments, residencies, and universities will improve our care, enhance our productivity, augment our community connections, and achieve our most fundamental ambition—doing good for our patients. This work product identifies issues and hurdles and develops a set of solutions and benchmarks to aid the academic surgical community in achieving these goals.

Goals

Chapter 1: Summarizes why *Ensuring Equity, Diversity, and Inclusion in Academic Surgery* is imperative, and catalogue the existing demographic data on underrepresentation in academic surgery. A full description of underrepresentation in medicine, and specifically in academic surgery must be multifaceted. We consider the absolute numbers of individual faculty and residents, the paucity of representation in leadership positions, and differential salaries and advancement. These issues exist for racial and ethnic minorities, women, LGBTQ, and physicians with disabilities. We will briefly outline the rationale for and benefits of correcting these inequities.

Chapter 2: Provides tools to: 1) Recognize the individual and organizational barriers that impede diversity and inclusion; and 2) Identify tools and metrics to measure individual and organizational performance relative to diversity and inclusion.

Chapter 3: Defines the ethical foundation for Diversity and Inclusion, recognize deficiencies in our response and to highlight behaviors to optimize success. Using dispassionate critical appraisal and individual introspection, the goal of reflecting our broader communities is achievable. The benefits accrued enhance the environment of our academic departments, improve our fiscal status and, most importantly, optimize patient care.

Chapter 4: Focuses on diversity —a powerful societal and institutional agent for change which, in Departments of Surgery, promises to contribute significantly to the missions of clinical care, education, and research. Fostering Diversity in a Department presents significant challenges and opportunities and it requires the development of a multi-year strategic plan. To this end this chapter provides an organizational structure to Deans of Medical Schools, Hospital leadership, department Chairs, senior faculty members and search committees identifying areas of focus and listing sources for assistance in order to facilitate recruitment of a diverse faculty and senior administrative staff to result in a diverse department, reflective of the environment in which we live, where all are valued and contribute innovative, forward-thinking and comprehensive solutions to the challenges we face.

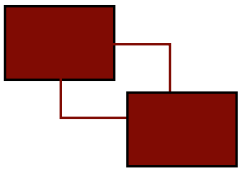
Chapter 5: Provides a roadmap for the academic success of faculty members, including a defined academic niche, identification of mentors, an understanding of the promotion process and the importance of self-care and well-being. Unlike the rest of this document, which is focused on strategies that can be implemented by those in leadership, this chapter focuses on strategies for the more junior faculty member. As optimal mentoring and development is a two-way process, this chapter aims to provide information and tools that will enable them to get the most out of mentoring and development efforts by their Division Chief, Chair, and institution.

Chapter 6: Describes the negative effects of bullying, harassment, sexual harassment and diversity driven microaggression, on the professional environment of surgery; to define the scope and nature of these problems; and to recommend policies and leadership practices that will create a culture of respect, equity and inclusion.

Chapter 7: Provides a list of specific items aimed at faculty leadership development, promotion and retention that will benefit all faculty and are specifically designed to ensure equity.

Chapter 8: Focuses primarily on the role of successful surgical leaders such as Chairs and Division Chiefs in ongoing systematic assessment of evidence-based outcomes and subsequent thoughtful modification of programs that are key to the success of careers of women, minorities and under-represented groups. Below we discuss the various levels at which continuous evaluation of workforce disparity can occur (individual, department, institution) and consider the tools which may be best suited for each level of assessment.

Chapter 9: Stresses the numerous ways that service and altruism contribute to the enhancement of diversity, equity, and inclusion within academic surgery. Many academic surgeons have embraced activities that advance these issues through community engagement and global health. This section provides examples of successful programs and insight into the best approaches to integrate these activities into academic departments as well as ways to value these activities through academic credit. Programs like those described provide opportunities for individuals who are underrepresented in medicine and those that are economically disadvantaged to be exposed to the medical field, opportunities, and role models which will enhance opportunities for inclusion in the diverse work force of the future.



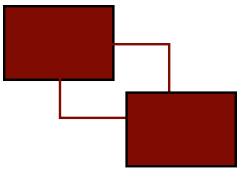
Contributors

Contributing Authors

Nita Ahuja, MD
Peter Angelos, MD, PhD
Barbara L. Bass, MD
Karen J. Brasel, MD
Herbert Chen, MD
Kimberly A. Davis, MD
Timothy J. Eberlein, MD
Yuman Fong, MD
Caprice C. Greenberg, MD, MPH
Shelley Hwang, MD
Keith D. Lillemoe, MD
Ronald V. Maier, MD
Mary C. McCarthy, MD
Fabrizio Michelassi, MD
Patricia J. Numann, MD
Sareh Parangi, MD
Jorge D. Reyes, MD
Hilary A. Sanfey, MB, BCh, MHPE
Steven C. Stain, MD
Ronald J. Weigel, MD, PhD
Michaela A. West, MD, PhD
Sherry M. Wren, MD

Contributing Reviewers

R. Daniel Beauchamp, MD
John R. Benfield, MD
Eileen M. Bulger, MD
Francisco G. Cigarroa, MD
Mary T. Hawn, MD
K. Craig Kent, MD
Mary E. Klingensmith, MD
M. Margaret Knudson, MD
Rosemary A. Kozar, MD
Scott A. LeMaire, MD
David W. McFadden, MD
Kenric M. Murayama, MD
Dmitry Oleynikov, MD
Aurora D. Pryor, MD
Mark Puder, MD, PhD
Patricia L. Roberts, MD
David A. Rothenberger, MD
William P. Schecter, MD
Martin A. Schreiber, MD
Douglas P. Slakey, MD, MPH
David I. Soybel, MD
David A. Spain, MD
Allan Tsung, MD
Sharon M. Weber, MD



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CHAPTER ONE

Making the Case for Change: Background and Scope of the Problem

Changing Demographics of the Surgical Workforce

The demographics of the Unites States is changing, and has become more racially and ethnically diverse than in the past (Figure 1-1).[1] Nearly 51% of the population are women, but the number of women in departments of surgery does not mirror the general population. In 2003, the Executive Council of the Association of American Medical Colleges (AAMC) adopted the following definition: "'Underrepresented in medicine' (URiM) means those racial and ethnic populations that are underrepresented in the medical profession relative to their numbers in the general population."[2] Women and racial/ethnic minorities (even beyond the URiM groups) have fewer opportunities to enter academic surgery, and even after starting their careers have not been retained or promoted in their academic careers at the same rates as their white male counterparts. There is less available data on the LGBTQ community and disabled surgeons, but there are not many success stories than can be identified.

Evidence from the Association of American Medical Colleges and the Accreditation Council for Graduate Medical Education (ACGME) shows far fewer women and URiM faculty in surgery departments than in the general population. This is magnified among senior faculty given that these populations experience higher levels of attrition and lack of promotion toward tenured positions and senior leadership.[3–5] The lack of concordance between the composition of the general population and faculty in academic departments of surgery is concerning.

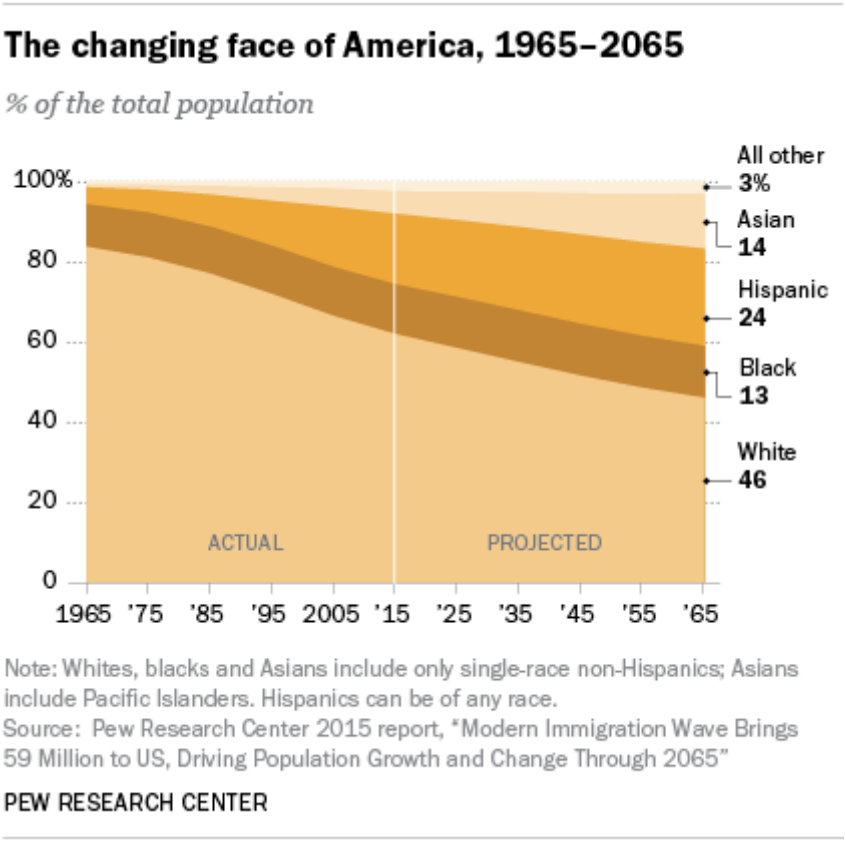

FIGURE 1-1: Adapted from Pew Research Center.[1]

Evidence of Inequity

Despite equivalent number of male and female matriculates and graduates of U.S. allopathic medical schools, there are disproportionately fewer women in every phase of the academic ladder in surgery.[6]

In a cross-sectional study of faculty with medical school appointments in 2014, 31.4% of male general surgery faculty were full professors compared to only 12.7 of women; overall 33.5% of male faculty worked at a top 20 ranked medical school compared to 15.0% of female faculty (Figure 1-2).[7] Surgeons who embody the intersection of these underrepresented groups are particularly vulnerable. According to the AAMC data, there are only nine African American women and five Hispanic women surgeons in the country that currently have tenure in Departments of Surgery.[8]

The inequity is even more pronounced when comparing the salaries of women and men surgeons.[9] The Medscape General Surgery Compensation Report reports an $83,000 pay gap between men and women general surgeons (Medscape. Medscape general surgeon compensation report 2016.[10] Women physician scientists also have lower salaries. In a study of mid-career academic physicians who had received NIH K23 and KO8 funding, the mean salary for women was $167,669 compared to $200,433 for men. Even after adjustment for differences in specialty, institutional characteristics, academic productivity, academic rank, work hours, and other factors, male gender was associated with higher salary ($13,399; P = .001).[11] These inequities in advancement and compensation have been clearly documented, and must be addressed in order to advance a culturally competent surgical workforce.

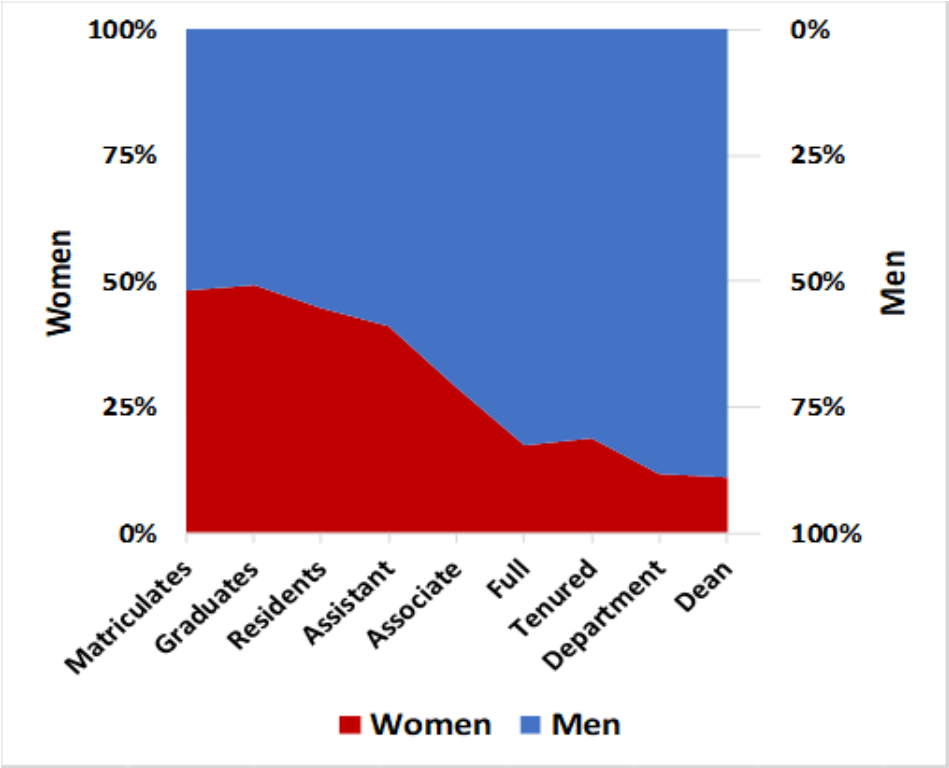

FIGURE 1-2: Representation by Gender per Academic Level. Adapted From: AAMC Faculty Resources and ACGME Data Resource Book.

Importance of Equity, Diversity, Inclusion

There is a growing body of evidence that suggests a diversity of opinion leads to better outcomes.[12] Many examples have confirmed that increasing diversity fosters innovation and creativity across a variety of disciplines.[13] In the business sector for example, this has had the direct and tangible benefits of increased profitability for those companies that have prioritized diversity among their employees.[14] In a report by McKinsey that analyzed the financial performance of 366 companies, those in the top quartile for racial and ethnic diversity were 35% more likely to have better than average financial returns.[15] However, it is not enough to just have diversity among the general workforce in an organization, it is also important to have diversity among senior leadership. Companies in which women made up 30% or more of the corporate leadership (CEO, the board, and other c-suite leaders) had higher net margins than companies that lacked female representation at this level.[16]

Bowen and Bok, former Presidents of Princeton and Harvard respectively, have suggested that because of the growing diversity of American society and the increasing interaction with other cultures, it is also advantageous to majority populations to be educated in a diverse environment.[17] One can apply this same argument to the workplace, with some companies adopting diversity as a compelling strategy for innovation and creativity. The need to increase diversity in healthcare is even more compelling. In 2004, the Institute of Medicine addressed the urgent necessity to increase diversity specifically in the healthcare workforce, citing the shifting demographics of the U.S. population and the importance of increasing ethnic/racial diversity among healthcare professionals.[18] This need was based upon the belief that diversity among healthcare providers would be associated with improved access to care for minorities, better communication between patients and their health care providers, and greater patient-centered care around healthcare decision-making. These contentions are strongly supported by studies that suggest patients may have better communication and more participatory decision making with providers of the same race or gender.[19]

While increasing diversity is important, another key component to providing equitable healthcare is to increase the "cultural competence" of physicians overall. Cultural competence requires an understanding of each patient's unique health beliefs and accounting for these beliefs while providing patient care. Studies suggest that cultural competence results in better health outcomes for the individual patient as well as for the health system, and addresses the fundamental value of providing fair and equitable healthcare regardless of race, ethnicity, gender, or culture.[20]

Etiology and Contributing Factors

In order to change the existing disparities in the workforce, we must understand why there are fewer women and URiM surgeons in our departments. The contributing and mitigating factors related to workforce diversity will vary based on local culture and policies; yet, most departments and institutions have never assessed their own level of diversity. While evaluation at the departmental level provides initial insight, it is also critical to recognize that each of us harbor attitudes or stereotypes as individuals that affect our understanding, actions, and decisions. Online exercises can give insight into individual biases that can impact how one approaches trainees, faculty candidates or colleagues.[21] It is important for each of us to recognize and admit to our own biases so that we can then identify the tools needed to mitigate the impact of our biases.

In 1970, Chester M. Pierce, a Professor of Psychiatry at Harvard University, coined the term microaggression to describe insults and dismissals by non-black Americans on African Americans.[22] In his book, *Microaggressions in Everyday Life: Race, Gender, and Sexual Orientation,* Derald Wing Sue argues that microaggressions occur in three forms: microassault, microinsult, and microinvalidation, and are brief everyday exchanges that send denigrating messages to certain individuals because of their group membership.[23] Sue has written that "*Microaggressions go beyond race and extend into socially constructed identities that embody privilege in different ways, such as income, social capital, religion, ableness, gender, and sexual orientation"*.[24] In describing his own experience as a trainee, Montenegro implores us that it is not sufficient merely to acknowledge that microaggressions exist. Each of us must strive to become an ally in creating an environment that promotes a medical community of safety, advocacy, and compassion.[25]

The absence of mentorship has been consistently cited as one of the most common reasons that women and URiM perceive barriers to career advancement.[26–27] Mentorship and the presence of role models have been shown to be an important factor in both recruitment and retention for both women and men, starting as early as medical school. As junior faculty, women also identified the lack of researcher role models and advice on promotion and grant writing as key deficits.[28] Thus, mentoring junior faculty is an important tool that must be better implemented in order to encourage more women and URiM to remain in surgery. In addition to mentorship, sponsorship by senior faculty for key positions on committees, boards, and panels is critical to maintaining long-term job career advancement. The greater inclusion of URiM and women in positions of influence and leadership will promote a stronger base from which to attract and promote junior faculty from underrespresented groups.

How Can "We" As Surgical Leaders Affect Change to This Problem

If we are to provide the highest quality, equitable surgical care, it is clear that we must act to promote diversity and inclusion in the surgical workforce. In this document, we hope to describe some intentional actions towards Ensuring Equity, Diversity, and Inclusion in Academic Surgery. Carnes describes the stages of change to effect diversity in academic medicine.[28] The first is "precontemplation"—members of an academic community do not see the lack of diversity in their institution as a problem needing to change. The second is "contemplation"—when administrators, faculty, and staff recognize the lack of diversity as a problem. The third stage is "preparation"—as individuals and institutions describe specifications they are planning to take to foster diversity. Next, the "action" stage—specific conscious behavioral changes that increase diversity on a small scale, and finally, the "maintenance" phase is characterized by continued monitoring, as institutions need to collect, analyze, and make public data on diversity of faculty hires, retention rates, invited speakers, and the composition of key committees. Investigators at Boston University have proposed a multifaceted approach to engage stakeholders regarding LGBT health care (Figure 1-3).[30]

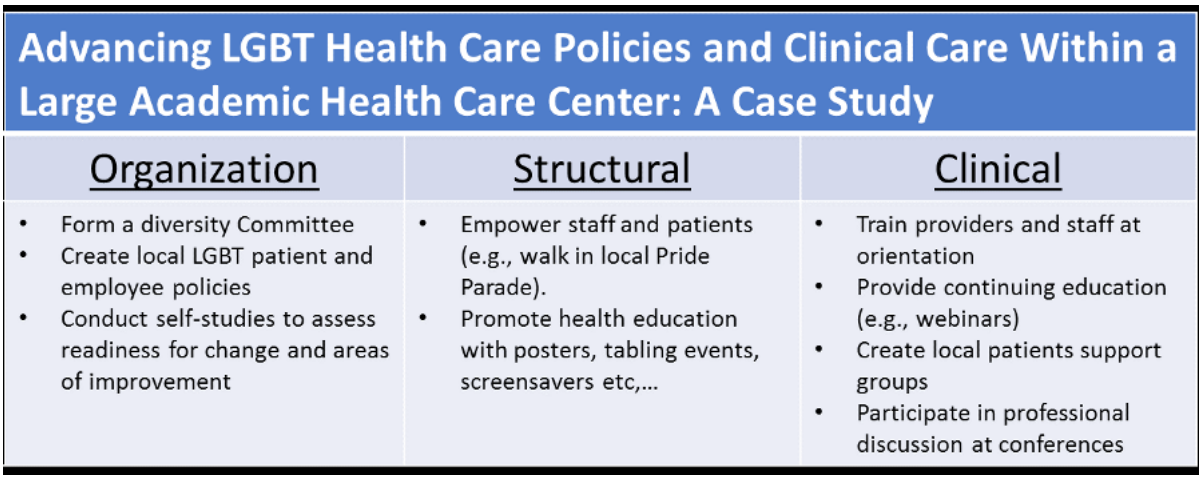

FIGURE 1-3: Adapted from Ruben et al. *J Homosexuality*. 2017;(64):1411–31.

The overarching goal of this document is to provide context and guidance for academic surgical leaders in those key domains related to diversity in the surgical workplace. Specifically, we seek to provide practical strategies to assist in the baseline assessment of the problem. We will then identify opportunities for education and engagement of the faculty to address this issue. Further we suggest initiatives to incorporate into the recruitment and retention process, as well as tools for conducting ongoing assessment of diversity in the workforce. Finally, we will provide examples of ways in which every individual can make an impact through outreach in their local communities as well as globally. The intent of this manual is to serve as a living document of best evidence and practice in order to foster a more diverse and inclusive surgical workforce.

Key Performance Indicators

- Surgical department demographics should mirror the general population for women and URiM.
- Current inequities in status and reimbursement should be corrected.
- Improvements in patient-centered care and quality require increased diversity in the department.
- Implicit bias and microaggressions need to be recognized and avoided.
- Surgical departments should be leaders in equity, diversity and inclusivity.

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CHAPTER TWO

Recognizing Individual and Organizational Barriers to Diversity and Inclusion

Introduction

We often think of diversity and inclusion in relation to gender or race, usually in isolation, but it is important to recognize that each individual has multiple characterizations of personal identity that can be impacted by these issues. The complex and cumulative way that the effects of different forms of discrimination (such as racism, sexism, and classism) combine, overlap, and intersect especially in the experiences of marginalized people or groups is referred to as intersectionality (Figure 2-1).[1] Kimberlé Crenshaw, who coined this term, says "If you are standing in the path of multiple forms of exclusion, you're likely to get hit by both". It is critical to recognize the complexity of these issues as individuals set out to identify the barriers to diversity and inclusion in themselves and their organizations.

FIGURE 2-1: Characteristics of personal identity That may lead to discrimination.

The first step to improving diversity and inclusion is to define and collect key performance measures to characterize individual or institutional baseline states and to identify targets for positive change. Measuring success (or improvement) will require individual self-assessment as well as an evaluation of institutional demographics, policies, practices, and culture. In order to be successful, efforts to improve diversity and inclusion must be based on accurate and current information that includes an assessment of the leadership, attention to problems in the institution's culture and practices, input from stakeholders and evaluation of results. Furthermore buy-in from leadership at all institutional levels is essential. Each individual and institution will manifest barriers to diversity and inclusion in unique ways that depend on the local contextual factors. A thorough baseline assessment is critical to make a case for change, design individualized interventions, and allow for measurement of progress.

Individual Self-Assessment

Explicit bias has largely decreased since the passage of the Education Amendment to the Civil Rights Act (Title IX). While there are still instances of overt discrimination, for the most part these can be addressed by institutional policies that forbid such behaviors and offer avenues to report policy violations. The veiled manifestation of discrimination characterized by the often unconscious exclusion of individuals from information related to job opportunities, negotiations, and organizational politics is far more prevalent and difficult to address. This phenomenon is known as unconscious or implicit bias and it refers to our tendency to be more comfortable around those individuals who look, think and talk like us. This may lead to exclusion of others based on characteristics of personal identity (Figure 2-1). A meta-analysis of 90 studies across a wide variety of disciplines showed that implicit bias was at least as detrimental as overt discrimination on a variety of outcomes including career success and satisfaction, stress level, job turnover and performance, and even physical and mental health symptoms.[2] Not only is implicit bias at least as damaging as overt bias, by definition, it is far more difficult to recognize and combat.

One of the greatest challenges in addressing implicit bias is the inability to recognize it in ourselves and others. At an individual level, biases can often be elicited by thoughtful reflection, for example by asking "am I comfortable working with people from all demographic groups or is there a group or groups that I struggle to accept?" One approach to addressing our personal biases is extrapolated from work by Carol-ann Moulton et.al.[3] In this paper Dr. Moulton describes how expert surgeons are able to recognize when it is necessary to "slow down" at critical points in an operation and move from an automatic to a more effortful, analytic behavior. In similar manner, if we learn to recognize our biases we can exert more control over the way our assumptions influence the choices we make.

More formally, individual biases can be measured by the implicit association test (IAT) which examines automatic associations that are evoked by rapid reactions in response to race, gender, age, sexual orientation, or other personal traits.[4] The IAT has, however, attracted some criticism from authors who debate the test's psychometric validity and reliability. Blanton et al have expressed the concern that it is being pushed into the public sphere, particularly into the hands of legal scholars who argue it can be used to reshape antidiscrimination laws, before it's been properly vetted.[5] Nonetheless, the use of implicit bias training is worthwhile and has been advocated for search committees, particularly when recruiting individuals who will be in a position of leadership.[6]

Another approach to diagnosing individual biases relies on building a safe culture where feedback is encouraged and provided freely. Individuals, particularly those in leadership positions, should enlist trusted colleagues to point out behaviors or comments that may be harmful to others. Leaders should empower all members of the community to call out racist, sexist, ageist, or ableist comments and actions when they occur. It is important to remember that we all have biases and that offenses due to these biases are often unintentional, and represent a blind spot that will not change without feedback. Whether such "calling out" occurs in real-time or in a confidential post-hoc setting depends on the situation, the relationship of the parties involved, and the egregiousness of the incident.

Organizational Assessment

Above all, diversity and inclusion includes respecting differences and ensuring that all individuals, regardless of their characteristics of personal identity, feel that they are valued, and believe that they have equal access to leadership and to other career advancement opportunities. The concept of inclusive leadership is illustrated in Figure 2-2.

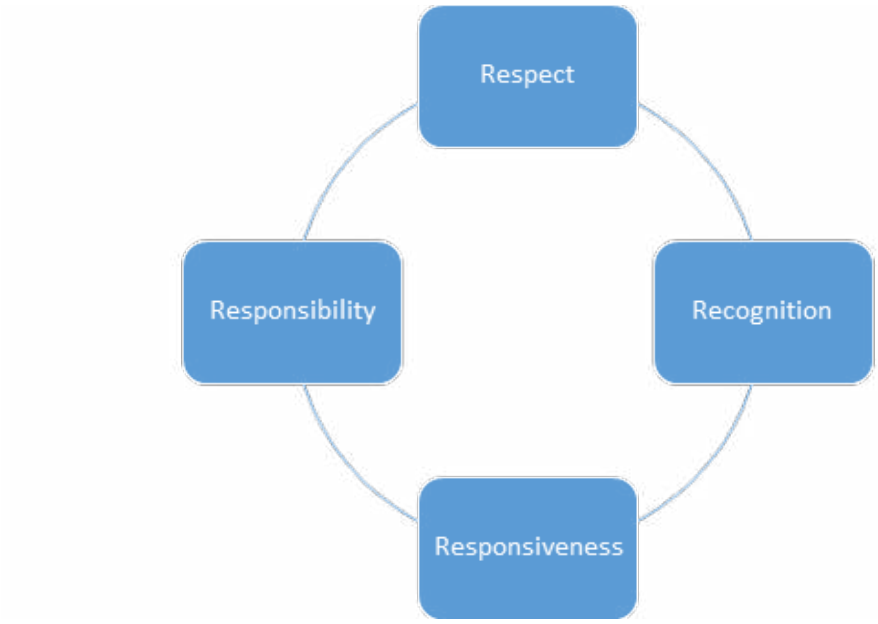

FIGURE 2-2: Modified from Inclusive Leadership Coaching by Mitchell Services. http://mitchellservices.net.au/inclusive-leadership-coaching/ Accessed March 22, 2018.

As noted above, defining and collecting key performance measures is necessary in order to identify the targets for positive change.[7] Furthermore institutional leaders will need to clarify what diversity, inclusion, and engagement will or should look like once achieved. Additional questions could be created in order to identify systematic and structural constraints built into academic institutions that have impeded the careers of certain individuals. A number of tools are available to explore diversity and inclusion in the workplace. Two of these are included in the Appendix. Person et al[8] identified eight engagement and inclusion factors, which formed their Diversity Engagement Framework and can be evaluated using the Diversity Engagement Survey (DES) (Table 2-1). The DES was developed as a validated, benchmarking tool that allows institutions to assess their engagement and inclusion efforts and develop a strategy for achieving their diversity goals according to the framework. The authors emphasize the importance of starting with an understanding of the extent to which individuals currently feel included and engaged in order to build institutional capacity for diversity.

TABLE 2-1: Diversity Engagement Survey (DES)[8]

Common Purpose	Individuals experience a connection to the mission, vision, and values of the organization.
Trust	Individuals have confidence that the policies, practices, and procedures of the organization will allow them to bring their best and full self to work.
Appreciation of Individual Attributes	Individuals perceive that they are valued and can successfully navigate the organizational structure in their expressed group identity.
Sense of Belonging	Individuals experience their social group identity as being connected with and accepted in the organization.
Access to Opportunity	Individuals perceive that they are able to find and utilize support for their professional development and advancement.
Equitable Reward and Recognition	Individuals perceive the organization as having equitable compensation practices and nonfinancial incentives.
Cultural Competence	Individuals believe the institution has the capacity to make creative use of its diverse workforce in a way that meets business goals and enhances performance.
Respect	Individuals experience a culture of civility and positive regard for diverse perspectives and ways of knowing

In addition to assessing perceptions of inclusion, engagement, and productivity, it is important to identify concrete areas of measurement in order to address specific barriers at the organizational level that can be targeted for improvement. For example, defining an effective recruitment strategy is important to develop and sustain a diverse workforce. Metrics to assess the recruitment strategy include number of diverse applicants identified, those invited back for second interviews, and those successfully recruited. Some metrics, such as retention of faculty, can be benchmarked against national data (available from AAMC). While these national data can be helpful, particularly in identifying global problems with diversity and inclusion, they may not be as helpful in measuring how successful a Department or Institution is in addressing their own cultural barriers to diversity and inclusion.

Measurement drives accountability and accountability drives behavior change. The choice of which metrics to use to assess the effectiveness of efforts to increase diversity and inclusion is based to a large degree on Departmental and Institutional priorities, prior experience, and assessment of known or hypothesized barriers. The Workforce Diversity Network has identified a list of metrics that can be used to assess factors that contribute to diversity and inclusion (Table 2-2).[9] These global metrics are intended for application in any field, but all could be applied to a Division, Department or Institution. Results of these assessments can be used to design specific initiatives to effect sustainable behavior change, and to build capacity in areas that are aligned with the organization's long-term direction. Furthermore, the information could be employed to ensure that all have equal access to job assignments and advancement opportunities. Carnes et al have described a useful change model for achieving diversity in an academic setting and also at the department level.[10–11]

TABLE 2-2: Quick List of Possible Metrics[9]
http://workforcediversitynetwork.com/res_articles_diversitymetricsmeasurementevaluation.aspx

- Percentage of minorities, EEO targets
- Increase in minority representation
- Increased representation of minorities at different levels of firm
- Employee satisfaction surveys
- Better relationships among diverse staff members;
- Fewer discrimination grievances and complaints;
- Fewer findings of discrimination by adjudicators and government agencies;
- Improved labor relations;
- Reduction of noose, graffiti, and hate incidents;
- More diverse hiring.
- Improvements in productivity.
- More innovation and creativity. (There are various metrics for this, such as patents granted per capita.)
- Improved job satisfaction.
- More career development over time for underrepresented group members.
- Use of bridge positions for lower level employees to bridge to professional positions.
- Better retention.
- Decrease in pay disparities.
- More positive responses on exit interviews.
- Higher ranking of the organization in terms of best places to work.
- Becoming an employer of choice.
- Awards from special interest and advocacy groups.
- Inclusion of diversity in corporate social responsibility efforts.
- Independence and professionalism of the diversity officer

Departmental Assessment

The first step in recognition of potential barriers to improving diversity and inclusion within a department is an honest evaluation of the current performance. A simple method is to tally the number of women, and underrepresented minority faculty and residents in the department, and to determine how many have been interviewed and selected for various positions. The next step could be to discuss what processes are in place for recruitment and retention of individuals, and assess the barriers which might prevent the Department from attracting a diverse group of individuals to the Department. Leadership by the Chair is key to setting the tone for the department and establishing an environment that respects diversity and inclusion. Although much of what has been discussed under Organizational Assessment applies to individual departments, there may be institutional constraints that restrict or limit a chair's sphere of influence.

Evaluation of Culture

Culture can be thought of as both a feeling and perception as well as the sum of quantifiable metrics. Organizational culture is a product of history and social evolution, which in the U.S. has been forged through waves of immigration; indeed, diversity has always been one of our most powerful agents for change. The culture of an organization is dynamic and complex, reflects deeply held values and, as with individuals and the larger society, shapes the ways institutions will recruit, mentor, and reward faculty. In 2007, the National Academies published a report "Beyond Biases & Barriers" which recommended that organizational culture should be evaluated in terms of how it could affect certain individuals in a different way, based on characteristics of personal identity.[12] However, as individuals we may represent a multiplicity of identities which (as noted in the introduction) intersect, layer, and stratify into our organizational culture. An NIH-sponsored study, by Westring et al[13] determined that the obstacles faced by women included gender bias and discrimination, unequal distribution of resources, lack of mentoring and challenges managing work and family and exclusion from informal social events, and leadership expectations that work (as opposed to family) should always be the top priority. The following recommendations can be generalized to all individuals regardless of characteristics of personal identity. The researchers came up with 46 items across 4 categories: equal access to opportunities, support for work-life balance, freedom from bias, and chair/chief support. Interestingly, women of color also experience racial dynamics which demonstrates the effect of multiple identities and social interactions; racism and gender bias will shift depending on the environment and culture. Nonetheless, our organizational culture essentially reflects our shared mission and is a source for strength; consequently, assessments may determine areas of dysfunctionality and define goals and efforts which can build capacity for diversity and inclusiveness.

Key Performance Indicators

- Staff satisfaction regarding perception of inclusion and access to opportunities for advancement.
- Percentages of women and minorities in positions of leadership.
- Retention and recruitment of women and minorities relative to other groups.
- Institutional mission statement that promotes diversity and inclusion and advocates zero tolerance for discrimination, harassment, or bullying.
- Transparency in the determination of salary, promotion, and career advancement.

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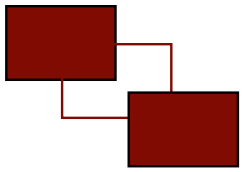

CHAPTER THREE

The Ethics of Diversity and Inclusion

Introduction

Why is it necessary for the future success of American surgery that the field become more diverse and inclusive? In the pages that follow, the American Surgical Association Equity Taskforce will articulate the ethical foundation for this initiative. In distinct contrast to the many areas of medicine where surgery has blazed new trails, surgery has been slow to embrace diversity when viewed by any measure—gender, race, ethnicity, sexual orientation, or other metrics. It is now time to move beyond recognizing the absence of diversity in surgery (see Chapter 1) to identify the goals and behaviors that can achieve greater diversity and inclusion.

The Ethical Framework for a Diverse Surgical Workforce

One of the most unique and enduring aspects of the discipline of surgery is the legacy of critically identifying problems and working to eradicate, eliminate, or improve areas where we fall short. This ethos underlies the centrality of the surgical morbidity and mortality conference, and, more consequentially, was a major reason that surgeons developed the American College of Surgeons, and its offshoot, the Joint Commission. The ideal goal of surgeons has traditionally been to treat *all* persons equally and respectfully, whether they be our patients, our students and trainees, or our colleagues. Indeed, when it comes to patients, the ethical foundation for surgical practice is reflected in the pledge that Fellows of the College take: *"I pledge to pursue the practice of surgery with honesty and to place the welfare and the rights of my patient above all else. I promise to deal with each patient as I would wish to be dealt with if I were in the patient's position, and I will respect the patient's autonomy and individuality."* Notwithstanding the lofty goals of this pledge, there are certainly many examples of where surgeons have not treated other people—be they patients or others—equally and respectfully. Thus surgeons must work to improve our consistency in treating all persons with respect and equity.

On a fundamental level, one can ask why is diversity and inclusion a good that we should expend effort to achieve? We believe that the goal of increased equity in surgery has both intrinsic and extrinsic value. What is the intrinsic value of increasing diversity and inclusion and thus the equity of surgery? Much as the core ethical principles of beneficence (doing good for patients) and non-maleficence (avoiding harming patients) may lead to good outcomes for patients, the ethos of modern U.S. medical practice is to assert these principles regardless of whether doing so helps patients live longer. Additionally, respect for the autonomous choices of patients is seen as an intrinsic value because it allows patients to be respected as persons. The recognition and improved understanding and assessment of the unique intersectionality of patients through increased diversity and inclusivity within our surgical communities enhances our ability to optimize both individual autonomy and overall patient

care. These core principles of medical ethics are considered to be valued intrinsically even when they often lead to better patient outcomes (an extrinsic good). However, when faced with an autonomous patient's choice to decline a potentially lifesaving surgery, we see that the intrinsic value of following the principle of respect for autonomy supersedes negative impact of the shortened life of the patient. Thus, the intrinsic value of our core principles in medicine and surgery outweigh the potentially negative outcomes.

The Surgical Personality

We all have biases, implicit or explicit, based in part on our comfort of being surrounded by those who "look like us" or are from similar cultures or backgrounds. There are undoubtedly personality traits common to many surgeons such as being decisive in the face of uncertainty, being comfortable with complex decision making, and being highly motivated and hard working. These are considered by most surgeons to be positive features of our personalities that make us ideal physicians to lead change toward increasing diversity in academic health centers. However, surgeons have also been known for their strong respect for hierarchy, resistance to change, and strong personalities. We believe that just as surgeons have been able to adapt to new techniques and technologies that benefit our patients despite these common traits listed above, we must also adapt our behaviors to improve equity and thus help to better our society. It may be unrealistic for surgeons alone to change the culture in which we live and practice our profession; however, we can be catalysts to greater equity in society that will ultimately be good for us all.

A Toolbox for Addressing Deficiencies in Equity, Inclusivity, and Diversity

How can the discipline of surgery produce the changes in behavior that need to occur? The first step is to recognize where we fall short. Surgery needs to apply (our characteristic) dispassionate critical appraisal to recognize that both explicit (conscious) and implicit (subconscious) biases, frequently stand in the way of increased diversity and inclusion. (see Harvard online test to identify the presence of implicit bias).[1] Individual surgeons must be appropriately introspective to allow us to identify our own implicit and explicit biases. We must then consider the extent to which such biases are reinforced within departments and academic health centers.

Although the above goals are laudable, it is essential to recognize that surgery departments should reflect the broader community or society in which we live and practice. Academic surgery should lead by example, through making concerted efforts to increase diversity and inclusion. We need to identify and outline specific strategies that will allow academic surgery to be a catalyst for changing the broader community to expect diversity and demand inclusion.

We believe that increased diversity and inclusion in surgery will lead to a greater appreciation of differing points of view about what is best for patients. It will go a long way toward also breaking down the implicit and explicit biases that have perpetuated the underrepresentation of so many groups in surgery. For these reasons, we believe that increasing diversity and inclusion in surgery is an intrinsically important laudable goal. The presence of a more diverse, inclusive surgical faculty and residency will: 1) facilitate recruitment and retention of personnel diversity. 2) make our patients more comfortable with the care we provide. 3) break down engagement barriers with communities in our service areas (communities of color, religious minority communities, LGBT community, etc.), and 4) lead by example within academic medical centers and universities ("if we can do it, you can do it!").

The Business Case for Diversity, Equity, and Inclusion

The ethical case for more diversity and inclusion is self-evident with even a bit of reflection, but addressing our past deficiencies may also produce objective tangible benefits. Evidence suggests that the performance of groups of humans working across multiple tasks is positively correlated with the proportion of females in the group.[2] There is abundant data from the business and financial sphere that demonstrates that "more diverse" companies with women are on the whole more profitable.[3,4] Numerous studies have shown that groups perform better than the best individuals, and groups with more differing viewpoints and perspectives have the very best results.[2,5] For departments of surgery it is likely that more viewpoints and skills (more diversity

and inclusion) will produce better results and enhance patient outcomes (and satisfaction). Additional benefits that we cannot even imagine now may also result. By increasing diversity and equity in surgery departments, we will see more talented persons involved in academic medicine and this will improve the health of our communities.

Concluding Remarks

Surgeons and the discipline of surgery have a tradition of leadership in medicine and within society. We must harness our innate curiosity, hard work, and perseverance to address the historically significant deficiencies within our field in the area of diversity, equity, and inclusion. Surgery should identify areas for improvement and work iteratively to address and correct past deficiencies. This requires honest and ongoing identification and correction of implicit and explicit biases. Just as patient autonomy is an accepted core concept overriding our potential biases, the benefits to us, our departments, and our patients produced by diversity override any potential for negative consequences. The inherent good of individual identity yields autonomy, while the inherent good for our patients' optimal outcomes yields the mandate for diversity. More diverse departments, residencies, clinics, and universities will improve our care, enhance our productivity, augment our community connections, and achieve our most fundamental ambition- doing good for our patients.

Key Performance Indicators

- Just as it is inherently ethical to respect of the autonomy of patients, so to it is inherently ethical for surgeons to improve diversity and inclusion.
- Although aspects of the personality of surgeons have tended to resist change, there is no reason that we cannot marshal the high degree of motivation and hard work that many surgeons have to be catalysts for change to improve diversity and inclusion and reduce inequities.
- In addition to the intrinsic value of improving diversity and inclusion, there are also extrinsic reasons to create more diverse surgical departments and a more inclusive surgical workforce.

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CHAPTER FOUR

Recruitment of Diversity: Impacting Change

Introduction

Efforts to open access to Diversity within our institutions of higher education has been evolving since the end of the civil war but only gained momentum during the civil rights era, and were in synchrony with desegregation and affirmative action. Though these efforts were trailblazing in minimizing discrimination, it was further actions establishing financial aid and educational grants, the mandating of access for women to athletics, and ultimately the Americans with Disabilities Act requiring access for persons with disabilities, which set the platform for the present work on faculty Diversity.

It is the insightful analysis of the environment by Deans, Hospital leadership, Department Chairs, Senior Faculty and staff which eventually leads to institutional policies for change and education, thus preparing the platform for recruitment. An institutional and a departmental environment where Diversity is valued and support for women and underrepresented faculty (URiM, inclusive of racial, ethnic, religious, sexual orientation minorities and physicians with disabilities) is available facilitates recruitment of minority and URiM. The Chair of Surgery and the senior surgical faculty must play a vital role in the development of this environment and in the crafting of a long-term plan for the Department. He/she will have the best chance for success if involved in the Diversity discourse locally (institution and department) and nationally.

The Institutional Environment

Through the efforts of key institutional leaders, many Institutions have recently created an institutional Office of Diversity and Inclusion (ODI) to coordinate Diversity efforts across the Institution. The ODI is usually led by a Dean/Officer of Diversity and Inclusion and it is strengthened by a similar office on the Hospital side for resident matters. Together they enhance and coordinate staff, faculty, residents and medical students' efforts and activities in Diversity and Inclusion. In this chapter we will refer to the ODI as the sum of all these offices.

It is customary for the ODI to plan institution-wide seminars, workshops and conferences focusing on Diversity and inclusion, mentoring, career advancement and the academic process, and promoting well-being and family-workplace balance. Surgical faculty participation to these activities must be encouraged by the Chair of the Department of Surgery and the senior surgical faculty.

Another common activity of the ODI revolves around an annual Diversity Awards Ceremony to showcase accomplishments and individuals in the Diversity arena either as part of a Diversity Recognition Event or as part of a broader faculty recognition event. Some Medical Schools have initiated an annual Diversity Week, during which Departments are encouraged to plan Diversity events. This is a good opportunity for the Institution to focus on Diversity and for the Department of Surgery to join forces with other departments in efforts at increasing Diversity.

The ODI is usually responsible for creating a Women Council and a URiM Council, composed of highly accomplished female and URiM faculty, to focus specifically on developing programs to facilitate career progression of female and URiM faculty and enhance their ability to become institutional leaders. It is advantageous for the Chair of the Department of Surgery and the senior surgical faculty to encourage female and URiM surgical faculty to participate in these Councils and in Institutional activities and efforts devoted to minorities and Diversity.

The ODI also takes on the responsibility to arrange institution-wide faculty social "Mixers" & Networking Events for female and URiM faculty. Participation to these events allows for networking with female and URiM faculty community and for interacting with other Departments on issues of Diversity and Inclusion. Again, the Chair of Surgery and the senior surgical faculty must publicize these events and encourage faculty and residents to attend.

Fostering Diversity pipeline efforts within high schools, colleges and community centers is another common activity for the ODI. The Department of Surgery needs to participate in these pipeline efforts by offering shadowing opportunities, visiting clerkships, summer research activities and mentoring. Partnering with the Student Diversity Office, when present, in their outreach activities to schools is a good way of fostering pipeline programs. A surgical department can pair with the Student Diversity Office to give lectures, participate on panels (i.e., "a day in the life of a surgeon'), activities etc and to speak about a career in surgey. The department can also work with the Student Diversity Office to design specific programs centered on surgical careers. Members of the department can join national organizations that provide mentorship to URiMs such as the National Mentoring Research Network or the National Medical Association.[1–2] Methods of involvement include offering to give lecture or sponsoring faculty to attend. While engagement of high school and college students may seem a far way off from faculty recruitment, it is an avenue for existing faculty and residents to connect with the communities they are close to. Additionally, these activities are a strong message to the department and institution that commitment to Diversity is important. Some medical schools have initiated full-tuition scholarships for URiM medical students to enhance Diversity among medical students. The identification of worthy minority candidates through pipeline efforts coupled with fully funded Diversity scholarships offers a long-term vehicle for increasing Diversity in residencies, fellowships, and eventually faculty.

The creation of a caring environment that looks at family needs goes a long way to attract and retain faculty, including women and URiM faculty. ODI is frequently involved in the establishment of parental leave policy (including both mothers and fathers and providing time off for both after birth, adoption or surrogacy), lactation facilities for mothers throughout the institution and assistance with childcare through pre-school supervision with extended hours (early drop off and late pick up and even weekend and 24 hours). All these are measures of practical importance for residents and faculty with young families including women and URiM faculty. In addition, guidance with getting children into preschool and schools is an attractive benefit for faculty recruitment and retention. Being mindful of childcare responsibilities when setting meeting times, including alternating early morning, late evening, and daytime is a basic but often overlooked aspect of family-friendliness.

The creation of a fair and transparent institutional work environment is necessary to foster the development of female and URiM Diversity. As such, the ODI is frequently involved in the promulgation of a yearly "Transparency and Recruitment Reports" informing on faculty compensation, promotion and recruitments (inclusive of percentages of minorities interviewed, offered the job and recruited) across the institution specifically relating to gender, URiM and rank.

The partnership between the ODI and the Department of Surgery is critical and essential for both the Department and the ODI to be effective. Both can support and promote the activities of the other as well as recognize areas that require improvement and seek proactive solutions. Department Chairs should meet with members of the ODI and discuss their plans and challenges. The ODI should be included in issues related to recruitment and retention. If there is a possibility for faculty of the department of surgery to be involved in the ODI, the Chair should insure active participation through a representative (i.e., the Vice Chair for Diversity or similar).

Some of the initiatives and programs mentioned above are dealt with in more detail in Chapter 7. Yet, suffice to say here that the Chair of Surgery and the senior surgical faculty must participate and must encourage participation of Surgery faculty in these programs and efforts. If the institution lacks these initiatives and the programs described above, the Chair of the Department of

Surgery needs to advocate for them in the strongest possible terms and must be part of, or lead an institutional effort to create the appropriate environment conducive to supporting a diverse faculty.

At times, the Department of Surgery Chair will be asked to participate or Chair a search committee for an Institute's, a Center's or another department's chairperson. This is an important opportunity, which has the ability to shape the future of an institution and the Diversity composition of its faculty. As such, the Chair of the Department of Surgery must be willing to serve in these important searches, must expend energy and efforts at seeking female and URiM candidates and must give their candidacy close, and potentially preferential, attention during the evaluation process.

The Departmental of Surgery

Effective departmental activities to increase Diversity succeed in proportion to the foundation upon which they are built. A survey to assess the departmental climate such as the AAMC Diversity Engagement survey therefore is important to be administered.[3] Specific issues germane to an individual department's Diversity challenges can then be identified and addressed through targeted programing. Specifically, effective programs/methods to address issues uncovered through the survey can then be implemented, as well as goals set by the leadership of the department. There are several toolkits that detail validated programs and methods to enhance Diversity. These include the tools offered by the NIH Scientific Workshop Diversity Office (SWO).[4]

The most effective programs, however, have the clear public support of the Chair/Division chiefs and are supplied with adequate resources (personnel/administrative and financial support). The role of the Chair of Surgery within the department and his/her commitment to Diversity cannot be underestimated. The Chair needs to be the strongest advocate for Diversity in the department, must publicly embrace its value and must foster a welcoming environment for Diversity through education of faculty, residents and administrative staff.

On a more operational level, the Chair of the Department and the senior surgical faculty need to take a primary role in mentoring or in creating a robust departmental infrastructure for mentoring women and URiM faculty for their promotion and career progression. Careful monitoring of progress with honest feedback to help people progress is essential. If milestones for promotion are not being met, reasons why not and what can be done to help can be determined. Ultimately the Chair should foster career advancement by selecting women and URiM faculty to lead departmental divisions or sections, to be members of the Executive Committee of the Department, to nominate them for institutional and national awards and recognitions, and for local and national leadership positions.

Chairs of large Departments should give thought to creatimng the position of Diversity Officer or Vice Chair for Diversity to work with the department Chair and division chiefs to recruit, retain and promote women and URiM faculty, to advertise institutional activities in favor of Diversity such as seminars, workshops and conferences focusing on Diversity and inclusion, to coordinate activities across the department, to participate in the Diversity Pipeline efforts of the Institution at the undergraduate level and to establish competitive URiM Subinternships, which may lead to increased minority residents applications and matching. These positions work best when integrated within the Chair's leadership team, emphasizing the integral role of Diversity in the department. In large departments, the Diversity Officer or Vice Chair for Diversity is helped by a Departmental Diversity Council with participation of divisional faculty, residents, staff, and medical students. The formalization of a Diversity post in a large department provides for possibilities of enhanced programming, mentoring and scholarship. It also signals the importance of Diversity to the department and medical school at large. Smaller departments may be able to partner with like departments and take advantage of shared resources and expertise.

Departments of Surgery should consider establishing an Annual Diversity and Inclusion Lecture. This lecture can be timed with the activities of the institutional Diversity Week, if one exists, for the Department of Surgery to make an influential and unwavering statement regarding the importance of Diversity. The annual Diversity lecture sends a powerful message to all faculty and residents that the department values Diversity.

Independent of the Diversity Lecture, the Chair of the Department or the Vice Chair for Education must make a concerted effort to host a diverse group of speakers for lectures and talks. In addition to regular invitations for Departmental Grand Rounds and Visiting Professorships, there are specific opportunities to increase the Diversity of Visiting Professors afforded by minority and Diversity professional societies. As an example, the Association of Women in Surgery (AWS) offers the Kim Ephgrave Visiting Professor Program through which Department of Surgery can apply to host an AWS Visiting Professor. Whether

through regular invitations or through societal programs, a diverse roster of female and URiM speakers, offers an opportunity to share professional and personal experiences with faculty, residents and students through various activities (walk rounds, lunch with residents and students) and meetings with faculty during the visit. Speakers also serve as a potential pipeline for recruitment and goodwill in the community at large.

Additional ways to support the goal of Diversity within a department of Surgery include creating a Women in Surgery Faculty and Residents Group, sponsoring an annual Women in Surgery scientific and social event and sponsoring female and URiM faculty, residents and students for meetings, mentoring programs, networking opportunities and awards offered by the Association of Women in Surgery (AWS), the Society of Black Academic Surgeons (SBAS) and the Society of Asian Academic Surgeons (SAAS). Sponsorship of attendance at national conferences (e.g., AAMC URiM conferences, AWS, SBAS, SAAS) that provide career guidance and support for diverse faculty, enhancing their career advancement, offer valuable opportunities for the members of these departmental groups. All these programs and efforts are an opportunity for letting female and URiM faculty and residents know that they are valued by the department.

At the residency recruitment level, a presence at diverse student organization conferences is important.[5] Representative surgical residents should be sponsored to attend and represent the department highlighting their program. Sponsoring promising students with an interest in surgery represents another way to further recruitment. Acting Internship Diversity programs that target those from diverse groups for the residency program through visiting clerkships offer opportunities for the department to recruit excellent Diversity candidates who might not otherwise be able to participate or be selected for interviews. In the end, Diversity among residents signals the importance the Department puts on Diversity and may offer another source for Diversity faculty candidates.

All this should occur in the context of a fair departmental work environment with transparent compensation and promotion models in line with established equity criteria. If not existent, the Chairman of the Department of Surgery must remedy this deficiency personally or through tasking the Executive Council of the Department.

Critical in all cases is the assessment of program effectiveness. The Urban Universities for Health – Metric tool kit provides resources to help establish baseline measures to record progress over time, improve internal reporting, develop strategic plan metrics, and set long-term goals.[6]

The Chair of the Department should recognize that the Vice Chair for Diversity and faculty members/trainees involved in fostering Diversity may expend significant time in supporting and administering Diversity initiatives. Departmental Diversity Officers or Vice Chairs for Diversity need to be compensated for their effort and credited for their time and need to have budgets for programing and administrative staff. In addition, due to the underrepresentation of women and URiM faculty in a department, a Chair must be sensitive and careful to avoid excessive and disproportionate burden to female and URiM faculty in activities to enhance Diversity, an added "Diversity tax" in terms of time and effort. The activities of faculty members involved in Diversity efforts should be formally included in metrics for advancement/promotion. Failing to do so will impede rather than further progress to enhance departmental Diversity.

Role of the Chair of Surgery at the National Level

At the national level, the Chair of the Department of Surgery must lend support to Diversity professional societies such as the Association of Women in Surgery (AWS), the Society of Black Academic Surgeons (SBAS) and the Society of Asian Academic Surgeons (SAAS) with Institutional membership, support for their educational programs (AWS annual conference) and hosting opportunities (hosting the annual meeting of SBAS). It is important for the Chairman of a Department to attend the meetings of these societies in person to network with these constituent groups through visible presence and meaningful interactions.

In time and with opportunities, the Chair of Surgery must volunteer for workgroups addressing Diversity and equity issues through guidelines or other activities sponsored by professional societies. He/she must also be proactive with nominating female and URiM faculty from his/her department or other departments for leadership positions and higher office. If a member of a selection committee, he/she must give female and URiM candidates close attention during the evaluation process and stress Diversity as an important goal for any leadership group, professional society and institution.

A Plan to Recruit Diversity Candidates

Within the Department, the Chair should have an assessment of recruitment opportunities over the ensuing 3–5 years. Knowing which positions will likely become available either because of attrition or program expansion may help even before a search starts by identifying potential Diversity candidates at meetings and conferences, and actively encouraging them to apply for faculty positions. Keeping a log of female and URiM resident graduates to consider for future faculty openings is also helpful.

Knowledge of future recruitments in parallel with outreach efforts towards female and URiM candidates, along with building a nurturing and supportive departmental environment, lead to an ever increasing number of female and URiM faculty applicants when positions become open. With the commitment to Diversity by the Chair and the appreciation of the value of Diversity in the Department, it is likely that recruitments of women and URiM will soon start occurring. This will immediately change the reputation of the Department which in turn will lead to more women and URiM applicants (residents or faculty candidates). Ultimately, it results in more diverse candidates applying, being interviewed, and eventually selected.

The Actual Process of Recruitment

Recruitment of faculty is one of the most important functions of the Department Chair. The Chair can take an active role by selecting the members of the search committees and by personally soliciting diverse applicants to open positions through national networking.

The search committee is the key component to the recruitment effort. The Department Chair should select the members of the committee and its Chair, should share the Diversity goals of the Department and should delineate the task and expectations. There should be adequate women and URiM faculty representation both in number and in seniority. When searching for a divisional chief, if insufficient women and URiM faculty in the Department, female faculty and URiM faculty from other departments should be asked to participate in the search committee.

The committee should be instructed to count Diversity as a criterion to be strongly considered. Given the many potential explicit and implicit biases that exist, the AAMC Unconscious Bias online video training course should be reviewed by all members involved in recruitment efforts (at least at the Division Chiefs level) in an effort to create a search process free of interview and selection bias.[7] The interview process should be conducted according to a standardized process with all questions vetted prior to interviewing candidates.

All positions should be advertised through the AAMC Group on Diversity and Inclusion as well as in women and URiM surgical society websites (SBAS, AWS and SAAS) to encourage a broad and diverse applicant pool for all faculty positions. The President and senior members of these societies should be contacted personally to elicit nominations. Positions should be advertised through social media.

In the final phases of the recruitment process, the Chair of the Department can work within the institution to identify funds and institutional resources to provide start up packages and to assist in the recruitment. Some institutions have established funds specifically to attract highly qualified diverse faculty candidates.[8–10] Additional institutional resources such as the ODI, Women Council and a URiM Council can all help in attesting to the departmental and institutional supportive environment.

Key Performance Indicators

- Create a multi-year Departmental Diversity Recruitment Goals document.
- Review search committee composition of women and URiM in terms of number and seniority annually.
- Have all members of Division Chiefs search committees trained in unconscious bias by taking the AAMC Unconscious Bias online video training course.

- Provide an annual "Recruitment Report" of recruitments efforts with specific data percentages of women and URiM interviews, job offers, and rank to inform Institutional leadership and Department faculty.
- Develop a checklist to monitor activities that promote an environment of Equity and Inclusiveness.

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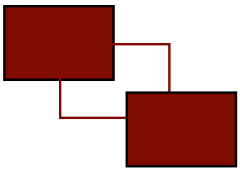

CHAPTER FIVE

Success in Academic Surgery: Faculty Focus

Introduction

Orientation and guidance of the individual faculty member is necessary for a solid foundation in academic surgery. Ensuring fair and competitive compensation and benefits, providing access to departmental and medical school policies and procedures, mentors and educational resources are necessary to progress in a career.

The transition from a resident or fellow to a faculty member may be challenging. There are many elements of a new position to consider, typically grouped and described as—**patient care, education, research, and administrative roles**. The initial focus should be on gaining clinical experience and achieving excellence, but planning a career direction is essential. Today, with the reduction in resident work hours, all residents are spending less time in the operating room and performing fewer cases than program directors see as desirable.[1–2] Almost certainly the increasing number of residents who are choosing to do post-residency fellowship training reflects the residents' own concern about their readiness for independent practice. Therefore, newly graduated residents are not expected to be able to function completely independently, and should not hesitate to ask a more senior attending to be present for complex cases.

This chapter offers key points for each new faculty member. Although departmental activities and resources are key, ultimately the success for each faculty member's career also rests in their own hands.

Faculty Onboarding

Academic training is marked by well-defined competencies and transitions at each stage. The process of assuming a new faculty position should also be viewed in this light. Most institutions will have faculty onboarding offered by their hospital, the school of medicine and the department. These transitional events are important to attend as they highlight institutional policies and give the faculty an understanding of their benefits—health insurance, disability, tuition benefits and retirement. They also clarify additional faculty resources that are available through the School of Medicine including the Office of Faculty Development and the Office of Diversity and Women's Groups. It is crucial to know what is expected of you and what is available to support you.

It is also important for all new faculty to attend departmental onboarding events. These events provide an opportunity to meet departmental leaders and administrators and understand departmental policies and the additional resources that are available to help with grants management. Furthermore, these onboarding sessions provide an opportunity to understand the institutional promotion pathways and the culture of this new environment.

Compensation

It is important to understand the Department's compensation policies, including the rules of the probation period. Transparency around compensation is the first step in ensuring equity. Beyond the metrics of work Relative Value Units (wRVUs), Academic Value Units may be included as well as other performance metrics such as quality assurance, safety commitment or patient satisfaction and commitment to diversity activities. In a recent study of early career surgical researchers receiving mentored career development (K08 or K23) awards, women earned a salary 15% lower than men. Gender differences in salary tend to widen over time, so the initial salary merits particular attention. Challenges include the communal nature of women, faculty rank, family responsibilities, hostile work environments, and the need to train women in the art of negotiation.[3] The Association of Women Surgeons recommends strategies to address salary inequities that should be implemented in every department.[4]

Rewarding the different aspects of the multifaceted academic mission in a compensation plan is complex but essential and inquiry as to the departmental approach is appropriate. The key considerations are:

- **Position Description**—this includes a description of the job to be performed and the percentages of time allocated to clinical, educational, research and administrative activity. On-call responsibilities are an important point to be negotiated.
- **Compensation**—inadequate or perceived unequal compensation correlates with dissatisfaction, whereas high compensation does not necessarily correlate clearly with satisfaction. A fair compensation is essential; individuals need to work for what they think they are worth if that is not inflated. Salary needs to be defined, as does the bonus structure. Faculty should ask what are the measures of productivity are. Acceptable measures include wRVU, charges and collections. There may be additional compensation for care provided at outreach clinics or other sites. How will raises and bonuses be determined? While the RVU scale is a valid measure of clinical work, charges are dependent on the physician professional fee structure used and collections are dependent on the payer mix. Profitability, or funds remaining after gross income minus expenses, is a common model, but it does not favor physicians because the components are not variables they can control. Asking for the range of bonuses or incentives recently achieved is appropriate and is best addressed to the department business manager rather than the chair.
- **Benefits**—Insurance, retirement, and personal development expenses should be covered. Costs of meeting attendance are real expenses for surgeons, as are hospital dues and license fees. Disability insurance for young surgeons is a must, whether general or specialty-specific, and should be discussed with an agent or departmental administrator.
- **Malpractice**—what is important is not what the employer pays, it is what is not covered. There are two types of malpractice insurance: 1) *occurrence-based*, which covers indefinitely acts that occurred during the coverage period; and 2) *claims made*, which covers for claims filed while the policy is in effect. The latter is less expensive, but requires an extended reporting endorsement, or "tail policy" to cover suits after leaving the practice. The payment for the cost of malpractice, and a tail, if required, should be negotiated up front.[5]
- **Termination Clauses**—There are two types of termination: 1) not for cause, which usually provides a notice period of 3, 6, or 12 months. This clause works to the benefit of both parties. Six months is a good compromise for a surgeon; and 2) for cause, which sets forth on what ground(s) the individual can be fired. Clear infractions, such as loss of license or felonies, are simple, but other issues such as personality conflicts should be considered.[5]
- **Loan Agreements**—Sometimes, hospital loan agreements or salary support is included in compensation. What are the repayment terms, what is "forgiveness," and what are the repercussions if the individual leaves prematurely?
- **Receivables**—who owns uncollected money if the individual leaves or retires?
- **Restrictive Covenants**—There are three components of a non-compete agreement: 1) non-competition, which sets forth the area and period in which one cannot practice close to a prior position; 2) non-solicitation, which sets forth rules about attracting patients to leave with the individual (this needs to be balanced with patient care interests); and 3) non-employment, which sets forth rules about poaching staff upon departure. Appreciate that these restrictive covenants are written to protect the practice, not the physician's or the patients' interests.[5]

Mentorship and Sponsorship

A mentor or a mentorship team is essential to academic success. Mentors should ideally be outside the immediate division although the division chief and colleagues in the division are important sources of support for developing a clinical practice. Mentors may be assigned by a Department, but in general, identification of a mentor that is a good fit is more important. Remember that mentors can be changed as the definition of goals and needs becomes better defined. Faculty often have a mentorship team helping with different facets of their academic life. For example, faculty may have a clinical mentor as well as one for their research interest. However, mentorship is a two-way street and the expectation is for the mentee to initiate interaction and meet with their mentor on a regular basis. Having a formal documentation process for the mentor-mentee review process which is akin to an individual development plan and time line for achievements for a graduate student, is helpful. This document can then be included in the annual review.[6]

Establishing a mentoring relationship is like establishing other relationships in that both parties usually have a desire to understand and respect the values and expectations of the other. Mentors serve the dual function of guiding professional and personal development and are essential in helping make professional transitions**.** Professional development can take many forms, including counseling, advising and providing constructive criticism of research proposals. But in broad terms it involves ensuring that the individual achieves academic milestones and career goals. Mentors can contribute to the personal development of their mentees by promoting their integration into the social environment of the workplace and ensuring that mentees are assisted in forming professional relationships that may lead to future collaboration. Mentors can also give advice on time management and provide guidance in navigating institutional politics.[6]

Beyond mentors, faculty also need sponsorship. Whereas mentors focus on academic growth and development, sponsors promote the faculty member for key academic opportunities such as visiting grand rounds, national committees, etc. Both roles are crucial for optimal success of the faculty member, regardless of the phase of development. No person is an island—we all need assistance throughout our careers.

Academic Niche

Identification of an academic niche for each faculty member is key. This may require additional training in clinical skills, such as advanced robotic surgery, or training in curriculum development for an educator. These discussions need to be personalized for each recruit and leadership in the Department should demonstrate a holistic view in ensuring success for the faculty member. Strive to be the best or a recognized expert in your niche.

Each institution has a different process for academic promotion and faculty should familiarize themselves with that process early in their career. Clarifying expectations and aligning these with the expectations of the chair and the institution are essential to success. It is helpful to develop a career timeline and the areas of academic, research and clinical focus. As noted above, mentors are critical for successful personal and professional development.

Development of a concise, focused description of the areas of clinical and research expertise, using every opportunity to make others aware of these, will facilitate networking with others and a recognition of accomplishments by the leadership of the institution.[7] And, while focus is critical, it is equally important to be aware of ongoing developments and opportunities and adapt and expand into new areas or related concepts to broaden and deepen expertise and contributions to the field.

Promotion Pathways

Onboarding is key to understanding the promotion pathways, just as residency training is a series of goals and milestones. Each institution has multiple pathways or tracks and understanding the criteria for each track is important in the academic journey. In addition, some institutions may have a clock to move on to the next step for traditional pathways or the faculty may be moved to a clinical track. Tenure may or may not be a part of the track. Choose the pathway that fits the overall goals and self-insights to achieve happiness and fulfillment.

Administrative Roles

New faculty members will often be inundated with requests to participate in committees and administrative commitments. Careful thought should be given to the role these may play in career development and be politely declined if they are not key to school or departmental expectations or career growth. While acceptance of some academic leadership roles within the department is expected, the burden of increasing reliance on service to the department and school of medicine is real and should be acknowledged, particularly for young faculty. In particular, females and URiM faculty may often bear a disproportionate administrative effort in activities to enhance departmental and institutional diversity efforts, the so called "Diversity tax" in terms of their time and effort (see Chapter 4). These administrative roles are important for departmental citizenship but there is a need for balance and appropriate support.

Annual Reviews

The annual review is an important activity that should be mandatory. Ideally a faculty member should meet with their division chief annually or biannually and, if possible logistically, also with the Chair annually. This activity is done in conjunction with a promotion discussion and should be related to previously discussed and documented expectations of the individual job description. The annual review is not simply a review of clinical activity but should have elements of academic productivity and goals and an educational component going forward. This should be a proactive exercise with each faculty member developing short and long-term goals in each of the domains of their mission.

Wellness and Work-Life Integration

"Life balance," better described as "life integration" is a broad concept including prioritizing between *work* (career and ambition) on the one hand and *life* (health, leisure, family and spiritual development) on the other. Prioritization of life and work commitments is essential to success in both arenas.[8] **Wellness** is the active process through which people choose a more successful and complete existence.

The surgical training system fosters maladaptive coping habits from medical school through residency and even as a faculty member. There is a cultural expectation that suffering should take place in silence, which can lead ultimately to impairment and burnout. Burnout is defined as a syndrome of emotional exhaustion, feelings of depersonalization and a lack of personal accomplishment, specifically in relation to one's professional activity.[9] The three most commonly employed surgeon coping strategies in a Canadian study were keeping stress to oneself, concentrating on what to do next and going on as if nothing happened.[10] These strategies reflect denial responses to stress and correlate with emotional exhaustion. Fewer participants used adaptive coping strategies, for example, taking time out, using humor or talking with colleagues to alleviate stress at work. Sakran and colleagues[11] note that even though the culture of surgery is slowly changing towards systematic analysis of adverse events and moving away from a culture of blame, routine activities such as quality assurance and morbidity and mortality conferences may still unintentionally shame those involved in a medical error. Finally, physicians trying to cope with the demands of their practice by working harder and longer may experience severe inefficiency, psychological impairment, poor patient care and an increase in medical errors, thus aggravating the deterioration and dysfunction.[12]

Spouses and children require special commitment and time. Ensuring that the family receives the share of time they deserve falls disproportionately on the woman in a relationship. Female surgeons from all specialties exhibited significantly higher levels of burnout (female: 26.7 ± 6.10, male: 24.6 ± 6.79; P = 0.035) and compassion fatigue (female: 24.2 ± 6.29, male: 21.9 ± 6.11; P = 0.021) compared with male surgeons.[13] Maternity and paternity leave policies for every institution should be part of the initial orientation along with plans for institutional support for child care challenges. Time off for adoption should also be available. Model policies are available.[14]

Concluding Points

An academic career is a continuous journey. It is the faculty member's responsibility to decide the direction or focus of their career and to proactively seek out resources for their academic development. However, the support of the department is crucial in providing the resources. The departmental leadership sets the culture and environment that is inclusive and supports and empowers all faculty on their academic path.

Once career direction has been established, it is important to identify a mentor or mentors. More than one mentor, or several may be necessary for the different aspects of a career. Mentees and mentors should meet regularly. Expectations should be set at the onset. Coaching is available in many institutions, both for leadership and skill development.

Educational resources should be available to faculty members to facilitate their career development at different stages. These resources may be available at the departmental/institutional level as well as by national societies such as the American College of Surgeons, Association of American Medical Colleges (Table 5-1) for early and mid-career development.

External courses are also available and range from courses on billing (mandatory for all early career faculty), leadership, negotiations, career development, clinical and basic research and education. These courses may be several days in length, or, for administrative development courses, more than a year, with targeted coursework and an in-person commitment (e.g., Executive Leadership in Academic Medicine).

TABLE 5-1: Education Resources for Surgical Faculty

Association of Academic Medical Colleges (AAMC) Leadership Development Courses https://www.aamc.org/members/leadership
AAS/SUS Surgical Investigator's Course https://www.susweb.org/Professional-Development/13/Upcoming-Programs
American College of Surgeons Surgeons as Leaders: From Operating Room to Boardroom https://www.facs.org/education/division-of-education/courses/surgeons-as-leaders Surgeons as Educators https://www.facs.org/education/division-of-education/courses/surgeons-as-educators Academy of Master Surgeon Educators https://www.facs.org/education/program/academy
Executive Leadership in Academic Medicine (ELAM) http://drexel.edu/medicine/academics/womens-health-and-leadership/elam/
Society of University Surgeons SUS-SBAS Promising Leaders Program https://www.susweb.org/SUS-SBAS-Application Mid-Career Academic Surgery Development Course https://www.susweb.org/Professional-Development/13/Upcoming-Programs

Key Performance Indicators

- New faculty members should be oriented to departmental and institutional policies.
- An annual review should be performed of faculty progress towards promotion, accomplishments, short and long-term goals.
- Compensation should be fair and equitable for all department members.
- Wellness and work-life integration should be included in faculty orientation and assessment.

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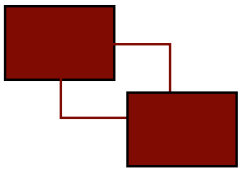

CHAPTER SIX

Creating and Enforcing a Culture of Respect, Equity, and Inclusion

Introduction

Creating a safe environment requires that each person be treated with respect. Medicine and surgery, has traditionally engaged a hierarchical operational system, from educational pathways to the practice environment. Despite recent evidence that a more horizontal team approach to management creates better performance, solutions and policies, in practice, the culture of surgery still places significant value on hierarchical leadership structures. Medical students, trainees, and less empowered members of the surgical team (nurses, residents, students etc.) respect this authority when coupled with humility and respectful treatment of the team. Regrettably, in historical context, empowered holders of leadership in surgery have not always used their authority position to emulate positive behaviors and to set standards of excellence for those on the team. Rather, our discipline is considered by some to be a profession that utilizes intimidation, harassment and bullying to the detriment of the less empowered parties in the surgical environment. The hierarchical empowerment structure leaves those in harm's way of such adverse and toxic behaviors with a sense of fear, humiliation, and anxiety. To further exacerbate the harm, the targeted individual or group is very often fearful of bringing complaints forward for fear of retribution, leaving the victim to endure the adverse situation or to depart the profession and environment all together. This is the cycle of harassment in its many forms.

Growing evidence reveals that harassment, bullying, sexual harassment and microaggression cause not only personal harm to the victim but also to the environment of patient care, with flawed team performance leading to decrements in patient safety and quality. Harassment and bullying, sexual harassment, and microaggression can impact any vulnerable group, but most typically in surgery the targets are those groups in minority representation and those newer to the professional group: women, racial minority individuals, LGBT individuals, those of certain religious faiths or national origin. This chapter will define the characteristics of these adverse behaviors in surgery and propose strategies to foster the creation of a safe and equitable environment for all individuals working in surgery, and to develop tools to identify and remedy these behaviors when they occur. The essential role of institutional, departmental and faculty leadership to create a culture in which harmful behaviors are not tolerated will be addressed.

Microaggression

Microaggressions are the everyday verbal, nonverbal and environmental slights, snubs, or insults, whether intentional or unintentional, that communicate hostile, derogatory, or negative messages to target persons based solely upon their marginalized group membership.[1] The tool for this program "Recognizing Microaggressions and the Message They send" points out that recognition is critical to addressing the problem (Appendix 3). The document describes ten themes prevalent in microaggressions, gives examples of each and tells the message that the statement sends to the marginalized individual. The first "alien in one's own land" describes the behavior of people in the dominant culture of asking others "Where are you from?" or "Where were you born?" based on physical traits. This sends a message of being a foreigner, perhaps less welcome, in one's own country. Certainly, the context in which these questions are asked and one's relationship to the person can alter the intent and impact. Other categories are ascription of intelligence, color blindness, criminality/assumption of criminal status, myth of meritocracy, denial of individual racism/sexual heterosexism, anthologizing cultural values/communication styles, second class citizens, sexist/heterosexist language and traditional gender role prejudicing and stereotyping. These behaviors frequently make explicit one's unconscious bias. Reading this tool will often open one's eyes to a type of discrimination an individual or leader may not have previously examined in self-reflection or understood.

Harassment

Harassment may be used to discredit a person, challenge one's professional status or be sexual in nature. Harassment is the act of systematic and/or unwanted actions by a party or group, including threats and demands. The drivers of harassment may vary and include racial prejudice or personal malice, or simply be an expression of flawed empowerment to gain sadistic pleasure by creating fear and/or anxiety in a vulnerable target. Harassment may also include the use of threatening, insulting or abusive words.[2] Harassing behaviors are more common in professions such as medicine, where significant hierarchies exist.[3] A recent systematic review of discrimination and harassment during specialty training programs found a higher incidence of these behaviors in surgery compared with other medical professions.[4]

The most common types of harassment are verbal. Comments that are deliberately rude, discourteous or impolite are common, as are episodes of ridicule—comments made in a sarcastic tone aimed at intimidation. Other forms of verbal harassment include belittling or patronizing verbiage.

Harassment is prevalent in medicine. A recent meta-analysis of the available literature documents that 59% of trainees reported harassment. The most common type of abuse experienced was verbal harassment (63%) whereas the least common type was physical harassment (15.3%) (Figure 6-1). According to a UK workplace survey 37% of junior doctors reported having been bullied, a finding similar across levels of training and trainee age.[5] A similar survey showed 18% of trainees had been exposed to bullying and identified senior doctors as the main source of this, but also noted that only a third (32%) reported the incident. Those who opted not to report either deemed the matter insufficiently serious (31%) or were afraid of the consequences (25%).[6]

Studies have demonstrated that individuals who witness harassing behaviors are more likely to respond to harassment "actively" if the harassment contains an element of physical intimidation or unwanted contact, whereas rude and/or ridiculing comments are more likely to be ignored. Reasons for this inaction may include manifestations of learned behavior and acceptance of bullying and harassing behaviors as the norm due to the hierarchical nature of the surgical profession.[7,8] A survey of surgeons' reactions to videoed interactions involving intimidation and belittling between trainees and attendings found that participants were more likely to rationalize the actions of the perpetrator if the behavior was perceived to have a positive effect on clinical care, education, or safety.[9]

A recent study demonstrated that not all harassment is recognized by surgeons, and when it is recognized, it is not always challenged. There is a considerable need to improve surgeons' situational awareness, and provide tools to mitigate these behaviors.[7] Methods to respond to harassing behavior include but are not limited to reprimand, an interruption of the behavior, and distraction from the behavior. Interruption techniques are more likely to be used when physical intimidation is involved. The first two interventions are more active, while the latter is more passive. A failure to respond to inappropriate harassment merely serves to validate and propagate the behavior, and results in a hostile work environment.

Prevalence of Harassment and Discrimination Among Trainees, According to Studies Identified in a 2011 Systematic Review of the Literature

Type of harassment	No. of studies	Sample size	Mean	Median	Min/Max	95% CI	I^2
% Harassment	51	38,353	59.4	69	11/100	52.0–66.7	0.99
% Verbal abuse	28	27,258	63	61	28/94	54.8–71.2	0.99
% Gender discrimination	13	6,237	53.6	56	19/92	40.3–67.0	0.99
% Academic	14	5,319	36.1	37	3/71	24.9–47.2	0.99
% Sexual	35	27,919	33.1	48	3/93	27.6–38.5	0.99
% Racial discrimination	10	19,455	23.8	30.9	3.8/58	15.2–32.4	0.99
% Physical	24	23,776	15.3	52	3/100	12.1–18.6	0.98

Abbreviation: CI indicates confidence interval.

FIGURE 6-1: Fais N, Soobiah C, Chen MH, et al. Harassment and discrimination in medical training: a systematic review and meta-analysis. *Acad Med*. 2014;89:817-827, used with permission.

It is the job of leadership to model behaviors that are free of harassment and to call out and intervene when such behaviors are identified and reported. As perpetrators of harassment and bullying are typically wise enough to restrict their actions in the presence of more empowered individuals (chairs, institutional or departmental leadership), the leadership group must rely on reports from others who have witnessed these behaviors to initiate investigations and to craft corrective or punitive actions. Chairs and departmental leadership are also charged with defining the line between "high professional expectations" and harassment. In the hierarchical and demanding environment of surgical training and performance, this line may blur in the perspectives of some in senior positions, while for the learner and trainee groups, that line is likely more sharp. It is the job of leadership to define acceptable and unacceptable behaviors and boundaries for expectations and communications.

Professional harassment is also prevalent in medicine. An individual's competence and professional accomplishments may be called into question to discredit them or gain professional advantage. Reporting a colleague to a professional board, hospital staff or the media for unexpected events, subjecting their practices to excessive chart reviews, and limitation of the use of common resources are examples of this behavior. One must balance the exposure of wrong doing versus harassment in these circumstances. Each causes the accused to use resources and time to defend and maintain their professional status. In these circumstances, leadership is obliged to engage objective investigation of the accused by an unbiased group to ensure adequate defense of the accused. Persons in positions of authority should be cautious when such accusations are made to be fair in their investigation. Hospitals and professional organizations have processes set up to investigate these claims which assure the accused of due process. They should be followed.

Sexual Harassment

The U.S. Equal Opportunity Employment Commission (EEOC) defines workplace **sexual harassment** as unwelcome sexual advances or conduct of a sexual nature which unreasonably interferes with the performance of a person's job or creates an intimidating, hostile, or offensive work environment. Sexual harassment constitutes an unlawful employment practice in violation of Title VII of the Civil Rights Act of 1964, the federal equal employment opportunity law that prohibits discrimination based on five protected classes: Race, color, sex, religion and national origin. Behavior often associated with sexual harassment include offensive comments, unwanted attention, unwelcome verbal advances, unwanted persistent invitations, unwelcome persistent propositions, offensive displays, offensive body language, unwanted physical advances and sexual bribery.[10]

Sexual harassment is reported in all work environments. Jagsi and her colleagues reported that 30% of women compared to 4% of men reported sexual harassment in the workplace. Although lower than in 1995 this is high considering that during the period studied the proportion of female students exceeded 40%.[11] Most of the harassment was done by a person of the opposite gender. The behavior was usually by a person of higher status. For women surgeons, it was mostly surgical directors and attendings. There is little specific data for American surgery but a study from Australia cited a percentage between 4 and 13 for various surgical specialties.[12] Sexual innuendo and propositioning were the most common behaviors (54%) with physical contact and inappropriate jokes at 12 and 11% respectively. The recent "#me Too" movement suggests that the practice is common in surgery.

In response to the publicity the Australian report received, the President of the Royal Australasian College of Surgeons issued an apology and commissioned a review and recommendations to eliminate this behavior. His words which begin" Everyone has a right to be treated with respect and to train and work without being subjected to discrimination, bullying or sexual harassment" should be universally accepted. The recommendations of their study which call for transparency and cultural change should be adopted by all.[13] A progress report of the commission was released in September of 2016 and is helpful in addressing the issue.[14] The Association of Women Surgeons has one of the few explicit policies condemning sexual harassment.[15]

Recognition of sexual harassment can be challenging. While unwanted sexual activity or solicitation of sex from a subordinate in exchange for evading harm or for advancing a career is an obvious act that all agree constitutes sexual harassment, more subtle forms of sexual harassment and sexism has long been a component of the surgical environment. The operating room environment itself presents a venue where sexualization of the environment can occur: physical closeness, occasionally intense emotional events, physical guidance for operating maneuvers, and gender imbalanced groups with a hierarchical leadership structure. Sexualization of the surgical environment has until recently been a not uncommon element of the operating room environment. However, the changing demographic of surgery has revealed that this once considered benign banter has in fact alienated and indeed harmed younger surgeons and nurses, primarily women, although both genders can be victimized. While tolerating sexual innuendo inspired by operating motions of trainees, or their body appearances and anatomy, may once have been considered as an irritating rite of passage privilege delivered by the empowered more senior surgeon, anesthesiologist, or nurse, there can be no doubt that the less empowered recipient typically suffered embarrassment, anxiety and sometimes fear. In fact, sexual harassment in professional environments reflects power much like all other forms of harassment, and the consequences for the targeted individual are equally disabling.

Recognizing sexualization in the work environment and sexual harassment can be challenging for those long accustomed to such familiarities; some may even consider their words to be flattering or entertaining. The fact is, sexualization of the surgical environment is alienating and harmful to many and can no longer be tolerated in any form in our programs, faculty, or organizations. As our workforce demographic has changed, and as our society has established new rules for gender-based discourse, there is need to ensure that the environment of surgery is renewed to eliminate sexual harassment and sexualization as well.

There are few studies on effective mechanisms to eliminate sexual harassment in its subtler forms. Even sexual predatory behavior can be a challenge to eliminate as the perpetrators will typically invoke consensual sexual engagement as the origin of the harassing sexual interaction; it is not uncommon to find the reporting victim in a defensive posture. This fact is why many victims of sexual harassment do not come forward with their allegations or wait for years, when they have reached a more empowered position, to come forward with allegations. It is the job of leadership to ensure that victims are not diminished in the critical review process. As the victims are typically in subordinate positions, accusing a powerful surgeon, their safety must be ensured during the review process to avoid further alienation and harm.

Establishing a culture free of sexual harassment is challenging. A most effective tool is to create an environment that has no tolerance for such behaviors. This begins with modeling of appropriate behavior by the leadership and empowered individuals in the environment. Critically important is that all in the environment are aware of the harms associated with sexual harassment in the work environment. A "stop the line" policy to ensure that witnesses to sexual harassment are either empowered to speak up or are provided with an explicit pathway for reporting concerns to leadership is essential. Reported episodes must be investigated carefully and confidentially, both by professional peers, and by institutional authorities responsible for employee and work environment safety (e.g., the human resources department). Leaders of organizations should receive training in sexual harassment and be knowledgeable of policies and procedures to address and remedy concerns. Presuming the charge is less than rape or sexual assault or solicitation of sex for favors, perpetrators should be required to complete remediation with educational

programs and counseling. However, during this period of remediation, close observation to ensure that the victim is not subject to retribution must be ensured. Failure to remedy behavior, or repeated episodes, should result in escalating penalties, up to and including dismissal.

The goal of addressing sexual harassment is to create a work environment that is considered safe and supportive for all who work in the profession and our surgical environment. While perspectives on sexual innuendo, sexual humor, and sexualization may vary widely among individuals and groups in our environment, the safest and most appropriate pathway to achieving a sexual harassment free environment is to create a no tolerance zone with active enforcement from the leadership to empower the disadvantaged groups. Such a policy not only protects individuals as targets, but also creates a positive environment for the individuals working in the organization and ultimately a superior environment for the patient. Departments and organizations should have explicit policies and enforce these policies to create a sexual harassment free work place.

Bullying

Although there is no uniformly agreed upon definition of workplace bullying, consensus opinion of a definition is that bullying is a persistent pattern of mistreatment from others in the workplace that causes either physical or emotional harm. The behavior includes such tactics as *verbal*, *nonverbal*, *psychological*, or *physical* abuse and *humiliation*. The behavior occurs regularly, is enduring, frequently escalates, is intentional and is usually hierarchical although it can come from peers or coworkers. Recent literature reports the rate of bullying in surgery as high as 39%—47%.[12,16]

The rigorous training, stressful situations, sleep deprivation, and hierarchical nature of surgical training can lead to behavior such as bullying, which has a negative impact on the health and well-being of surgeons and the safety of the patients. Accumulating data shows the negative impact bullying and harassment have on the work environment and the workers. Several reports have documented the pain, mental distress, physical illness, and career damage suffered by victims of bullying.

We cannot afford to lose talented surgeons or risk the safety of our patients due to bullying, therefore we must educate surgeons about the types of behavior that constitute bullying and ways to intervene and eliminate the behavior. Much of the early work on bullying has been done in Scandinavia then more recently in Australia. Staale Einarsen has published an excellent Negative Acts Questionnaire-Revised [NAQ-R] which has been the commonly used assessment tool to survey the environment of an organization.[17] The NAQ-R is comprised of 22 personal and work-related behaviors (Appendix 4). The participants were asked to respond"no," "yes, very rarely," "yes, now and then," "yes, several times per month," "yes, several times per week" and "yes, almost daily." They were also asked who the perpetrator was.[17] This tool has been validated numerous times but may be modified based on cultural differences.

The identity of the perpetrator and the bullied also adds insight into the process. Usually the bully is a supervisor or superior. The perpetrator can be the same gender or not. Marginalized and non-majority populations are the most vulnerable. When investigating the situation, one must gather data on who is the perpetrator and what their relationship is to the bullied. Not uncommonly nurses bully residents and women surgeons.[16]

Rayner and Hole add another perspective to the issue by defining 5 categories of workplace bullying (Table 6-1)[18]:

TABLE 6-1: Five Categories of Workplace Bullying

Threats to professional status (belittling, humiliation)
Threats to personal standing (teasing, insults)
Isolation (withholding information)
Overwork (impossible deadlines, unnecessary disruptions)
Destabilization (meaningless tasks, shifting of goal posts)

Adapted from Rayner C & Hoel H. "A summary review of literature relating to workplace bullying". *Journal of Community and Applied Social Psychology.* 1997;7:181-91.

Assessing this type of behavior in the workplace can also be a screen for an unsupportive environment. Clearly bullying is a detrimental behavior to the person and the workplace so measures to eliminate the behavior are important. Mayhew and Chappell suggested that the ideal proactive strategy to prevent workplace bullying is for the Chief Executive Officer/Manager to lead by example and support the introduction of system-wide, comprehensive policies, procedures and practices that 'design out' internal violence in all its forms. Demonstrated top management commitment to a policy of zero tolerance is of core importance, with this commitment included in mission statements. Numerous work place anti bullying posters are available on line.[19]

In addition to crafting policy, empowered leaders in the department are personally responsible for exhibiting positive behaviors that create a culture where harassment, bullying and sexual harassment are not condoned or tolerated. Examples of positive behaviors include engaging in exemplary professional interactions towards junior faculty and subordinates, regardless of gender, ethnicity, race or religion. Exemplary behaviors in the professional and social environment are characterized by avoidance of flirtatious interactions, refraining from physical touch, avoidance of comments on personal appearance, and avoidance of ethnic, sexual or gender based humor. Importantly, empowered leaders must call out and interrupt others who exhibit demeaning or harassing behaviors or fail to meet expected professional standards of behavior. Last, empowered leaders will actively model the professionalism of equity by treating all of their faculty with respect and appropriate professional support in all environments.[20]

Every surgical department should know the prevalence of harassment, sexual harassment and bullying that is present in its environment. Periodic surveys of the environment are necessary to assure that the behavior is not ignored. Explicit policies about these behaviors and processes in which to safely report them should exist within every department. Promulgation of these policies should be included in the onboarding of faculty, residents and staff. The leaders must clearly set the expectations and the example. A no tolerance policy should be explicit. Appropriate avenues for reporting and investigation which include privacy and lack of retaliation must be in place. Appropriate interventions should be readily available for those affected.

Key Performance Indicators

- Surgical organizations should have position statements on microaggression, harassment and bullying.
- Panel discussions on the topic at National and Local meetings should feature panel discussions and presentations on these topics.
- Dissemination of departmental policies with ongoing assessment/scan of behavioral metrics and remediation programs should be done regularly.
- Research papers on best practices to assess and modify negative behaviors should be encouraged and accepted for presentation at all types of meetings.

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CHAPTER SEVEN

Departmental Initiatives for Faculty Leadership Development, Retention, and Promotion

Introduction

The Department Chair is responsible for creating a culture that promotes and develops faculty leadership in an equitable manner. Viewed from one perspective, what is good for one faculty member is good for all, regardless of race or ethnicity. However, there are also specific initiatives and metrics that can and should be enacted to ensure that women and URiM are able to benefit equally.

Mission and Vision Statement

The Department should have a mission and vision statement that includes a statement on diversity and equity. Highlighting it in that way grounds it in the culture of the Department and allows all faculty, both potential recruits as well as long-tenured faculty, to understand the commitment of the Department to diversity. The other way that grounds it in the culture is to ensure that the mission and vision come from the faculty, both in original development and in annual updating. The Department Chair should review it with faculty on an annual basis to ensure that all faculty activities are consistent with the Department's mission and vision.

Faculty Onboarding

Plans for faculty leadership development, paths for promotion and the role of individual faculty in living the mission and vision as related to diversity and inclusion should be clear at the time of hire, and should be further explained during faculty onboarding. Onboarding of junior faculty can be done at the Division level, but needs to be complemented by Departmental and Institutional onboarding.

Onboarding can be overwhelming, regardless of whether it is a first job or a mid- or late-career move. Information needs to be prioritized and distributed across the first quarter or even the first year.

It is easy to immediately overburden faculty from underrepresented groups, including women, with additional "diversity" demands or expectations (e.g., multiple committee assignments or multiple advisees, multiple peer or student mentees). Junior faculty may want to take much of this on and need to be guided to achieve the appropriate balance that is key to professional and personal success.

Compensation Plans

Organizations with pay equity have greater trust in leadership, greater engagement, less turnover, and improved performance. So in addition to it being the right thing to do, and the law in some states, it is a good business and leadership practice. Compensation should be tied to both rank and leadership within a Department and institution, so long-term equitable compensation is inextricably linked to leadership development.

The process for establishing pay equity is outlined with the acronym EQUAL—Establish parameters, Quantify gaps, Understand drivers, Action planning, and Lead change.

- AAMC benchmarks are an excellent starting place in Establishing parameters. They are easily available, and provide transparency across institutions throughout the country. Other parameters include rank and leadership roles.
- An analysis of the data used for identifying Quantify gaps leads to understanding the drivers of gaps that do exist. Potential drivers include RVUs, time in rank, rank, and hospital support.
- Use of academic value units is one way to address gaps in an Action plan. One department has defined academic value units as a weighted score of 65 research, education, innovation, academic service, and peer review activities. The weights were established by department priorities and were inversely proportional to academic rank, suggesting a model that could easily be incorporated by other departments who could decide on their own priority-based weights.[1]
- Transparency in Leading change to any compensation plan is key, as is the listening aspect of communication and thorough vetting with faculty. This is particularly important with senior Department leadership. Yearly reports to the faculty about pay equity are key aspects of ongoing transparency and managing change.

The use of financial metrics to reward high producers from a clinical standpoint has several potential pitfalls, particularly if systems promote internal competition while devaluing teamwork. This is exacerbated when the women and minorities are younger and just beginning their practice. It can manifest in differential clinic coverage, with senior surgeons asking their junior partners to cover clinic while spending a much greater portion of their time in the operating room.

Two recent examples of implementing compensation equity show that with intentionality and transparency a more equitable compensation plan can be a reality in an academic Department of Surgery. They also highlight that it is an ongoing process that might not achieve the desired goal with the first attempt. Continual effort with the ultimate goal in mind is critical.[2,3]

Leadership Development Plan

Leadership development in a Department of Surgery is essential for faculty retention and engagement of faculty in essential departmental activities. Principles for leadership development include first identifying opportunities and naming roles, having a single role for a single person, and using finite terms of appointment to allow for development and progression. Time-limited leadership allows these opportunities to be available to many in the department, avoiding the leadership bottleneck that can exist at the senior faculty level.

Formal Leadership Courses

Formal leadership courses are offered by the AAMC for early and mid-career faculty as well as by the Association for Academic Surgery. Opportunities for senior faculty include ELAM and many mini-courses that are specific to leadership combined with either business or policy interests.

Leadership Roles Within a Department

Most directly and explicitly linked to diversity and equity is the naming or establishing of a Departmental Vice-Chair/Diversity Champion. Naming a Departmental Diversity Champion is an explicit statement of the importance of diversity and equity in the

life of the department. Making this role a senior leadership role makes a significant statement and is also important in ensuring that the existence of such a role actually increases equity and diversity. Although there are many activities that such a person will be involved in, importantly they should be a part of all recruitment efforts, the promotion and tenure committee, mentoring, and highlighting diversity efforts within the Department and across the institution.

Leadership should not be restricted to those in their mid- or later career. Roles at the junior level are particularly important as they introduce leadership skills that will reap benefits for the individual as well as the department throughout the tenure of that faculty in the Department. As junior faculty are successful in these roles, they will rise to other leadership roles in the Department. They will also have developed skills that make them competitive for and successful in national leadership roles. There are many leadership roles that either exist or can be created to provide leadership opportunities for those at all levels.

Opportunities for junior faculty

- Grand Rounds director
- Medical student clerkship directors
- Leaders of Women in Surgery and Minority groups within the Department
- Simulation lab Director

Opportunities for more senior faculty

- Section or Division Chiefs
- Residency and Fellowship directors
- Vice-Chairs
  - Education
  - Research
  - Clinical Affairs
  - Quality
  - Faculty Development

Leadership Roles in Professional Societies

Different level leadership does not just refer to rank. It means involvement in a variety of surgical societies, with the goal of engaging faculty in leadership roles in these societies. In addition to specialty-specific societies, all faculty should be involved in regional and national societies. During annual reviews, specific surgical societies should be targeted for each faculty. The Association for Academic Surgery is geared to junior faculty, and provides numerous opportunities for engagement and leadership. Once members, specific committees and leadership opportunities within these societies can be targeted. The chair should help identify these opportunities, work on nomination and sponsorship within the society and coach the faculty member on how to participate actively to the life of the professional society and contribute to its committees.

Sponsorship and Nomination

There are numerous awards, scholarships, and other opportunities for recognition and leadership that exist within institutions and societies, and the Department Leadership should keep track of the deadlines for these awards, scholarships, grants, and other opportunities for recognition and nominate a faculty member for each one. Grants exist from the American Surgical Association, Society of University Surgeons, American College of Surgeons, Association of Women Surgeons; opportunities for traveling fellowships, or visiting professorships and awards from the AWS, Society of Asian American Surgeons and ACS.

Another opportunity for leadership is a Grand Rounds partnership with a neighboring institution. "Trading" junior faculty gives them opportunities for networking and development as well as recognition as a visiting professor earlier in their career than might otherwise occur. All of these things are subsequently helpful during the promotion process.

Annual/Biannual Reviews/Mentoring

In order for faculty to make desired progress there should be a structured process to ensure success. This process should be transparent and outlined during Department onboarding. The process starts with a formal mentoring program (see also Chapter 5). There are several examples of successful mentoring programs, most of which have several similar elements. Mentoring teams may be more successful than an individual mentor as they are able to bring multiple perspectives to help the individual faculty member articulate his or her own goals. Although both formal and informal mentoring are important, the formal Department mentor should ideally be outside of the Section or Division. Informal mentoring, and direct reporting, occurs within the Division. Second, the mentor (or mentoring committee) and faculty member should meet regularly. Third, a standardized form should be used to track development and progress.

Annual or biannual reviews should occur with the Department Chair or Division Chief, and should include information from the formal mentor or mentoring committee. If progress is not being made toward goals, the committee can provide insight into what changes or resources are necessary to achieve the goals agreed to by the Department Chair and the faculty. This can then be shared with the Division or Section Chief.

Departmental P&T Committee

Having a Departmental promotion and tenure committee that reviews all applications for promotion and tenure maximizes the likelihood that these will be successful at the institutional level. Small departments can combine to provide the same benefit to their faculty.

Many Departments use an existing Executive Committee or committee of Division chiefs as their promotion and tenure committee. This may work if the Vice-Chair for diversity or Chief Diversity Officer is a member. If not, it is important that the Departmental P&T committee have a racial and gender diversity. One of the most important aspects these members bring is the ability to view career accomplishments and a candidate's CV using a different lens.

Training of this committee needs to occur both on the criteria for promotion within the different pathways that may be available at the institution but also on bias and its effect on promotion and tenure decisions. This training should occur with appointment to the committee and a refresher should occur at all meetings where decisions about recommendation for promotion and tenure are made.

Departmental Initiatives

Departmental initiatives that establish a culture of inclusion, equity, and diversity are important both in recruitment (discussed in Chapter 4) and retention. The Department Chair is most likely to be successful in achieving such a culture when working with a Chief Diversity Officer or Vice-Chair that works with a Diversity Committee or Council. The first step is to review data on the composition of the Department, followed by developing appropriate metrics for Diversity and inclusion that are reviewed at least annually and presented to the faculty in a transparent manner.

Establishing a visiting medical student diversity scholarship is a tangible act the chair can work on with Education Leadership, along with intentional recruitment efforts for residents.

Planning and organizing Departmental activities highlighting and celebrating Diversity and inclusion is also important; these can include an annual Diversity and Inclusion lecture as well as a Women in Surgery group. Institutional memberships and visible presence of the chair at the Association of Women Surgeons, Society of Black Academic Surgeons and Society of Asian Academic Surgeons along with scholarships or sponsorships for medical students, residents, and faculty to attend speak volumes about the culture and commitment of a Department to diversity and inclusion.

Transparency Report on KPIs

Once the KPIs have been made part of the Department's ongoing strategic process, an annual report on progress should be made to the faculty. Data transparency is integrally related to accountability, and is particularly important when goals have not been met. Concomitant with transparency, an action plan for achieving unmet goals related to the KPIs is key.

Involvement in Community

The Department of Surgery does not exist in a vacuum. The existence of a community for both women and minority faculty is strongly tied to both recruitment and retention. It is therefore important for the Department Chair to become involved in promoting diversity at both the institutional level but also to become involved in the community of diversity outside the medical center both personally as well as by making it a priority for faculty. This includes programs and visibility at local junior high schools, high schools, colleges, community centers, Boys and Girls clubs.

One example of a recent successful recruitment effort included a session held in a community clinic dedicated to serving the URiM community. Although no surgeons practice at that clinic, the opportunity to have an honest discussion about life as a URiM person in the community as well as a URiM surgeon was viewed as an incredible commitment by the Department to both individuals being recruited but of perhaps greater impact to the community at large.

Concluding Points

The Department Chair must establish a culture that makes leadership development, diversity and inclusion consciously a part of its thinking. It must be intentional, requires time and constant attention.

Key Performance Indicators

- Develop an annual pay equity report by Division and rank.
- Identify leadership roles with succession plans that demonstrate equity and diversity, revisited annually.
- Produce a promotion track record that compares URiM and women to overall Department Statistics.
- Track the number of exit interviews conducted for faculty that have left, with a target of 100%.

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CHAPTER EIGHT

Continuous Ongoing Self-Assessment of the Academic Environment

Introduction

It is clear from previous chapters that the problem of promotion/retention is no longer manifested in overt discrimination, but rather in unrecognized or more subtle features of the organizational culture that affect URiM differently.[1] Evidence has shown that departmental leadership as a predictor of faculty satisfaction is an important element in determining the perceived supportiveness of the local environment for promotion/retention.[2] Multiple studies have shown that the ideal departmental/divisional culture provides equal access to opportunities and resources for all faculty, encourages work-life balance, facilitates the discussion of potential biases, and has a chair/chief who is supportive. Indeed, obstacles to satisfaction and retention that women and URiM faculty report are often the factors that are controlled at the department or divisional level such as salary, allocated resources, access to administrative staff, allocation of time and start-up funds.[3] In very large departments in excess of 100 faculty, the division level culture is probably more impactful. While the culture of a University or School of Medicine does affect a person's career, this effect is likely more distant and less consequential. The specific design of any particular survey or intervention is less important than a clear demonstration of tangible support by senior leaders in departments of surgery.

Need for Self-Assessment

The call for increased diversity in the medical workforce is important from the perspectives of fairness and parity, but is of practical value as well. Cohen and colleagues identified four pragmatic motivations to justify increasing diversity among healthcare providers: "1) advancing cultural competency, 2) increasing access to high-quality health care services, 3) strengthening the medical research agenda, and 4) ensuring optimal management of the health care system."[4] Once measures have been implemented to address the practical and moral imperative of increasing diversity and inclusion among healthcare providers, there is a need for continuous vigilance and self-assessment in order to track progress, identify areas in need of improvement, and to provide benchmarking measures against other institutions.

The responsibility for continuous assessment falls upon individuals at all levels of the institution—starting from the individual surgeon and extending to the Department leadership, to the institution and the medical center. At each assessment level, there are differing opportunities for evaluation and impact. However, regardless of when and at what level the assessment occurs, the metrics used for evaluating progress must engage key stakeholders and must involve methodology and metrics that promote broad engagement that is evidence based to the extent possible. The continuous assessment of the workforce is of central importance in achieving the goals of cultural competency and equitable delivery of health care.

Tools for Personal Ongoing Assessment

Facing promotion in academic medicine can be challenging for faculty members unfamiliar with the process. Even for senior faculty, the process of preparing for semi-annual or annual evaluations with Departmental leadership can be intimidating, but for some URiM faculty, this can be particularly daunting. As one prepares for this process, it is important to perform a self-assessment of one's current state and desired future state, with an eye towards a "career map" to help guide discussions. Each individual should aim to have defined goals and objectives for each of the four pillars of academic surgery: clinical care, research, education and administration.

Faculty must meet a variety of expectations across the entire scope of academic activity. Clinical productivity may be a confounder of academic productivity.[5] Several metrics are available to monitor clinical activity. One of the most common metrics is the work relative value unit (wRVU), a measure of clinical productivity based on Common Procedural Terminology (CPT) coding, which allows a standardized assessment of patient care volume. Other common assessments of faculty clinical performance include quality metrics such as Ongoing Professional Practice Evaluations (OPPE) which assess operational and quality metrics including but not limited to length of stay, mortality, readmissions, and infectious morbidities. OPPE is frequently performed by the Medical Staff Offices. Faculty should have the opportunity to review these reports prior to (or less optimally at) their formal reviews. Vizient (formerly UHC) and other quality benchmarking programs such as those through the American College of Surgeons, may further inform data on an individual surgeon's clinical outcomes.

Research publication and impact of scholarly work are two of the most important measures of faculty accomplishment in academic medicine.[6] While there is a common misconception that only the number of publications matters, increasingly academic institutions are focused on the quality of publications. Commonly utilized indices such as the H-index or Google Scholar index may be determined using web-based programs such as *Publish or Perish*.[7] Further information, including a resource developed by the National Institutes of Health known as iCite allows faculty to review their relative citation index, and assess the impact of their scholarly works.[8]

One cannot underestimate the importance of educational commitment in academic medicine. Faculty should have access to, and be aware of, evaluations of their teaching performed by medical students and residents in their program. These data should be available from the Office of Surgical Education. Some organizations may also provide 360-degree evaluations, with input from senior members of the faculty, peers and trainees. It is imperative to have opportunity to review these evaluations.

When it comes time for a quarterly or annual review, it is often helpful for the surgeon to provide a self-assessment of their work. In doing so, it is important to highlight what they have accomplished since the last assessment. Making it a routine to simply record accomplishments and activities on a regular basis so they are available when needed is a habit that will save the faculty member enormous amounts of time in the long run.

During the review process, it is recommended that faculty review their personal performance with an eye towards the future. This will help to define a "career map" or "career trajectory". In defining career trajectory, an individual SWOT (strengths, weaknesses, opportunities, threats) may be useful. Faculty should emphasize their positive traits but be cognizant of individual shortcomings. Any errors should be acknowledged carefully, using developmental language. For example, rather than saying "this is where I fail", the discussion should be framed in terms of opportunity: i.e., "here is what I want to work on" or "this is what I've learned".[9]

Mentorship, and more importantly sponsorship (defined as advocacy for opportunities for junior faculty members) are central to academic advancement.[10] As part of the opportunities section of the self-evaluation, it is important to identify what is needed to reach the next step, be it training, mentorship or sponsorship. Advocating for one's self is a skill: to be an effective self-advocate, one must be self-confident and believe that what is desired is deserved. Having a plan to make a request a reality requires forethought, but helps to ensure success. These are not emotional discussions but rather should be carefully considered requests tailored to the receiving audience. Leadership often responds favorably to requests that further the organizational mission, so it often necessary to explain how the desired goals will further the department, school or organization. Being respectful, inclusive and speaking to shared values can increase the effectiveness of self-advocacy.

During the evaluation process, it is important to recognize bias, both implicit and explicit. Implicit bias is defined as the attitudes or stereotypes that affect our understanding, actions, and decisions in an unconscious manner. Decisions about who you date, where you live, and how you describe individuals may be impacted by implicit biases. We have a bias when, rather than being neutral, we have a preference for (or aversion to) a person or group of people. Harvard's *Project Implicit* features a

battery of «implicit association tests» where participants can measure levels of implicit bias around certain topics based on the strength of associations between concepts and evaluations.[11] "Explicit bias" refers to the attitudes and beliefs we have about a person or group on a conscious level. Much of the time, these biases and their expression arise as the direct result of a perceived threat. When people feel threatened, they are more likely to draw group boundaries to distinguish themselves from others. Our evaluation of performance and ability to manage is impacted by our bias, which more often than not are implicit rather than explicit. When receiving, and providing feedback, this may mean you feel more comfortable interacting with someone who is similar to you, as compared to an individual whose responses you do not necessarily understand. Performance evaluations can be driven in part by rater bias, rather than actual performance criteria.[12] One of the ways to identify and mitigate against bias is to develop emotional intelligence, defined as the capability to recognize one's own *emotions* and those of others, to discriminate between different feelings and label them appropriately, to use emotional information to guide thinking and behavior, and to manage and/or adjust emotions to adapt to environments or to achieve one›s goal(s).[13] Emotional intelligence can impact one's ability to *manage up*, which reflects the good and positive relationship between the employee and his/her supervisor.[14] Previous research found that quality of this relationship may interfere in the results of the subjective rating of job performance evaluation.[15] Personal awareness and ongoing assessment of these biases will provide greater equity among faculty, regardless of race, sex, or background.

Tools for Department Chairs and Administrators

Leaders are instrumental in creating and changing an organization's culture. Surgical chairs are no exception, and part of the leader's influence is exerted through role modeling (Figure 8-1). Understanding the culture in one's department and knowing the culture one wants to create are the first steps to continuous assessment. Surgeons are used to getting feedback about their performance when they are students and residents; yet levels of feedback fall off the further away from residency a surgeon may be. It is possible, in fact, that chairs and division chiefs receive the least amount of feedback which can impair identification of areas for improvement. Chairs who learn how to use feedback effectively develop greater self-awareness, and can then focus on system-level improvements rather than on an overly narrow focus on individual-level progress. Successful departments of surgery exist in a matrix where performance of the chair is evaluated not only through financial and quality measures but also includes surgeon engagement, satisfaction, burnout and promotion measures that are reported up to the hospital administrators and the Board. It is likely that many institutions have designed and implemented distinct interventions but little of these results have been shared outside of the local environment, thus precluding others from learning from the experience.

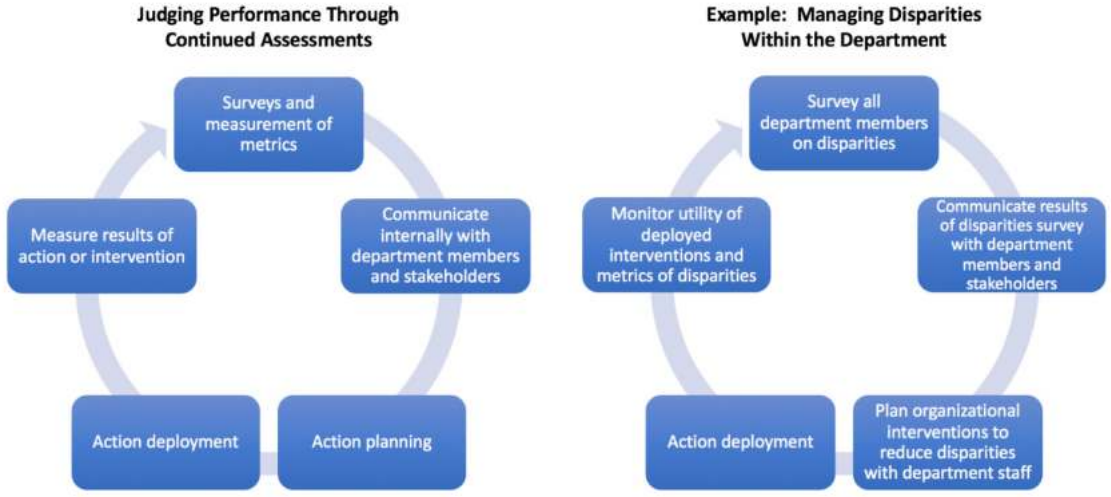

FIGURE 8-1: The Mayo Clinic "Listen-Act-Develop" model (left); the model can be adapted to evaluate and address workforce disparities within a surgical department (right).

Two examples of how Departments and hospitals have successfully implemented continual analysis and measurement to implement change are provided here:

- A meta-analysis of interventions for burnout for example shows that organization directed interventions were associated with higher efficacy when compared to physician directed interventions.[16] Clearly the "Listen-Act-Develop" Model implemented at the Mayo Clinic has led to successful programs. One example includes physician burnout was measured annually at Mayo, benchmarked against national data and divisions needing help are identified and helped. Physician feedback has shown that for every time a leader increases their leadership score (Max of 60) by one point, physician burnout decreases by 3.3%.[17–19]
- Another recent example includes a survey of Stanford School of Medicine Faculty which found that very few female faculty felt "supported" in their career development. As a result, the administration considered novel ways to improve work life integration and hoped to prevent burn out- this included a pilot "time bank" in which faculty were rewarded for serving on various committees and to trade time spent in these activities for in home support such as meal delivery or cleaning services, or support at work such as editorial assistance on grants and papers. These services while open to all was used most by women who then went on to double their rates of satisfaction by the end of the pilot.[20]

For some departments, having a 360-degree type evaluation is a good start but having an action plan and metrics to measure progress along the way is more important. In addition, what works for one division or faculty member may not work for others. Thus, individualized and personalized attention will be necessary in many areas.

- **Onboarding:** Onboarding refers to a process through which new faculty learn the attitudes, knowledge, skills and cultural behaviors required to function effectively within an organization as a valued team member. Departments of Surgery can transmit their values, norms and behavioral patterns to new faculty. If Departments can successfully socialize new employees into becoming insiders, accepted by their peers, this confidence will in turn translate into more effective surgeons with higher job satisfaction and retention rates. Part of the onboarding process should include: formal orientation with review of promotion and advancement criteria as well as financial framework of the practice and department, networking and relation building, emphasizing importance of feedback and facilitating time with mentors and leaders.
- **Annual Reviews:** Although standard metrics for academic advancement (number of publications, grants, etc.) should be applied as a broad basis for ongoing assessment of faculty, the support of a diverse faculty requires that Departments of Surgery consider and employ other, less standard metrics with which to evaluate faculty who may be disadvantaged due to training, cultural background, or lack of mentorship. These could include leadership positions in special interest societies such as the Society of Black American Surgeons, and the Association of Women Surgeons, as well as recognition for achieving milestone "firsts" for URiMs within the institution.

Continuous Assessment Measures for the Institution

The Department is one important unit of measure for promoting diversity and inclusion, but some initiatives may engage across multiple departments or more broadly across the institution. In Chapter 2, we presented the Workforce Diversity Network list of metrics that can be used to assess factors that contribute to diversity and inclusion of an institution. As highlighted in this list, an early critical point of assessment is in the hiring phase where workforce diversity is established. The University of Wisconsin, through the Wisconsin-Madison's Women in Science & Engineering Leadership Institute (WISELI), has published influential research and has successfully organized workshops around best practices to create a diverse and inclusive academic climate. Based on this experience, WISELI has developed a comprehensive guide to assist search committees in hiring a talented and diverse faculty. This handbook focuses on 6 elements: running a search committee, recruiting a diverse pool of applicants, raising awareness of unconscious bias, ensuring a fair review, developing an effective interview process, and successfully hiring the candidate. The second edition of this handbook was published in 2012, and has been influential in educating search committees and affecting important changes in the hiring process to include greater representation from women and URiM.[21]

Engagement Cluster	Inclusion Factors
Vision/Purpose	common purpose, access to opportunity, equitable reward and recognition, cultural competence
Camaraderie	trust, sense of belonging
Appreciation	appreciation of individual attributes, respect

FIGURE 8-2: Each of the 22 items in the DES is mapped to both an engagement cluster and inclusion factor which are designed to assess the extent to which an institutional environment supports inclusion and diversity.

Sheridan and colleagues from WISELI have published their results on implementation of an institution-wide initiative, including workshops incorporating their handbook, with an explicit goal of hiring more women. As an ongoing evaluation of the impact of this program, both the proportion of female new hires as well as survey data regarding satisfaction with the hiring process were elicited. Both the number of female recruits and the satisfaction with the recruitment process were improved in departments that engaged in the workshops[22]. Such activities and metrics can provide an ongoing assessment of any biases perceived at the point of hiring.

Clearly, the assessment of diversity and inclusion can start as early at the hiring stage, but is also important as part of ongoing workforce culture assessment. In the past 5 years, many Academic Medical Centers have used the Diversity Engagement Survey (DES), a 10-minute survey aimed to help institutions evaluate their workplace culture with respect to diversity and inclusion. The DES was developed in 2011 as a collaboration between the University of Massachusetts Medical School and the AAMC.[23] The tool was tested at 13 academic medical centers between 2011 and 2012 to provide benchmarking data for other institutions.[24] The DES consists of 22 items based on workforce engagement theory and has been useful in providing institutions an assessment of an institution's strengths as well as areas to target for improvement (Figure 8-2).

Other metrics that institutions and departments have identified as useful elements of ongoing assessment include an appraisal of whether there exists the necessary infrastructure to accommodate faculty with unique needs. This can take many forms, such as considerations for those with disabilities or special needs, such as elder care or dependent care. In addition, programs to support domestic partner benefits, tenure clock extensions, and family leave can be important metrics to ensure that faculty with unique needs, and thus vulnerabilities for unequal treatment, are being sufficiently accommodated. Opportunities to elicit faculty input on these important metrics should be undertaken throughout a faculty member's tenure within the institution, but also importantly at the time of an exit interview, which will provide an ideal opportunity for honest, unbiased assessment.

Conclusion

Ongoing assessment is part of creating a diverse, inclusive work environment, and must include engagement and commitment at all levels, including the individual faculty member, the Department, and the institution. Both practical and validated tools have been reported, including those such as the Diversity Engagement Survey (DES) and assessments published by leaders in the field including the Mayo Clinic, Stanford University, and the Wisconsin-Madison's Women in Science & Engineering Leadership Institute (WISELI). As academic surgical departments invest resources to create greater workforce diversity, the processes and goals for ongoing assessment should also be an important component of these diversity initiatives.

Key Performance Indicators

- Continuous self-assessment should be encouraged as a key component of achieving sustained, tractable diversity and inclusion in the surgical workforce.
- Faculty and staff should be educated in how implicit and explicit bias may impact the evaluative process and how to develop the necessary emotional intelligence to mitigate against bias.
- Preparation, self-awareness and an understanding of individual strengths and weaknesses is an important part of the evaluative process.
- Existing evidence-based assessment tools should be used whenever applicable to monitor individual, departmental, and institutional progress.

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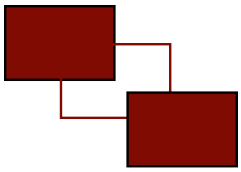

CHAPTER NINE

Service and Altruism

Introduction

Service and altruism have always been part of a surgeon's commitment. That duty is embodied in our responsibility to create a diverse, inclusive, and equitable health care system locally, nationally and globally. We also need to include a focus on the underrepresented populations we serve which includes women, ethnic groups, the LGBTQ community, and economically disadvantaged patient populations. Academic surgeons can provide meaningful opportunities and programs to undertake the changes required to achieve a fully diverse and inclusive health care system. Surgeons need to be accountable for the impact our efforts have on the next generation of surgeons and the quality of care in our communities (domestic and global).

Recognition and commitment to these activities are receiving increasing attention at all levels of academic surgery. In 2008, the Liaison Committee for Medical Education (LCME) adopted a new standard to encourage all medical schools to further student community engagement during their medical education. The standard states that, "Medical schools should make available sufficient opportunities for medical students to participate in service-learning activities, and should encourage and support student participation."[1,2] Graduate medical education and academic surgery have embraced health disparities research as a way to address disparate outcomes and lack of access for various unique populations within the U.S.[3] Academic departments are also increasingly expanding into international sites through resident clinical rotations, research activities, and faculty projects in education, research, and capacity building. Resident service learning was recognized in 2011 by the Accreditation Council for Graduate Medical Education (ACGME) and the American Board of Surgery (ABS) as activities that contributed to the clinical portfolio of residency and board eligibility. In a 2015 publication of program directors, 34 departments had international clinical experiences, 73.5% with ACGME/ABS approval.[4] Lastly the largest surgical organization in the world, the American College of Surgeons (ACS), has recognized the desire for surgeons to contribute through service and altruism. In 2004, the ACS founded Operation Giving Back with its mission to "leverage the passion, skills, and humanitarian ethos of the surgical community to effectively meet the needs of the medically underserved". The last decade has seen an increasing role for academic surgeons as leaders, mentors, and educators in service activities, but Academic Surgery as a whole has yet to position itself to support these activities in a consistent manner. This chapter will highlight domestic and international examples of service and altruism by academic surgeons and suggest ways that this vital activity could be valued within departments.

Local or National Community Service

High-School and Medical School Outreach: As children begin to consider career choices, our academic mission requires that we continue to attract diverse trainees to our specialty. It is recognized that early outreach helps students from diverse backgrounds consider careers in the biomedical sciences and increases the pipeline into medical schools.[5] It is important for surgery departments to develop a framework that highlights existing departmental diversity and education/scholarship/research/clinical strengths into community programs to inspire school-age children from inner cities, or other underserved areas, to choose medicine (and surgery) as a career. Involving all faculty while showcasing departmental diversity in programs such as "Doctor for a Day" or "Surgical subinternships" helps to attract "the best and the brightest" students to medical schools. Once matriculation to medical school has occurred it is also important to attract students into our field of surgery. Unfortunately, overall interest in general surgery has continued to drop in U.S. senior medical students due to perceptions of lifestyle, surgical stereotypes, and lack of exposure to surgeons in the early years of school.[6,7] Surgeons should be encouraged and rewarded within the department for community outreach starting at middle and high school levels and continuing into the preclinical and clinical years of medical school.

Examples of outstanding programs supported by surgeons and academic departments are:

1. The Academic Success Through Surgical Education and Training (ASSET) program at Duke Department of Surgery. This is a partnership of the department with the Durham Nativity School, a tuition-free middle school for boys from low-income families. It aims to foster high achievement in science through surgical education for financially disadvantaged students. Students have contact with surgical faculty and participate in skills sessions, and anatomy training.[8]
2. The Health Career Academy is a national program that brings health careers education, information, and mentoring to low-income and ethnic minority high school students. The program, conceived and started by a surgeon, currently exists in ten metropolitan areas.[9]
3. Stanford University's Medical Scholars Research Program provides research and mentorship opportunities to medical students. It was started in 1980 and pairs faculty with medical students for funded research projects beginning as early as in the first year of medical school.[10]
4. Formal or informal mentorship opportunities with surgical faculty have been shown to positively influence medical student choices for surgical careers, typically in the area of specialty of the mentor.[11]
5. Surgical Interest Groups are important and provide early exposure to surgical faculty and career in the field. For example, The Benjamin Rush Surgical Society (BRSS) of Rutgers—New Jersey Medical School has a structured student-run program with faculty participation for all levels of students in 2019. Offerings include, clinical observations, surgical skills training, panels, surgical specialty education, and radiology workshops that aim to prepare students for careers in surgery. Over a five year period an 85% increase in students matched to surgical specialties was observed.[12]
6. The Association of Women Surgeons (AWS) has student chapters in many medical schools to enhance exposure of women students to surgeons and surgery, beginning in their first year of medical school.
7. At the New York-Presbyterian Cornell Weill Medical Center early exposure to surgical faculty and a life in surgery is achieved through a program called PreOp. Preclinical students complete rotations in general surgery, vascular, transplant, plastics, breast, pediatric, burn, otolaryngology, colorectal, and interventional radiology. This program offers an experience that goes beyond strict shadowing, adding as much hands-on exposure as possible, skills workshops, and lectures under the supervision of PreOp mentors.
8. The surgery department at the University of Washington (UW) developed the Careers in Healthcare Youth Outreach Program (CHYOP) with the goal to inspire and encourage minority students at the middle and high school level to consider a career in Medicine. This is a collaboration between URiM surgery residents, Student National Medical Association local chapter, and the UW- Network for Underrepresented Residents and Fellows. This program has now extended to Native American students through the Association of American Indians Physicians. A Diversity Visiting Student Internships Program was also designed to give medical students with diverse backgrounds an advanced Sub-I experience and allows UW to have a "national' draw on exceptional candidates for recruitment into academic surgery.

Increasing awareness and participation by academic surgeons will present opportunities for students and provide special opportunities for under-represented or disadvantaged students with the goal of inspiring them to pursue a career in medicine and surgery.

Community Outreach

Many medically underserved areas exist within the United States, often in close proximity to medical schools. Participation in community outreach through service, education, and research is a vital role for academic faculty and contribute to both the health of society and the academic mission. Community outreach is also a strong recruiting tool for trainees interested in health disparities and service. These endeavors frequently also provide robust research opportunities and are often supported by foundation, government, and private funds. Clinical services, as well as cancer and injury prevention outreach, within the community also provide tangible value in terms of goodwill and improved reputation of the medical center. Faculty participating in these programs are also modeling service and altruism to trainees and contributing to their professional development.

Examples of outstanding programs supported by surgeons and academic departments are:

1. Operation Access, founded in 1993, enables San Francisco Bay Area health care providers to donate vital surgical and specialty care to people in need. Partnerships with health care providers includes more than 1500 volunteer medical professionals, 40 hospitals and ambulatory care centers, and 20 medical groups that currently provide outpatient surgical procedures and diagnostic screenings to patients from more than 80 community clinics.[13]
2. Oregon Health and Sciences University Department of Surgery provides rural surgery outreach through education and locum tenens work. The primary goal is to help maintain surgical services in smaller rural hospitals while strengthening relationships with surgeons and hospitals throughout the state.[14]
3. The Health Access Project in Salt Lake City was started in 2001 with a mission to, "improve access to coordinated, comprehensive health care for low-income uninsured individuals." Currently, more than 600 physicians and all nine area hospitals provide free care to qualified individuals. Since 2002 the program has donated more than $22 million in health care.[15]
4. Johns Hopkins University Trauma Survivors Network is a partnership between the Johns Hopkins Injury Center and the American Trauma Society (ATS). The goal of the partnership is to ease the burden of injury and its consequences for patients and their families through exchange of reliable information, education, peer support and, most importantly, promotion of self-management programs.[16]
5. The City of Hope Medical Center developed a comprehensive outreach program to the Hispanic community in nearby Riverside county. Programs included the Eugene and Ruth Roberts Summer Student Academy, a summer research program for high school and college students. In addition, a grants program pairs faculty with University of California-Riverside investigators to stimulate research related to and performed in underserved areas. Finally, clinical trials are made available to this underserved area through partnership with community leaders resulting in increased access to these trials which often is not present in underserved communities.

Engagement of the underserved within the United States particularly in the areas surrounding our medical schools provides a powerful engine for recruitment into the medical/surgical field, education, research, and access to medical care to populations.

International Outreach

The growing interest in global surgery has created new and better opportunities for students, residents, and faculty interested in this area. Global outreach programs have proliferated so much that the American Surgical Association formed a Working Group on Global Surgery in 2018. The working group wrote the *Global Surgery: Effective Involvement of U.S. Academic Surgery* document

to outline the appropriate roles and mechanisms for academic surgery to engage in Global Health.[17] A key recommendation was that academic departments should assure that the programs they support develop increased capacity, educational opportunities, development of research into disease patterns, treatment, and prevention as well as care delivery in their partner programs. Another role for departments could be to take a leadership role in supporting the professional development of international faculty. Examples of successful programs are the exchange scholarships offered by the American College of Surgeons or the Women Surgeons in Low & Middle Income Countries Award sponsored by the Association of Women Surgeons.[18,19] Adoption of these types of programs by departments would help to increase diversity in the world's surgical workforce.

Surgical education programs for surgeons from outside the United States should have a meaningful experience while visiting U.S. medical centers. Ensuring that this occurs would also be a useful task for academic departments to undertake. Academic departments have created novel GME and CME courses to properly prepare U.S. surgeons who participate clinically in global settings for the experience. The University of Colorado has a GME focused residents' course and Stanford University has a CME surgeons focused Humanitarian Surgery course, but more learning opportunities in this area are needed. Many course attendees provide both clinical care and education in the most underserved areas of the world.[20,21] Other possible endeavors would include developing content in cultural competence, medical language guides, and ethics for different cultures.

As more and more faculty work in global settings, academic departments must develop plans to keep these surgeons as integral parts of their department, with appropriate policies on promotion, leave, and pay. Hopefully, the engagement of academic surgery and the numerous global organizations will foster access to quality health care and a gender inclusive workforce will exist throughout the world.

Faculty Development, Mentoring, Research, and Recognition

The work done by faculty in these outreach efforts are critical to achieving the goals of diversity and inclusion. These efforts also serve as examples and inspiration for students, residents, and faculty and "pay it forward" in helping improve the future. Academic surgery departments should be expected to support, and reward faculty participation. Examples of departmental content and support include:

- **Training Programs**: Residency and medical student curricula should include specific instruction on health care disparities, issues related to lack of access to care, cultural competencies, and ethics, using the lens of health care based locally, nationally, and in the developing world.
- **Faculty development:** It is critical for departments to develop recognition and valuation schema for faculty engaged in these critical areas. Traditional measures of productivity, such as publications, grants, and presentations, may not be applicable to faculty involvement in these activities. New methods to recognize these contributions will need to be determined. Examples of how this can be accomplished already exist such as; point systems, service dossier or portfolios in the academic CV's, faculty awards or recognition at departmental and instructional events and newsletters. For faculty who wish to have service as a significant portion of their education or research work, flexibility in their clinical schedules may be necessary to support those efforts. Lastly, metrics to value contributions need to be developed for participation in departmental appointment, promotion, and tenure decisions.
- **Individual or Institutional Education, Research, and Capacity Building Initiatives:** Academic support for faculty with significant interest or involvement in community or international work will often be necessary in the development phase of program. It is important to recognize that faculty efforts will need to be adjusted to support time away from the clinical units to develop programs such as cancer or injury outreach, global research, or educational collaboratives. These types of programs also require financial investment, either through startup funds or internal seed grants, and support is also needed to submit foundation or governmental grants. Academic value for this type of funding, which is different than traditional NIH mechanism, will also need to be taken into account in promotion and tenure decisions. Lastly, these programs can help to broaden the types of development funds that can be raised by the department.

Conclusions

Service and altruism are increasingly being recognized as part of the portfolio of many academic surgeons. For years, significant service and outreach contributions by many faculty have not been valued by traditional departmental metrics. Over time many of these areas become the basis of the faculty member's ongoing research, but many instances of service remain unknown and opportunities to inspire trainees, donors, and community members are lost. If surgeons are to remain leaders in Academic Health Centers, departments of surgery must demonstrate the value of these programs to the enterprise. We are accountable for the impact that our vision of diversity has on the next generation of surgeons and the quality of care within all our communities.

Key Performance Indicators

- Surgery departments should include information on health care disparities, cultural competence and service in curricula for students and residents.
- Surgical departments should have a system to expect, acknowledge, and reward service and altruistic activities.
- Surgical departments should actively participate in student and resident community and global service projects.
- Surgical departments should encourage research in health care disparities and access to care, locally and globally.
- Surgical departments should make opportunities for global surgical engagement available to residents.

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APPENDIX ONE

Chapter 2: Employee/Faculty/Staff Survey to Evaluate Diversity—Multiple Sources

The following statements will be on a Likert Scale of Strongly Agree/Agree/Disagree/Strongly Disagree/I Don't Know

- There is a fair distribution of women and men hired for internal and external job vacancies.
- Advertising methods promote your organization's vision of a gender diverse workforce and are explicitly gender inclusive.
- Advertising methods promote your organization's vision of a respectful and inclusive workforce.
- Succession plans promote your organization's vision of a gender diverse workforce and value the different experiences of women and men.
- There is equal access to opportunities such as special assignments and acting positions for both men and women.
- Recruitment methods draw on a variety of approaches to ensure a diverse applicant pool including outreach to local advocacy organizations.
- Your organization's recruitment campaigns are inclusive of women and sensitive to cultural differences and languages.
- Your organization's job advertisements clearly outline essential job requirements.
- Your organization has taken necessary measures in its Gender Diversity Action Plan to achieve equality in pay.
- When screening applications, your organization takes into consideration potential career gaps due to family responsibilities.
- Skills gained from volunteer work are valued in your organization's hiring processes.
- Skills gained from work in other countries are valued in your organization's hiring processes.
- To ensure fair and unbiased hiring, your organization avoids the use of gender stereotypes.

- All the tests used in your organization's hiring process have been proven to be reliable predictors of job performance and are unbiased.
- Your organization has a diverse panel of interviewers so all candidates feel welcome.
- Your organization's interview questions have been carefully reviewed for inherent biases and stereotypes.
- Your organization has a standard process for assessing all interview questions to support the choice of a particular candidate.
- Your organization uses a standardized process for checking references which avoids questions that might discriminate on a ground prohibited by Human Rights Legislation.
- Your organization's HR processes include tracking offers of temporary and permanent positions by gender.

APPENDIX TWO

Chapter 2: Organizational Diversity, Inclusion, and Equity—A Self-Assessment Tool

Please rank the status of each of the following items on a scale of 0 to 3, according to the ratings shown below:

0 Not Yet Started
1 Beginning Phase
2 Well Under-Way
3 Fully Developed (including monitoring/review procedures)
N/A Not Applicable/Don't know

Where appropriate, please add your comments to explain or illustrate your rating.

Standards	Measures	STATUS	COMMENTS
A. GOVERNANCE			
1. POLICIES, GUIDELINES AND PRACTICES **Vision:** *The organization's commitment to creating an environment free of systemic and individual barriers to inclusion and equity is incorporated into the policies, guidelines and practices of the organization.*			
1.1 The organization's commitment to diversity and inclusion is known and understood by all Board members, management, staff, volunteers, members and organizational affiliates.	**1.** The Board has made public their commitment to diversity, inclusion and equity. **2.** Opportunities for the involvement of diverse segments of the population, as well as all members of the organization (Board, staff, volunteers) have been clearly defined in the development of organizational policies and strategies.		
1.2 Anti-discrimination and workplace harassment policies are in place, including principles and objectives of diversity, inclusion and equity in the areas of governance, programs, services and human resources management.	**1.** The organization has incorporated the principles of diversity, inclusion and equity into its statement of values. **2.** The organization allocates appropriate resources (staffing, time, financial) to the development and review of policies relating to diversity, inclusion and equity.		

Standards	Measures	STATUS	COMMENTS
1.3 Principles of diversity, inclusion and equity are embedded in all organizational policies and practices.	**1.** The organization has addressed issues of diversity and inclusion in its strategic plan. **2.** The organization has assessed its existing policies, guidelines and practices to determine if they are congruent with the principles of diversity and inclusion.		
1.4 Mechanisms are established to monitor and measure progress towards achieving organizational change to reduce barriers to inclusion and equity.	**1.** The Board has explored the possibility of systemic barriers to inclusion existing in their governance and Board policies and practices. **2.** The Board has formulated an action plan to eliminate barriers to inclusion. **3.** The Board has put a monitoring procedure in place with respect to progress made in the areas of diversity, inclusion and equity.		
2. LEADERSHIP **Vision:** *The organization's leaders' commitment to diversity, inclusion and equity is known within the organization and in the community and is reflected in the decision-making structures and processes of the organization.*			
2.1 The Board and management provide informed leadership in the implementation of anti-discrimination and workplace harassment policies.	**1.** The Board has clearly outlined its expectations for management on the implementation of diversity, inclusion and equity policies. **2.** The Board has clearly outlined its expectations for management on the implementation of workplace discrimination/harassment policies. **3.** The Board has developed clear guidelines to follow if the policies are breached. **4.** The Board and management have committed resources for the effective implementation of diversity, inclusion, equity and workplace discrimination/harassment policies and programs.		
3. INCLUSIVENESS OF PROCESS **Vision:** *The decision-making process is inclusive and reflects community needs and expectations.*			
3.1 Information concerning governance structure and opportunities to serve are effectively communicated to members of diverse communities within the service area.	**1.** The organization has developed a communications strategy to inform diverse populations of its activities and invite them to participate. **2.** The organization has developed a comprehensive list of community and ethnic media. **3.** The organization has developed a comprehensive list of community, regional and provincial groups and organizations that deal directly with diverse and/or marginalized populations.		

Continued

Standards	Measures	STATUS	COMMENTS
3.1 *(Continued)* Information concerning governance structure and opportunities to serve are effectively communicated to members of diverse communities within the service area.	**4.** The organization has developed a comprehensive list of other points of access for reaching diverse communities (i.e., places of worship, community centres, social clubs etc.). **5.** The organization has compiled and updated provincial and regional profiles including demographics and social, economic, health and environmental issues.		
3.2 Partnerships between community organizations and the organization are in place, reflect the diversity of the population, and are functioning well.	**1.** The organization has developed an effective and inclusive formal and informal working relationship with diverse community groups and organizations. **2.** The organization has developed a two-way consultation mechanism with diverse communities. **3.** Partnerships are actively sought with organizations representing diverse populations. **4.** Partnership agreements include a process for conflict resolution.		
3.3 Members of diverse communities are equitably represented in the different levels of the organization, i.e., Board, committees and management.	**1.** The organization has explored the possibility of systemic barriers in the recruitment, selection and retention processes for Board, committees and senior management. (i.e., advertising outlets, criteria for selection, interview process, time/financial requirements for participation). **2.** The Board has explored the possibility of barriers existing in the way it and its committees function. (e.g., time and location of meetings, accessibility of building, availability of child/ elder care, meeting style). **3.** Orientation and training are provided to members as needed to increase their ability to participate effectively. **4.** Time is set aside in meetings for each member to express their perspective and concerns. **5.** Ground rules have been determined which state how group members are to relate to one another. **6.** Terms of reference for committees include a process for conflict resolution. **7.** The organization has developed a plan to eliminate barriers and to enhance participation in the Board and committees.		

Standards	Measures	STATUS	COMMENTS
3.4 Effective mechanisms are in place to handle complaints about incidence of discrimination from organizational affiliates, volunteers and community groups.	**1.** The organization has developed a mechanism for effectively handling complaints of incidences of discrimination from organizational partners, affiliates, volunteers and community groups. **2.** The organization has developed a strategy to ensure that the Board, management, staff, organizational affiliates, volunteers and community groups are aware of their right to access the complaints procedure to address any incidence of discrimination.		
B. PROGRAMS & SERVICES			
1. SERVICE PLANNING **Vision**: *Services are barrier-free and appropriate to the needs of diverse communities.*			
1.1 Participation of diverse communities in the needs identification and planning of organizational programs and services is supported and encouraged.	**1.** Key members of diverse communities have been invited to participate in the planning of the organization's programs and services. **2.** The organization has obtained information about the needs and interests of these diverse communities.		
2. SERVICE DELIVERY **Vision:** *Programs and services are responsive to the values, norms and needs of diverse communities.*			
2.1 Programs and services are adapted to take into account and accommodate the values, norms and issues of diverse communities.	**1.** Staff adapt programs and services to respond to identified needs and issues; e.g.: – Meals/childcare/transportation – Respect for faith/spiritual practices – Meeting times, locations and structures – Services respond to expressed issues and needs		–
2.2 Appropriate linguistic resources are provided to ensure equitable utilization of organizational programs and services by the diverse communities.	**1.** The various linguistic groups have been identified within its service area. **2.** The organization has developed an action plan with members of diverse communities to eliminate language barriers to accessing programs and services.		
3. OUTREACH **Vision:** *Diverse communities in the service area know of the organization's programs and services.*			
3.1 Effective, equitable and appropriate strategies are utilized to communicate programs and services with diverse communities within the service area.	**1.** An outreach strategy has been developed and appropriate resources allocated to reach the various communities in an equitable manner.		

Continued

Standards	Measures	STATUS	COMMENTS
3.1 *(Continued)* Effective, equitable and appropriate strategies are utilized to communicate programs and services with diverse communities within the service area.	**2.** A communication strategy has been developed to provide information to various communities within the service area, including: – Targeted media (TV, audio/radio, print) – Community newspapers – Key informants – Community leaders **3.** The organization has established a two-way communication mechanism with diverse communities in its service area.		
C. HUMAN RESOURCES			
1. STAFF RECRUITMENT/RETENTION/PROMOTION **Vision:** *All levels of staff reflect the diversity found in the province.*			
1.1 Staff, organizational affiliates and volunteers are reflective of the diverse communities in the broader community.	**1.** The organization has explored the possibility of barriers in the recruitment, hiring, promotion and retention of diverse staff, organizational affiliates and volunteers. **2.** Paid and volunteer opportunities have been advertised in non-mainstream media. (i.e., target media, community newspapers, newsletters of professional associations and community organizations). **3.** The organization has consulted with members of diverse communities regarding the development of the recruitment process. **4.** The organization has reviewed the interview process for biases, such as: diversity among the interviewers and bias-free questions. **5.** Mentoring and conflict resolution systems have been put into place to ensure the retention of diverse staff, organizational affiliates and volunteers.		
2. BOARD/STAFF/VOLUNTEER TRAINING **Vision**: *All staff and volunteers are knowledgeable about how social, political, economic and cultural differences affect the ability of diverse groups to fully participate in their communities, and are skilled in working with diverse members of the community.*			
2.1 All staff, Board members and volunteers are given opportunities to participate in diversity, inclusion and equity knowledge and skill development programs.	**1.** The knowledge and skills of its Board, management, staff and volunteers have been assessed in the areas of diversity, inclusion and equity. **2.** The organization has developed a diversity, inclusion and equity education program, attended by all staff, Board members and volunteers.		

Standards	Measures	STATUS	COMMENTS
2.1 *(Continued)* All staff, Board members and volunteers are given opportunities to participate in diversity, inclusion and equity knowledge and skill development programs.	**3.** The organization has involved members of diverse communities in the planning, delivery and evaluation of the diversity, inclusion and equity education program. **4.** The organization keeps its resources current for staff, professionals and volunteers to update their knowledge and skills on appropriate service delivery to diverse communities.		
3. PERFORMANCE APPRAISALS **Vision:** *Improved staff, Board and volunteer performance promotes an environment free of all forms of discrimination, workplace harassment and barriers to inclusion and equity.*			
3.1 Evaluation of management, staff and volunteers includes adherence to discrimination and workplace harassment prevention policies.	**1.** The organization has developed clear guidelines for staff to provide cross-cultural services within an inclusive framework. **2.** Indicators of diversity and inclusion are included in the performance appraisal of staff. **3.** Consideration is given to volunteers' contributions to promoting diversity, inclusion and equity during volunteer appraisals. **4.** Indicators of diversity and inclusion are included in the performance appraisal of the Board of directors' functions.		
4. EVALUATION AND MONITORING **Vision**: *The organization's programs and services are responsive to the needs of diverse communities.*			
4.1 An evaluation plan is in place to monitor the accessibility, appropriateness and effectiveness of programs and services.	**1.** The organization has consulted with diverse communities in the development of an evaluation plan. **2.** The organization has established an evaluation process to monitor the accessibility, appropriateness and effectiveness of programs and services to diverse communities.		
ADDITIONAL COMMENTS			

APPENDIX THREE

Chapter 6: Tool: Recognizing Microaggressions and the Messages They Send

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

THEMES	MICROAGGRESSION EXAMPLES	MESSAGE
Alien in One's Own Land When Asian Americans, Latino Americans and others who look different or are named differently from the dominant culture are assumed to be foreign-born	• *"Where are you from or where were you born?"* • *"You speak English very well."* • *"What are you? You're so interesting looking!"* • A person asking an Asian American or Latino American to teach them words in their native language. • Continuing to mispronounce the names of students after students have corrected the person time and time again. Not willing to listen closely and learn the pronunciation of a non-English based name.	You are not a true American. You are a perpetual foreigner in your own country. Your ethnic/racial identity makes you exotic.
Ascription of Intelligence Assigning intelligence to a person of color or a woman based on his/her race/gender	• *"You are a credit to your race."* • *"Wow! How did you become so good in math?"* • To an Asian person, *"You must be good in math, can you help me with this problem?"* • To a woman of color: *"I would have never guessed that you were a scientist."*	People of color are generally not as intelligent as Whites. All Asians are intelligent and good in math/science. It is unusual for a woman to have strong mathematical skills.
Color Blindness Statements that indicate that a White person does not want to or need to acknowledge race.	• *"When I look at you, I don't see color."* • *"There is only one race, the human race."* • *"America is a melting pot."* • *"I don't believe in race."* • Denying the experiences of students by questioning the credibility /validity of their stories.	Assimilate to the dominant culture. Denying the significance of a person of color's racial/ethnic experience and history. Denying the individual as a racial/cultural being.
Criminality/Assumption of Criminal Status A person of color is presumed to be dangerous, criminal, or deviant based on his/her race.	• A White man or woman clutches his/her purse or checks wallet as a Black or Latino person approaches. • A store owner following a customer of color around the store. • Someone crosses to the other side of the street to avoid a person of color. • While walking through the halls of the Chemistry building, a professor approaches a post-doctoral student of color to ask if she/he is lost, making the assumption that the person is trying to break into one of the labs.	You are a criminal. You are going to steal/you are poor, you do not belong. You are dangerous.
Denial of Individual Racism/Sexism/Heterosexism A statement made when bias is denied.	• *"I'm not racist. I have several Black friends."* • *"As a woman, I know what you go through as a racial minority."* • To a person of color: *"Are you sure you were being followed in the store? I can't believe it."*	I could never be racist because I have friends of color. Your racial oppression is no different than my gender oppression. I can't be a racist. I'm like you. Denying the personal experience of individuals who experience bias.
Myth of Meritocracy Statements which assert that race or gender does not play a role in life successes, for example in issues like faculty demographics.	• *"I believe the most qualified person should get the job."* • *"Of course he'll get tenure, even though he hasn't published much—he's Black!"* • *"Men and women have equal opportunities for achievement."* • *"Gender plays no part in who we hire."* • *"America is the land of opportunity."* • *"Everyone can succeed in this society, if they work hard enough."* • *"Affirmative action is racist."*	People of color are given extra unfair benefits because of their race. The playing field is even so if women cannot make it, the problem is with them. People of color are lazy and/or incompetent and need to work harder.

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

THEMES	MICROAGGRESSION	MESSAGE
Pathologizing Cultural Values/Communication Styles The notion that the values and communication styles of the dominant/White culture are ideal/"normal".	• To an Asian, Latino or Native American: *"Why are you so quiet? We want to know what you think. Be more verbal." "Speak up more."* • Asking a Black person: *"Why do you have to be so loud/animated? Just calm down."* • *"Why are you always angry?"* anytime race is brought up in the classroom discussion. • Dismissing an individual who brings up race/culture in work/school setting.	Assimilate to dominant culture. Leave your cultural baggage outside. There is no room for difference.
Second-Class Citizen Occurs when a target group member receives differential treatment from the power group; for example, being given preferential treatment as a consumer over a person of color.	• Faculty of color mistaken for a service worker. • Not wanting to sit by someone because of his/her color. • Female doctor mistaken for a nurse. • Being ignored at a store counter as attention is given to the White customer. • Saying *"You people..."* • An advisor assigns a Black post-doctoral student to escort a visiting scientist of the same race even though there are other non-Black scientists in this person's specific area of research. • An advisor sends an email to another work colleague describing another individual as a "good Black scientist." • Raising your voice or speaking slowly when addressing a blind student. • In class, an instructor tends to call on male students more frequently than female ones.	People of color are servants to Whites. They couldn't possibly occupy high status positions. Women occupy nurturing positions. Whites are more valued customers than people of color. You don't belong. You are a lesser being. A person with a disability is defined as lesser in all aspects of physical and mental functioning. The contributions of female students are less worthy than the contributions of male students.
Sexist/Heterosexist Language Terms that exclude or degrade women and LGBT persons.	• Use of the pronoun "he" to refer to all people. • Being constantly reminded by a coworker that *"we are only women."* • Being forced to choose Male or Female when completing basic forms. • Two options for relationship status: married or single. • A heterosexual man who often hangs out with his female friends more than his male friends is labeled as gay.	Male experience is universal. Female experience is invisible. LGBT categories are not recognized. LGBT partnerships are invisible. Men who do not fit male stereotypes are inferior.
Traditional Gender Role Prejudicing and Stereotyping Occurs when expectations of traditional roles or stereotypes are conveyed.	• When a female student asks a male professor for extra help on an engineering assignment, he *asks "What do you need to work on this for anyway?"* • *"You're a girl, you don't have to be good at math."* • A person asks a woman her age and, upon hearing she is 31, looks quickly at her ring finger. • An advisor asks a female student if she is planning on having children while in postdoctoral training. • Shows surprise when a feminine woman turns out to be a lesbian. • Labeling an assertive female committee chair/dean as a "b____," while describing a male counterpart as a "forceful leader."	Women are less capable in math and science. Women should be married during child-bearing ages because that is their primary purpose. Women are out of line when they are aggressive.

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

APPENDIX FOUR

Chapter 6: Negative Acts Questionnaire Revised

Staale Einarsten has published an excellent Negative Acts questionnaire-Revised [NAQ-R], which has been the commonly used assessment tool to survey the environment of an organization. The NAQ-R is comprised of 22 personal- and work-related behaviors (Appendix 2). Below are the 22 questions divided into 3 categories.

Work-Related

1. Someone withholding information which affects your performance
3. Being ordered to do work below your level of competence
14. Having your opinions ignored
16. Being given tasks with unreasonable deadlines
18. Excessive monitoring of your work
19. Pressure not to claim something to which by right you are entitled (e.g., sick leave, holiday entitlement, travel expenses)
21. Being exposed to an unmanageable workload

Person-Related Bullying

2. Being humiliated or ridiculed in connection with your work
4. Having key areas of responsibility removed or replaced with more trivial or unpleasant tasks
5. Spreading of gossip and rumors about you
6. Being ignored or excluded
7. Having insulting or offensive remarks made about your person, attitudes, or your private life
10. Hints or signals from others that you should quit your job
11. Repeated reminders of your errors or mistakes
12. Being ignored or facing a hostile reaction when you approach
13. Persistent criticism of your errors or mistakes
15. Practical jokes carried out by people you don't get along with
17. Having allegations made against you
20. Being the subject of excessive teasing and sarcasm

Physically Intimidating Bullying

8. Being shouted at or being the target of spontaneous anger
9. Intimidating behaviors such as finger-pointing, invasion of personal space, shoving, blocking your way
22. Threats of violence or physical abuse or actual abuse

The participants were then asked to respond "no," "yes, very rarely," "yes, now and then," "yes, several times per month," "yes, several times per week" and "yes, almost daily".

The groups studies were then classified as having no bullying, some work criticism, occasional negative encounters, occasional bullying, work related bullying, severe bullying, and physical intimidation.

He points out that some of the questions may be culturally sensitive and that some questions may need to be added or modified depending on the group.

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GLOSSARY

Bullying

Abuse and mistreatment of someone vulnerable by someone stronger, more powerful.

Characteristics of Personal Identity

Multiple variables influence an individual's personal identity. The overlapping characteristics of identity include, but are not limited to: gender identification, sexual orientation, race, ethnic group, social class, region of origin, religion, level of ability.

Cultural Competence

Cultural competence is a set of congruent behaviors, knowledge, attitudes, and policies that come together in a system, organization, or among professionals that enables effective work in cross-cultural situations.

Diversity

Diversity is the range of human differences, including but not limited to race, ethnicity, gender, gender identity, sexual orientation, age, social class, physical ability or attributes, religious or ethical values system, national origin, and political beliefs.

EEO Targets

Preventing discrimination in areas such as firing, hiring, promotions, transfer or wage practices.

Equity

Quality of being fair and impartial with freedome of bias or favoritism.

Explicit Bias

Attitudes and beliefs we have about a person or group on a conscious level.

Harassment

To annoy persistently and create an unpleasant or hostile situation for especially by uninvited and unwelcome verbal or physical conduct.

Implicit Bias

Attitudes or stereotypes that affect our understanding, actions, and decisions in an unconscious manner. These biases, which encompass both favorable and unfavorable assessments, are activated involuntarily and without an individual's awareness or intentional control.

Inclusion

Inclusion is involvement and empowerment, where the inherent worth and dignity of all people are recognized. An inclusive organization promotes and sustains a sense of belonging; it values and practices respect for the talents, beliefs, backgrounds, and ways of living of its members.

Intersectionality

The interconnected nature of social categorizations such as race, class, and gender as they apply to a given individual or group, creating overlapping and interdependent systems of discrimination or disadvantage and contributing to specific type of systemic oppression and discrimination experienced by an individual.

Life balance/Life Integration

The traditional image of a scale associated with work/life balance creates a sense of competition between the two elements. Work/Life Integration instead is an approach that creates more synergies between all areas that define "life": work, home/family, community, personal well-being, and health.

Mentorship

A relationship in which a more experienced or more knowledgeable person helps to guide a less experienced or less knowledgeable person; and provides psychosocial support, career guidance, role modeling, and communication.

Microaggression

Microaggressions are brief and commonplace daily verbal, behavioral, and environmental indignities, whether intentional or unintentional, that communicate hostile, derogatory, or negative slights and insults to the target person or group.

Onboarding

The mechanism through which new employees acquire the necessary knowledge, skills, and behaviors to become effective organizational members and integration into the organization and its culture.

Pay Equity

A for reducing or eliminating the wage gap between or among groups such as women and men, or various ethnic groups by the use of compensation policies that assign wages after a careful determination of the content of jobs, such as the skill or effort required, the burden of responsibility, or the job's working conditions.

Physician Burnout

When physicians experience emotional exhaustion, depersonalization, and a diminished sense of personal accomplishment, which is primarily driven by workplace stressors.

Sponsorship

The use of strong influence to help obtain high visibility assignement, promotions or jobs by advocating in many settings, including behind closed doors to advocate for advancement and champion your work and potential.

Under Represented in Medicine

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

Wellness

An active process of becoming aware of and making choices toward a healthy and fulfilling life, and is a dynamic process of change and growth towards a state of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity."

MASTER REFERENCE LIST

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