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Addressing the Surgical Workplace: An Opportunity to Create a Culture of Belonging

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ADDRESSING THE SURGICAL WORKPLACE: AN OPPORTUNITY TO CREATE A CULTURE OF BELONGING

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SESSION INTRODUCTION – CO-MODERATORS:

Carla M. Pugh, MD, PhD - Stanford Medicine

Orlando C. Kirton, MD, MBA – Sidney Kimmel Medical College of Thomas Jefferson University

MICROAGRESSIONS IN THE SURGICAL WORKPLACE-WHY IS BELONGING SUCH A BIG DEAL?

Speaker: J.E. "Betsy" Tuttle-Newhall, MD, MHA - E. Carolina University / Brody School of Medicine

Discussants:

Ronald V. Maier, MD - University of Washington Medicine

Yue-Yang Hu, MD, MPH - Feinberg School of Medicine, Northwestern University

DO "NO TOLERANCE POLICIES WORK? A REVIEW AND DISCUSSION OF WORKPLACE INTERNVENTIONS

Speaker: John H. Stewart IV, MB, MBA - LSU Health

Discussants:

Julie Ann Freischlag, MD - Wake Forest Baptist Medical Center

Julie Ann Sosa, MD – University of California, San Francisco General Hospital

EQUITY AND INCLUSION AS A QUALITY METRIC-SETTING HIGH STANDARDS IN SURGERY

Co-Moderators:

Selwyn M. Vickers, MD - University of Alabama at Birmingham

Mary T. Hawn, MD - Stanford Medicine

Panelists:

Robert S. Higgins, MD - Brigham and Women's Hospital

Carlos A. Pellegrini, MD – University of Washington Medicine

Timothy J. Eberlein, MD - Washington Univeristy School of Medicine

Diana L. Farmer, MD - University of California Davis Health

SOCIETY RESPONSES FROM THE IDENTITY-BASED REPRESENTATIVES:

Association of Out Surgeons and Allies (AOSA): Sanziana A. Roman, MD – University of California, San Francisco General Hospital

Asociation of Women Surgeons (AWS): Marie L. Crandall, MD, MPH – University of Florida at Jacksonville

Latin Surgical Society (LSS): Christian M. De Virgilio, MD- Harbor UCLA Medical Center

Society of Asian American Surgeons (SAAS): Allan Tsung, MD - University of Virginia Health

Society of Black Academic Surgeons (SBAS): L.D. Britt, MD, MPH – Eastern Virginia Medical School

INTRODUCTION:

Co-moderators: Carla M. Pugh, MD, PhD & Orlando C. Kirton, MD, MBA

The demographic of the United States has become more racially and ethnically diverse. In 2003, the executive council of the Association of American Medical colleges (AAMC) adopted the following definition: "Underrepresented in Medicine" (URiM) to mean those racial and ethnic populations that are underrepresented in the medical professions relative to their number in the general population. Groups considered URIM have been traditionally disadvantaged, under-represented, or inadequately supported in medical training. These groups historically include those identifying as Black or African American, Hispanic, Latino or Spanish origin, American Indian or Alaskan native, or native Hawaiian or Pacific Islander. There is evidence that diversity of opinion leads to better health care delivery outcomes, and that it is advantageous to majority populations to be educated in diverse environments. It is well-known that several peer-reviewed articles have documented that women and racial and ethnic minorities and members of the LGBTQ community experience hurdles in the workplace that many of their majority counterparts rarely experience or are unaware. Conscious and unconscious bias relating to race, gender and sexual orientation often result in microaggressions and microexclusions that can affect work productivity, and more importantly, job satisfaction. This ASA session explored the opportunities that surgical leaders have to effect positive change in the surgical workforce. In October 2017, the leadership of American Surgical Association identified increasing diversity in the surgical workforce as a priority of the Association and approved the preparation of a handbook to aid Department of Surgery Chairs in achieving this aim. The committee composed a comprehensive document titled, "Ensuring equity, diversity, inclusion in academic surgery." In 2018 the manuscript, "Ensuring equity, diversity, and inclusion academic surgery," was

published as a white paper in Annals of Surgery. The conclusion was that surgery must 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. Increasing diversity in our departments of surgery, residencies, and universities will improve patient care, enhance productivity, augment community connections, and achieve our most fundamental ambition - doing good for our patients.

We thank the core organizers of the ASA Women in Surgery Breakfast, as this event that had been well-organized for many years, is the precursor to this diversity forum.

MICROAGGRESSIONS IN THE WORKPLACE: WHY IS BELONGING SUCH A BIG DEAL?"

Speaker: J.E. "Betsy" Tuttle-Newhall, MD, MHA

Microaggressions are intentional or unintentional communication of hostile, derogatory, or negative racial, gender, sexual orientation, religious slights, and insults to target a group or people. Our research team performed a survey of over 1600 US surgical residents. Nearly 3/4 of them reported experiencing microaggressions, and most commonly, the source of those microaggressions were patients. Unfortunately, nearly 1/3 of those residents who reported these microaggressions experienced retaliation. The focus of microaggressions experienced by the residents were feelings of being dismissed, devalued, or ignored because of one's sex, race, or ethnicity. In addition, there was an "ascription of intelligence", meaning specific demographics, for example, the color of our skin or your gender… or anything else… means that a certain level of intelligence is assigned to you. For those that are "different" (i.e., race, gender, sexual orientation) it was assumed there was a lower level of intelligence. Women trainees experience

more microaggressions than men, and African American trainees had more microaggressions when compared to non-African American trainees from patients, staff, faculty, and other residents. Creating a culture of belonging is, for many of us, our life's passion as a result of being in cultures where we did not feel like we belonged. In the business sector, it is noted that a single incident of micro-exclusion can lead to an immediate 25% decline in individual performance on a team project. In addition, workplace belonging can lead to an estimated 56% increase in job performance and a 50% reduction in turnover risk, and a 75% decrease in employee sick days. The role of leadership is to create a culture of value for the individual and belonging. Change can really only come from within. Our future as a specialty depends on how we mentor, support, and promote surgeons who reflect our students and especially, our patients. I think this is an amazing quote that Dr. Vickers talked about by Dr. Martin Luther King, "It's not the violence of the few that scares us, and it's the silence of many".

Discussant 1: Ronald V. Maier, MD

We have repeatedly elucidated the improvements in function associated with increased diversity in our healthcare teams. However, merely creating diversity within a team is not a guarantee for achieving the maximal benefit of diversity. As identified by elite military teams, it is not enough to collect a team of experts, but rather, it is necessary to foster and nourish respect and inclusivity to create an expert team. It is evident that in addition to increasing diversity, a well-functioning and inclusive team is necessary to provide optimal care and to provide retention, resilience, and sustainability of the team. As we strive to reach this goal, we are constantly reminded of how often these goals are prevented, frequently through intended and unintended microaggressions that destroy the fabric of our team and demoralizes our diversity membership.

I strongly recommend a recent book, “Did That Just Happen”, by two clinical psychologists, Drs. Pinder-Amaker and Wadsworth. They define the concept of identity related aggressions or IRAs as a better descriptor for microaggressions. “Micro” may have been a necessary “benefit of the doubt” to make the issue of aggression palatable in the past, but it does not truly define the devastating cumulative impact of such events. They define the individual targeted by an IRA as a representative of a social, ethnic, or cultural identity group with whom the individual presumably shares the traits being targeted by the focus of the harassment. And then, they provide numerous examples of how, as a bystander, to recognize, respond, and resolve IRAs. It is a responsibility for each of us to constantly train to recognize, respond, and resolve any IRA occurrence as critical, if we are to achieve highly inclusive and sustainable medical care teams and organizations.

Discussant 2: Yue-Yung Hu, MD, MPH

I’m one of the PIs of the Surgical Education Culture Optimization through targeted interventions based on National comparative Data (SECOND) Trial, and we study resident well-being. We conduct an annual post-ABSITE survey, and our findings are similar to Dr. Tuttle’s in that they indicate that identity-based mistreatment indicates a profound lack of belonging in our work and learning environments, and this is responsible for increased rates of burnout and attrition, as well as suicidality in surgeons who are women, racial and ethnic minorities, and LGBTQ+. This is problematic, I would submit, not only for these surgeons but also for all of our patients. There is a wealth of data that demonstrate that lack of physician diversity is a preventable cause of excess morbidity and mortality in minoritized populations. A recent scoping review of DEI work in surgery, indicates that the vast majority of efforts revolve around diversifying recruitment. This

is an important effort, yet both Dr. Tuttle's data and ours show that this is inadequate. Without inclusion, we cannot retain the diversity we are recruiting. The same review showed that most inclusion efforts seem to revolve around implicit bias training. At face value, this makes sense, because after all, micro- and macro-aggressions are individual behaviors that reflect individual beliefs. Unfortunately, however, the psychology literature demonstrates that not only are implicit biases and their associated behaviors highly resistant to change, but implicit bias training may actively be counter-productive. It can normalize and therefore reinforce biases, reducing perceptions of their harm, as well as the sense of accountability for them. Social/cultural psychologists who study organizational behavior would submit that our focus on individual beliefs and behaviors neglects the greater context of organizational culture. We cannot change behavior without changing culture, so we need to add organizational work to our individual level work on these problems. We need to examine how the formal policies and informal practices of our organizations reflect and sustain both our culture and our behavior. Changes to our infrastructure, our processes and systems, our leadership, our metrics, and rewards are necessary to lay the critical groundwork for more inclusive behavior.

DO "NO TOLERANCE" POLICIES WORK? A REVIEW AND DISCUSSION OF WORKPLACE INTERVENTIONS

Speaker: John H. Stewart IV, MB, MBA

Many thought that Barack Obama's election would usher in a post-racial America, one in which an individual's opportunities for educational advancement, access to good healthcare, and interactions with the justice system would not be predicated on the social construct of race. However, the subsequent killings of Tamar Rice and Trayvon Martin, the ongoing inequities in

healthcare, and uneven opportunities in education have led us to understand that we are far from a post-racial America. At the same time, there are segments of our society that felt as though the rise of a post-racial America threatens their self-perceived rights and privileges afforded to them by the social construct of race. Therefore, it is important for us to understand that racism never goes away, it just adapts. We must create policies that address the changing face of racism in our country.

So why is a zero-tolerance policy important? I would submit that no one in the workplace deserves to be on the receiving end of workplace incivility including the microaggressions that were mentioned in the previous session. This gives rise to instigated incivility in which others witness or experience incivility themselves, and in turn are more likely to exhibit incivility to others. This incivility has been shown to increase workplace turnover, lower employee engagement and lower morale at work, and again this was shown by our previous presenters. So how do we address this? How do we create policies that are more current and address the issues at hand? We must build a culture around justice, diversity, equity, and inclusion. Secondly, we have to employ hiring and on-boarding procedures that reflect the institution's commitment to justice, equity, diversity, and inclusion. And finally, we have to demand institutional assessment and accountability and support of new no-tolerance policies.

Discussant 1: Julie Ann Sosa, MD

Healthcare workers, faculty, staff, and learners have the right to work in an environment that is free from all forms of abuse. Examples of aggressive behavior extend from bullying, harassment, intimidation, and violence to failure to respond to staff instructions – all of us have seen this during the pandemic with patients' and the public's failure to comply with screening or to

appropriately wear a mask. Unfortunately, there are data to suggest rates of exposure to workplace aggression have changed little over time. Incidents go un- or under-reported, so it is essential to ensure that policies are in place and enforced in a timely way. There should be confidential reporting that protects victims from retaliation, and there should be resources from peers to counselors to support them. In the end, as leaders, we need to do more than execute on no-tolerance policies. We must strive to create and enforce a culture of respect and a community that is anchored in shared values, where participation in the community is a requirement, not an option. And where all the members of the community model and teach those values. These principles are the underpinnings of restorative justice. Restorative justice sees people not as powerless in need of higher authorities to accomplish justice for them, but rather as people to be supported in the work of recovering their safety, reclaiming their dignity, and renewing their place as whole and responsible members of the community. For example, at UCSF, we live by our PRIDE values - Professionalism, Respect, Integrity, Diversity and Excellence. These values are ingrained into our culture and are part of the fabric of our workplace. We display them, talk about them, believe in them, and have empowered all members of our community to hold each other accountable.

Discussant 2: Julie Ann Freischlag, MD

Workplace Interventions: **WAKE** Active Bystander Training - One of our culture commitments, or values, at Atrium Health Wake Forest Baptist and Wake Forest University School of Medicine is to create a space where all belong. We put this commitment into action through our **WAKE** Active Bystander Training, an educational program that gives faculty, students, and staff tools to interrupt moments of incivility and misconduct with professionalism and respect. More than 100

departments, units and teams across our health system have taken the training since its inception in 2019. **WAKE** stands for: **W**ork with who you are (know your strengths); **A**sk questions; engage **K**ey people (find others to help); and **E**mploy distraction techniques. During the training, participants learn the importance of being an active bystander and practice intervention techniques through various scenarios. One strategy that I use as an active bystander is to say, "I'm sure you didn't mean that how it came across. Can you explain?" Sometimes, a more direct approach is needed, like saying, "We can't speak like that in the operating room. Our team could provide better care if we interacted in a more positive way." Speaking up to stop behavior can be difficult, especially for learners. Identifying key allies, like a dean, chair, or fellow teammate, who can work with you toward a solution is critical. Distraction techniques like deflecting to another topic or humor also can be used. Our words, actions and attitudes carry such an impact. Let's look for opportunities to advance our commitment to inclusion – and speak up and be brave as active bystanders. Those in the room with us will be forever grateful and, together, our teams will grow even stronger.

EQUITY AND INCLUSION AS A QUALITY METRIC: SETTING HIGH STANDARDS IN SURGERY

Co-Moderators: Selwyn M. Vickers, MD & Mary T. Hawn, MD

Panelist 1: Robert A. Higgins, MD

We welcome the Associations' allyship on this journey. Really, it's about the practice of emphasizing social justice, inclusion, and human rights by ASA members to advance the interests of a marginalized group. We acknowledge that everyone has their own unique experiences of discrimination and oppression. And this concept requires that we see the world

through each other's lens to understand the challenges many face and the opportunities that will level the playing field for everyone, our understanding of these issues requires clarity on the definition of intersectionality, which underscores that we're all in this together. Justice will only be served when those who are unaffected are as outraged as those who are affected. One of the greatest challenges and opportunities as leaders in academic medicine, is to extend our impact in the identification, training, and professional development of healthcare professionals from under-represented groups in medicine, and this includes ethnic minorities, women, those from diverse religions, national origins, lower socioeconomic status, and sexual orientation. As accountable academic leaders, we must learn from lessons of our past to champion, as Dr. Vickers referred to yesterday, inclusive excellence. It's the recognition that an academic community or institution's success is dependent on how well the values engages, promotes, and includes the rich diversity of students, staff, faculty, and administration. It embraces the excellence of all learners and faculty. But inclusion must be part of any effort to be more diverse. In the words of Barack Obama, "Justice is not only the absence of racism, but the presence of opportunity". So, these efforts must include increasing under-represented minority faculty identification and recruitment when hiring new fellows or faculty. It also includes meeting with department directors and chairs to ensure diverse candidate inclusion in new faculty recruitment searches and considering even monitoring and incentivizing department leadership based upon their performance in addressing diversity initiatives. But if under-represented candidates and selected leaders don't get the resources, tools, and needed support to promote their success leading a department or an enterprise, these initiatives will fail by anyone's standards or metrics, and set everyone back. We are better and stronger together and we welcome the opportunity to work with the ASA on these critically important efforts.

Panelist 2: Carlos A. Pellegrini, MD

"You cannot improve what you don't measure", a quote frequently attributed to Drucker, highlights the importance of having a measurement that is accurate, that is simple, that is devoid of noise, to make progress in whatever you're trying to do. So, I would like to propose a methodology that I have promoted and have used in other places. The method is composed of two components to get to the hard data that you need to make important decisions. One is what I like to call the static component and the other one is the flow component. For the static component, I will propose 2 measurements that, on the one hand, have racial group, ethnicity, religion, or whatever other measurement you want. The organization counting each individual that is currently in the organization belonging to each group. On the second column, compare that to the place where these people are being recruited from, and lastly in the third column, put whatever desired outcome you want after a certain period of time. The second part of the study component requires that you look at the same composition of people by hierarchal position. How many of them are directors, how many of them are either associate professors, or faculty positions, or whatever hierarchical way you want to do to give you an idea of progression.

This was the static part, as for the flow part, three parts, I think are easy to obtain and are reasonable to measure for hard data. The first one will be to look at each group entering the organization over the defined period of time, usually one year. The second one is how many of these individuals are leaving the organization in that same period of time. And the third one is how many individuals that are in the organization are being promoted to the next hierarchal period. These five components give a little bit of hard measurement that can be used to address

inequities and to promote diversity. Let me be clear, the most important thing, perhaps, is what we cannot measure with the numbers. For example, respect, integrity, collaboration and most importantly the emotional state of an individual that makes that individual loyal to the institution, and makes that person want to stay in an institution, cannot necessarily be measured with numbers. For that, I think we can use the immersion science of soft measurements and soft data and through discussions, through meetings, the feelings of that particular group, then you mix the soft data you have acquired with the hard data that I propose, and then the work begins, because when the leadership is provided with those pieces of data then the leadership must decide what is the timeframe in which they want to get that particular outcome.

Panelist 3: Timothy J. Eberlein, MD

Like other organizations represented by our panelists, our institution has been on a journey to improve justice, equity, diversity, and inclusion. Over the last decade or two, we've seen some dramatic improvements in departmental, programmatic, and health system leadership. Efforts are ongoing to diversify that leadership, faculty, trainees, medical students, and our staff. Embracing DEI provides Departments of Surgery with an opportunity to reduce disparities in healthcare, and provide better access, and reduce health inequities. Our department's journey began some 20+ years ago. We began by providing cardiothoracic care at a medically underserved minority population institution. This was located in North St. Louis County near Ferguson and Florissant. We then instituted, in our department, a program for the elimination of cancer disparities. The combination of these programs emphasized education, outreach, communications, and relationships with existing organizations in the community. Over the years, we developed additional support mechanisms to encourage minority, medically underserved, and rural

populations to access our care. We provided free rides, especially for patients undergoing active treatment or participation in a clinical trial. We provided navigators to help these patients navigate their own treatment journeys. What were measurable that these efforts produced? Over the last eight years, we have seen a 43% reduction in the late-stage presentation of breast cancer in African American women. Similarly, we've seen smaller, but very significant reduction in colorectal cancer. We will have active programs in prostate and lung cancers. We also have now matched outpatient population in accrual of under-represented rural and underserved patients in therapeutic clinical trials. As a corollary to the progress, we have written significant public health grants to provide screening and implementation science initiatives. These programs have led to the implementation of smoking cessation, HPV vaccination drives, and coordination of health fairs with the urban league in North St. Louis County. Over the last seven years, the department has expanded the scope of surgical services and now provides all the surgical subspecialties as well as trauma and acute care surgery at Christian Hospital. Our institutions were therefore convinced to invest $38 million in developing a cancer satellite, specifically in Florissant, Missouri, which includes a community room, where community members can utilize the facility for non-medical purposes. The major take-away of these expansive efforts is the concept of a permanent partnership once a program is initiated. There has to be a commitment to a permanent partnership with the community. Toward that end, our department has developed extensive relationships with the churches, with the pastors in North St. Louis County and city, and organizations such as the Breakfast Club which is breast cancer, the Empowerment Network for prostate cancer, and the Urban League which provides free screening, vaccinations, COVID vaccinations, and access to community health workers. Our efforts in North St. Louis County are now being expanded to other rural and underserved communities.

Panelist 4: Diana L. Farmer, MD

Diversity change begins with real action, more than just conversation, and while building the pipeline is a long-term commitment, it is THE place to start. The metrics of success, the pipeline programs, require patience, but the only way we will get more diverse surgeons, is to have more diverse medical students, more diverse college applicants, more diverse high school kids interested in science… etc., etc. So academic medicine has made great strides in recent years to promote and achieve a more diverse workforce that represents the diversity of our patients and ensures health equity across the continuum of care, yet data show that there is still a great deal of work that needs to be done to meet this need. There are a variety of pipeline programs that have been supported by HRSA under Title 7 and Title 8 of the Public Health Services Act, as well as other federal programs that are proven solutions to addressing these issues, and help to promote a culturally competent diverse, prepared health care and biomedical workforce. But it is important for surgeons to be involved in all steps of pipeline development from grade school onwards. We need to be in high schools, sharing the joy and excitement of what we do now examples of some of these federal programs NERA, the Northeast Regional Alliance Med-Prep program, is a combination that is federally funded… a program that is federally funded, and it brings together Rutgers, Columbia, Icahn School at Mount Sinai, and the Zucker School to Hofstra, and they combined with community based organizations to better prepare young students from under-represented groups. The We Build Detroit Program at Wayne State is another program that is funded by the National Institutes of Health building infrastructure initiative that is specifically focused on biomedical research at the Bachelor's and Master's level The Summer Health Professions Education Program or SHEP, are free summer programs sponsored by the Robert Wood Johnson Foundation and it is, again, a summer enrichment program focused on improving

information and resources for college students in the health professions. Several of these programs have been described, and are in evolution, and involve metrics of success, which again is a long-term commitment. You as an individual probably won't see that high school student that you influenced, achieve entry as a surgeon, but occasionally you do get a letter back from someone that you probably don't remember. "I met you when you gave a lecture 20 years ago at my high school", and those are very heartening letters to get. There are so many ways to get this process started, primarily it's by getting boots on the ground and showing up.

SOCIETY RESPONSES FROM THE IDENTITY-BASED REPRESENTATIVES:

Sanziana A. Roman, MD – Association of Out Surgeons and Allies (AOSA):

I am one of the founding members of the Association of Out Surgeons and Allies (AOSA). Our society is comprised of LGBTQ+ surgeons, learners, and allies from all surgical specialties. LGBTQ+ surgeons and learners have historically been a hidden minority, often feeling like surgery was not a welcoming profession. This is of particular concern for learners because studies have shown that nearly 90% of LGBTQ+ residents do not reveal their sexual orientation or speak freely of issues that may imply they are not heterosexual when applying for residency as they fear this would impact their chances of acceptance. Once in residency, 60% fear discussing or attending social events with their partner, often limiting who they can be. LGBTQ+ residents also report very significant homophobic abuse, egregious microaggressions, especially from the surgical attendings, which makes them feel like they do not belong. This can lead to depression, career changes, and thoughts of suicide. Microaggressions that occur commonly include people promoting and assuming a cis-gender hetero-normative culture, which puts LGBTQ+ colleagues and patients on the defense. Using correct pronouns is a sign of respect for others, and therefore

mis-gendering patients, colleagues and learners lessens them and denies them their personhood. Many of us need to spend significant amounts of cognitive load on simply trying to survive instead of focusing energies in the service of our profession. It is our duty as senior surgical mentors and sponsors, particularly those of us in AOSA, to ensure that we continue to change and build our culture to be diverse and inclusive. AOSA has developed a mentorship program to help LGBTQ+ surgeons advance their careers. We have aligned ourselves with larger societies to help them develop LGBTQ+ inclusive education and garner a larger network of allies who can support our surgeons with intersectional identities.

Marie L. Crandall, MD – Association of Women Surgeons (AWS):

Microaggressions are considered by some to be a more subtle form of discrimination. However, the language used is deliberately subtle, and as such can be more difficult to combat: “You're pretty good for a woman surgeon” may seem like a compliment to the speaker. The Tuttle paper discussed at this meeting underscores the fact that women bear a disproportionate burden of microaggressions directed at residents. 94.8% of women residents, compared with 33.1% of men, reported personally experiencing microaggressions. When you add racial and ethnic discrimination experienced by physicians of color, AWS recognizes that under-represented minority surgeons are at high risk of attrition and burnout. Intersectionality is critically important for our members, and our organization has a strong focus on diversity, equity, and inclusion. The mission statement of the Association of Women’s Surgeons is to inspire, encourage, and enable women surgeons to realize their professional and personal goals. Combatting microaggressions is an important aspect of upholding that mission; as well as advocating for things like pay equity, family leave, and professional development. AWS has created webinars, blogposts, original

research articles, and toolkits specifically addressing microaggressions, all available on our website. Additional AWS resources include the Pocket Mentor for students and residents, our signature speaker series, and leadership training opportunities. AWS is looking forward to the day when gender, gender identity, ethnicity, religion, and other areas subject to bias, are regarded only to the extent that we recognize a diverse workforce improves institutional strength and resilience, and that we would be judged solely by our ability to practice as confident surgeons.

Christian M. De Virgilio, MD – Latino Surgical Society (LSS):

My name is Christian Miguel De Virgilio. I am the Chair of the Department of Surgery at Harbor-UCLA Medical Center, and a member of the Advisory Board for the Latino Surgical Society (LSS). I am also an immigrant from Argentina. Unconscious bias, micro-aggressions, and racism have played a role in the under-development and retention of Latino surgeons. A recent study demonstrated that attrition rates for Hispanic surgical residents was nearly double that of non-Hispanic surgical residents. Latino/Hispanic individuals are greatly underrepresented in medicine and surgery. Until the surgical workforce reflects the diversity of the US population, disparities and micro-aggressions will continue. The recruitment of under-represented students into surgery needs to start early, meaning as early as high school or even middle school. Under-represented students have dreams like all of us. Students from low socioeconomic backgrounds struggle to transform what feels like a far-off dream into a tangible goal and have no idea of where to begin or whom to ask for help. We need to do a better at creating a path to medicine for them.

As a professional organization, the LSS aims to nurture and support the advancement of Latino surgeons and to motivate, mentor, and inspire under-represented people who wish to pursue careers in surgery. We would like to see more DEI training for all surgical leadership. We would also support a task force that addresses why the attrition rate of under-represented surgical residents is higher than that of their peers. As stated by one of the LSS co-founders, Dr. Minerva Romero Arenas "We must strategically and responsibly use prior research findings to study the factors contributing to the higher rate of attrition in under-represented residents. Systemic factors should be addressed to help all achieve clinical and academic success." Our surgical training programs and career faculty development must focus on meeting the educational needs of an increasingly diverse surgical workforce.

Allan Tsung, MD – Society of Asian American Surgeons (SAAS):

As a minority group, Asian Americans have experienced a surge in hate crimes since the start of the COVID-19 pandemic. Although these incidents have only recently been highlighted in the media, the Asian community has experienced microaggressions for many years. These microaggressions are not only found in our schools, our communities, and are everyday occurrences for many of our Asian surgical colleagues in the workplace. We hear from patients, staff, and colleagues, "What country are you from? Your English is really good." This recurring day-to-day microaggressions negatively affect our self-esteem, question our belonging here in this country and give us the feeling of being a perpetual foreigner. Despite this, Asians are often excluded from discussions of discrimination in the workplace. As a result, our voices and our stories are muffled, if not muted. Many of these microaggressions stem from the fact that Asian Americans are stereotyped as the model minority, and the assumption that through hard work,

intelligence, respect for authority, Asians as an ethnic group have been able to prosper in both academia as well as society. However, these same cultural stereotypes depict us as timid, unassertive, "not" charismatic. This can result in the notion that Asian Americans are good worker bees but, are not capable of leading. Moreover, during discussions about diversity and inclusion, Asian Americans are often omitted, considered by both the majority and other non-Asian minority groups to be not disadvantaged enough or not discriminated against. Due to the continued microaggressions and perpetuations of these stereotypes, Asian Americans are often overlooked when it comes to leadership opportunities. American Surgical members, many here who are in positions of leadership around the country need to learn about the model minority stereotype and to understand the specific challenges in advancing into leadership roles for many Asian, mid-career and senior faculty.

L.D. Britt, MD, MPH – Society of Black Academic Surgeons (SBAS):

An open discussion on the topic of micro-aggressions in the surgical workplace is long overdue. The data are very clear. Two separate surgical studies came to similar conclusions. And here today, the society leaders (AWS, SAAS, LSS, AOSA) have underscored the impact on their members. This is a rampant problem in the workplace that must be addressed. We don't have data on the effects of microaggressions on workplace productivity because the problem has gone unrecognized as a serious threat and that is a mistake that will continue to have costly outcomes on the quality of care.

An outline for a way forward:

1. This issue and its effect on the workplace must be taken seriously and it must be measured.

2. Formal processes must be put in place to capture data on the incidence of these events, not to prove that it is happening, but to better understand if there are clinical areas that are more at risk than others.
3. In addition, we need an action plan to mitigate these un-monitored occurrences.
4. A major part of that plan is to identify and educate those involved regarding the effects on team cohesiveness and productivity. We have allowed patients and faculty to remain uneducated on the system level effects of this type of behavior on the workplace.
5. We already have an incident reporting system in healthcare. Micro-aggressions need to be added to the formal structures of the existing system or a similar process developed to allow everyone to be held accountable for their actions. Patients and faculty must be educated.
6. This is a great opportunity for the leaders of the American Surgical to take action.
7. This is not the work of SBAS and the other societies to do on their own.
8. For those of you interested in partnering with us the time is now.

Summary Comments:

We have learned today that microaggressions and microexclusions negatively affect the surgical workplace and erode and prevent a culture of belonging. To support equity and inclusion, there is a critical need for policies and metrics that can help to guide and track success as well as measure and define areas for improvement. The identity based surgical societies exist to provide support and mentorship to those who are under-represented in medicine and medical leadership. These organizations are critical partners necessary in forging a path forward however, diversity and inclusion is not the work of these societies alone. Our profession will only make progress if

we all work together. Providing a safety net relating to microaggressions and microexclusions in the workplace represents a first step.