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Society of Asian Academic Surgeons

Adapting to the COVID-19 Pandemic

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ARTICLE INFO

Article history:
Received 17 February 2021
Revised 6 March 2021
Accepted 9 March 2021
Available online 1 April 2021

Keywords:
Asian
COVID-19
#BlackLivesMatter
Racism
Graduate medical education
Diversity
Inclusion

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https://doi.org/10.1016/j.jss.2021.03.033

Introduction

The 2020 fifth annual Society of Asian Academic Surgeons Conference took place in a virtual format on September 24, 2020-September 25, 2020 due to the ongoing COVID-19 pandemic. This year's meeting comprised of four sessions, which were organized by our Program Committee, led by the Program Committee Chair, Dr Jennifer Kuo. The first session entitled, "Adapting to the COVID-19 Pandemic", was a panel discussion which focused on the challenges imposed by the pandemic and how it impacted surgical leadership in a variety of academic and healthcare organizations. In addition, the impact of the "Black Lives Matter" (BLM) movement fueled by the murder of George Floyd was discussed to examine how each of these organizations has addressed issues of diversity, equity and inclusiveness.

The moderators of the session were Dr. Eugene Kim, Professor of Surgery and Pediatrics at University of Southern California Keck School of Medicine and Dr Julia Tchou, Professor of Clinical Surgery at the Perelman School of Medicine at the University of Pennsylvania.

The panelists represent a broad swath of healthcare and surgical organizations. Dr Paris Butler, Assistant Professor of Surgery at the University of Pennsylvania, represented the American Board of Surgery (ABS). Dr Tom Nasca serves as the Chief Executive Officer of the Accreditation Council for Graduate Medical Education (ACGME). Dr Mark Mugiishi serves as the Chief Health Officer and Chief Medical Officer for Hawaii Medical Service Association and is the Associate Chair for the Department of Surgery at the University of Hawaii. Dr Jennifer Tseng is the James Utley Professor and Chair of the Department of Surgery at Boston University School of Medicine. Below represents the transcript of the first session.

Dr. Kim

Good afternoon everybody. I'm Dr Eugene Kim. I'm a pediatric surgeon from Los Angeles and I have the privilege of moderating this first session of our meeting with Doctor Julia Tchou, who is Professor of Clinical Surgery at Penn, and this first session will focus on how these various medical and surgical organizations adapted not only to the COVID-19 pandemic but also to the historic "Black Lives Matter" (BLM) movement that followed shortly thereafter.

Dr. Tchou

Welcome everyone, we have four panelists today and we have Dr Paris Butler, Assistant Professor of Surgery from the University of Pennsylvania. He is a director of the American Board of Surgery. Next we have Dr Tom Nasca. He's the CEO of the ACGME. Dr Mark Mugiishi is the President and CEO of Blue Cross Blue Shield, Hawaii and Associate Chair of the Department of Surgery at University of Hawaii. And finally, we have Dr Jennifer Tseng, who is the James Utley Professor and Chair of Surgery, Boston University School of Medicine.

So you know we have a diverse group of organizations represented here. I think we all have been profoundly affected over the last 6 mo. It will be so great to hear your opinion, and so we'll start with our first question. With the recent COVID-19 pandemic followed closely by the BLM movement, how has your organization been affected by these two important issues? What were some of the immediate challenges that you faced and what were some of your best responses as an organization? And we'll start off with Doctor Butler.

Reflections from surgery leaders on adapting to the COVID-19 pandemic

Dr. Butler

First and foremost, thanks so much for the invitation to both Eugene and Julia. My original invitation actually came from Dr George Yang, who I'm extremely fond of. He was my PI during my 3 y of research in his and Dr Michael Longaker's lab, so it is a pleasure to join SAAS as a component of your virtual conference and as a relatively new director of the American Board of Surgery. You all are aware that the American Board of Surgery restructured about a year and a half ago. With the ABS leadership restructuring, overlay that with the fact that we're in the midst of a pandemic, it's been even more interesting so I could easily talk for a couple of hours regarding both of these topics because they've greatly impacted the board. And I think ultimately, it's going to be in a very positive way.

So first I'll address the pandemic challenge. As many of you know, because in the majority of participating today is in academia, it's our responsibility to ensure that our Chief Residents successfully get through the Board certification process. We know about the challenges and the failure that the American Board of Surgery had regarding our qualifying (QE) written examination. I guess I should probably step back. A great amount of credit goes to Jo Buyske, who's our Executive Director as well as our ABS staff that they were able to arrange in an extremely short period of time the change from in person oral assessment (CE) to a virtual platform. We did this for pediatric surgery. We did it again in May for general surgery and again in June for general surgery, and it went off without a hitch. The CE assessment was fantastic.

We had no idea that the pandemic would last through July or let alone into the fall, so we had to prepare for our written exam (QE) and unfortunately those 1400 candidates that took the exam did not have a positive experience. Our heart goes out to them because the exam delivery failed halfway through, it was a failure of the platform, which basically imploded. We used some well vetted companies in order to try to carry out our QE. Unfortunately, all of the Pearson centers where the written exam (QE) historically had taken place could not guarantee enough secured testing center seats because each state had its own set of guidelines. They could not accommodate our 1400 candidates that needed to take the exam, so we needed to develop an exam platform that could be provided at the candidates' home, apartment, condominium or institution, and it needed to be proctored. And I think that's where the real challenge was. This is unchartered territory for all boards. Once you take on the proctoring component, a lot of that burden falls on the candidate, and looking back we underestimated that. In short, due to platform challenges and failures, we could not carry out the QE.

So, what have we done since then? I think in a very strategic and appropriate way, we established some principles that we're sticking to and I'm happy to send out those principles. I won't bore you with all of them; however basically, we need to deliver an exam that is safe and secure to all candidates and keep them on course to carry out the certification process and get on with their lives. Additionally, we need to uphold our responsibility to the American public, that we are certifying safe and competent surgeons So moving forward, we're going to have the new QE this coming April. We have postponed everything until next spring for this current group of Chief Residents, who need to take their exam. Additionally, the ABS is providing a 1 y free subscription to SCORE (the general surgery resident curriculum) or providing a $400 discount to all of the candidates that aren't taking the exam. We are also providing cyber security to all of the involved candidates for 2 y, so we're doing all these things in order to do our best to rectify an incredibly challenging situation.

But once again, we think that the qualifying and certification process is an important one. It's highly valued by our hospitals, the government, insurance companies, our profession, and the American public. We're going to make sure that we get it right. I'll pause there, but in later remarks I'll be happy to take on the Black Lives Matter topic.

Dr. Kim

OK, thank you for that thoughtful answer to some of the challenges that the Board saw, and we appreciate everything that you've done for those candidates. Our next panelist, Dr Tom Nasca from the ACGME, if you wouldn't mind commenting on how your organization has reacted and adjusted and responded to some of the recent crises.

Dr. Nasca

Well thanks Dr Kim. It's a pleasure to be with you all. It would have been nicer to be in person and to get a chance to spend a little time together. We encountered the challenge from a different perspective, than a certifying board. We accredit residency and fellowship programs, and the main vehicle for accomplishing that effort involves person to person interchange in the traditional sense. So we had to adjust very rapidly for the absence of physical site visits as a main challenge to deal with immediately. Our cycle of accreditation requires a significant number of site visits in the spring of the year, often applications for new programs. We have made that transition to virtual site visits. We conducted a series of experiments to test the validity and reliability of those efforts and some of you may have actually been involved in some of those site visits as faculty members, some with individual interviews. And we found that they are more sensitive in some ways and less sensitive in other ways, and we've had to adapt with other forms of information gathering from programs.

I think that the next immediate and obvious challenge for us was as the pandemic mounted in its impact, especially in the Northeast, we recognize that the structure of graduate medical education and the clinical care needs were rapidly changing. Individuals from many disciplines were deployed to the Emergency Department and to the ambulatory environment for video conferencing. We had to make accommodations in the common program requirements quickly for video conference interviews of patients. And we needed to understand what were the limits of adaptation that we were going to permit. These limits were severely tested in New York, where the governor actually suspended New York State's resident duty hours, but the ACGME did not. We enforced a particular set of standards, a set of COVID standards for institutions who are in emergency status and found that they gave the latitude necessary for programs and residents to both be safe as well as provide care to the legion of patients who were in need of acute medical care during a pandemic, especially in New York City. This emergency status has been used by 184 institutions over the course of the last 6 mo, most recently in in the Southwest and the West Coast. We currently only have 4 institutions that are in emergency status.

From that structural dimension, residency training is back within the confines of the usual standards of oversight. But we all recognize that the post-COVID world or even the intra-COVID world in many disciplines isn't what it used to be just seven or 8 mo ago. This is particularly acute in the surgical disciplines where tremendous pressure is levied on surgical departments to make up clinical volume, especially elective surgical volume, that was lost during the pandemic, and the impact of that is felt by not only the faculty but also by the residents. We are very concerned about that as well, especially in the surgical disciplines as they cope with this.

After having coped with redeployment in support of COVID patients, most usually in the critical care unit and on the floors, this has provided some opportunities for us to rethink. As I mentioned telemedicine now as part of the lexicon of clinical care and is likely to persist in higher volume post-COVID, but how it will form and how it will be limited is not yet clear on how it will be used in the educational environment and has to be derived from those decisions that are made clinically. I think that the change in patient expectations and fears around accessing acute or subacute medical care really will have a significant impact for years.

And as we play out the impact on vaccine news, we will have to understand its impact on medical education as well. I think finally the opportunity to move more rapidly toward competency-based education has been opened. That door is open wide right now. We've been working shoulder to shoulder with the American Board of Medical Specialties, the ABMS. In these conversations, you have seen and will continue to see releases of information and thought around our movement toward an accelerated movement toward competency-based education. There's more to come there, and that's obviously a pan-professional effort. It's not just the ACGME. Perhaps I will stop there and hand it over to the next speaker.

Dr. Kim

Thank you Dr Nasca. Dr Mugiishi, who represents the largest insurance carrier in Hawaii's medical system, as well as being Associate Chair of Surgery, if you wouldn't mind commenting on your experience with dealing with the latest impact, both for the health and social issues going on.

Dr. Mugiishi

Thank you, Eugene. Hello everybody, wish we could have had the conference here. You see my Heather Brown painting in the back, and you could have all enjoyed surfing at the beach between sessions. But that's the pandemic that hit us, right? As you know, the challenges that have come about because of this pandemic are many. And we could go into many of them, but I wanted to focus on a couple of macrotrends that if anything is a silver lining, I think for the way we look at this, the first is that most Blue Cross Blue Shield or any type of health plan that exists was already starting on the path of becoming more of a Health Organization rather than a pure health insurer. And when I say that, I mean more vested in the interest of improving the lives of the people that they serve and the health of their communities; this pandemic has accelerated that, so there's been much more of a push for health plans to be involved in overall health and wellbeing during the COVID pandemic.

I know this society is very interested in the development of organizations and surgeons that fill organizational roles. And myself as a surgeon, I now find myself as President and CEO of a big plan, the biggest health system with the chief physician officer as a surgeon, and we have my Chief Medical Officer as a surgeon and so there are lots of opportunities for clinical input to come into policy decision-making because of this and then layering on top of that. The concept that whatever trends were existing anywhere in the health industry has been accelerated because of the current pandemic, and I'll just give a few examples for my different stakeholders. So, for our members, they were slowly creeping along, as Tom (Nasca) mentioned, using telehealth and now it's exploded. The use of telehealth is much more widely accepted and, our utilization has gone up a few 1000%. Actually, it's a pretty dramatic increase. For providers, they were kind of heading slowly and creeping along the path of value-based payments. We had put our primary care docs on a value-based payment model where they were getting paid a global (fee) per member per month. The payment takes care of their panel, but there was a lot of skepticism from everyone else. And then during the pandemic, they were actually protected from economic downturn and patients not being able to come in because of that, and suddenly health systems, hospitals, and specialists are all asking about value-based payments for us. And so I think that's accelerated a bit as well.

You know we are an employer of several thousand people here in Hawaii, and we have multiple sites where we have to send everybody home to work remotely. So the idea of remote work was slowly creeping along again, and it suddenly just became an explosion that you had to do it right away. And finally, the stakeholder of the government, who is looking for input from the community about how do we respond to this? Who did they turn to? They turn to the clinical leadership at places like the plan to help lead the pandemic response. I think that acceleration of all the slow trends that were beginning to happen is a good thing because it will get us to where we need to go faster. And again, as I start at the beginning, I just wanted to reiterate, I think it creates a wonderful opportunity for clinicians in general, surgeons in particular, and Asian surgeons in very particular, to take leadership roles in policy and the shaping of our society as we go forward. Thank you.

Dr. Kim

Thank you Dr Mugiishi. And finally our Past President of SAAS and Department Chair of Surgery at Boston Medical Center, Dr Jennifer Tseng. If you wouldn't mind commenting on how specifically your Department had shifted and responded to the recent issues with the pandemic.

Dr. Tseng

At Boston Medical Center, we are not just the safety net hospital, we are really THE hospital for Boston and for Greater Boston, and our population at our hospital looks like more like the melting pot of America than what you may think Boston looks like, i.e. white. Our population is even more enriched for racial minorities of all kinds, including Asians and Blacks and LatinX and immigrants and everything else. Yet it's still not just a safety net hospital but strives in general for top-notch cutting-edge care. The mantra is "Exceptional Care Without Exception."

We at BMC were at the storm, the center of the storm and not the eye, for COVID in the Greater Boston area. Our hospital, at one point, 75% of our patients were COVID patients. I remember talking to Herb (Chen), and we shared a Grand Rounds in the late Spring, and David McAneny our Vice Chair of Surgery and Chief Surgical Officer for BMC addressed UAB about lessons from COVID. At that point, Alabama had very little. At that time, at BMC, we had shut down elective operations early, and so we were largely rolling up our sleeves and taking care of COVID patients. And those of us who aren't trauma doctors were taking trauma calls and our elective surgeons took over the acute care surgery service, so our trauma / surgical critical care doctors could take care of COVID patients in the ICUs.

And it was an amazing transformation. I will say as surgeons we are largely just doers and also deniers. You *deny* the pain you're in and just roll up your sleeves and *do* the work. And so that was the case for the residents and the faculty and the nurses, assistants, and the people that clean the floors, and the food service workers, putting themselves at tremendous risk to take care of incredibly sick patients. We had the first cop who died of COVID I think in the northeast. (He) died right at our hospital, 43 y old and a man of color and we had all the cops in Massachusetts it seemed like lined up outside in a moving salute.

Overall, I think the hospital did a great job taking care of incredibly sick patients. But so early on we started to see that we were a "disproportionate share" hospital in these COVID patients. In Massachusetts, in a previous version of how the state makes health care work, the state government would recognize that we (and hospitals like UMass, in Worcester) see a disproportionate share of uninsured patients, so they would give some extra funds to so called DISH (Disproportionate Share Hospital) hospitals. We started to see that COVID is a DISH disease and that some people have a disproportionate share of COVID. People that were coming in with COVID and dying of

COVID are incredibly sick, they were also disproportionately the people that our hospital serves. People of color, working people, people that work for $15.00 an hour or much less, those are the people that were coming in being really sick and potentially dying in the hospital without a single visitor being able to see them, without anyone being able to help them, potentially not even speaking English as a first language and being struck by this incredibly swift disease. So, this was an early wake up call.

As we evaluate 2020, there is talk about Black Lives Matters that came after COVID. I quote a sage in our BMC Surgery Annual Report for this year, "Racism isn't new, right? It's getting filmed." Black Lives Matter isn't new, it was founded years ago, right? But it came to a head with the killing of George Floyd and subsequent murders like Breonna Taylor, but these are intimately connected. It's the intersectionality. I think the word for 2020 is intersectionality. So for an organization I think like SAAS, I see us as being uniquely poised to be able to be intersectional.

We know as Asian Americans and friends of Asian Americans that a diverse group lifts all up. We know as Asian Americans and friends of Asian Americans that the more we have diversity in surgery, the more we have diversity in academic medicine, that better all of our outcomes and all of our work. For me, I think these two things, both from the lens of the particular patient population that I serve, and when I mean serve, I mean it's a gift to me. It's a gift to me to be able to interact with our patients every day. And I suppose it rips off the smugness of our own self-satisfaction. I will say those of us that work at safety net hospitals, there is some self-righteousness especially among the non-Black, Indigenous, People of Color (BIPOC) physicians that we take care of this patient population like I'm a good person, I'm an ally, I care, I put the Pride flag or #BLM in my Twitter bio. We need to go deeper than that virtue signaling and act to eradicate injustice.

From the perspective of BMC and BUSM, we need to work for social justice because it's the right thing to do. I know that that in the end our academic and clinical missions will benefit from it. Our trainees want us to expose inequities and bias, even if it's not easy, even if it's uncomfortable. It's not necessarily "Asian" and how culturally, some of us were raised to keep your head down and work and not get involved in politics and not say the wrong word, but all of these things coming together for me, particularly at this hospital with the leadership positions that I have, it's very crystallizing in that sense. And so, I think it's affected my hospital in very specific ways. I think it's good largely. I think that it's affecting my residents and galvanizing.

There certainly can be negativity. I hope most of you don't know this, but the Journal of Vascular Surgery AKA #Medbikini paper, that caused so much ruckus, came out of my Department. The paper was a copy of two previously published papers from other institutions in other subspecialties, executed by a team with one senior woman from elsewhere and one Asian male med student, but otherwise white male vascular surgeons and trainees. No one thought they were doing Nobel level work, but no one intended evil. The intent was a paternalistic warning, "Be careful what you're putting on globally available social media!" The good news is, they didn't find anything truly unprofessional, and so – to have a publishable paper – they went to secondary outcomes which they categorized as "potentially unprofessional". And that's where the problem started. The authors, in attempting to warn others that people might judge them by their publicly available social media content (but really trying to get a paper published), were perceived as judging because they were being "judge-y". Then, the online #medbikini outcry. My honest first response to #medbikini was, this is a silly paper, but we have a COVID epidemic going on, BIPOC and transpeople are being murdered and people are worried about being judged for drinking their margaritas in a bikini and posting it for the world to see. I will say there were some misunderstandings of the methods of the paper, including people thinking that the investigators used dummy social media accounts to spy on privately posted social media, which was not true.

But 24 h later I started to see very real and heartfelt posts related to the medical professionalism sphere about "What if I look different than what somebody thinks a surgeon is supposed to look like?" And then there's so much intersectionality with that. Other voices: "What if I wear braids? What if I have an accent? Am I not perceived as a doctor, and am I not perceived as an American? If I speak up for justice, against racism, against disparities, if I advocate for what I think is right, will I be penalized professionally?" I see this is all coming together in 2020 at BMC, and in the country, and I think SAAS has a unique part to plan in this intersectionality, especially for our young people.

Vignettes from our medical leaders on COVID-19:

- Dr Butler (ABS) – After initial trials and tribulations, a robust virtual platform was adopted as the platform for qualifying written and certifying oral exams at the ABS.
- Dr Nasca (ACGME) – The need for trainees to share the care for COVID-19 patients across disciplines accelerated and paved the way for implementation of a competency-based education model in graduate medical education in the future.
- Dr Mugiishi (Hawaii BC/BS) – Telehealth, slow in uptake prior to COVID-19, was adopted nearly universally overnight. The impact of COVID-19 accelerated the movement of insurer/payor organization to a Health Organization to improve overall population health and facilitated the acceptance of value-based payment model.
- Dr Tseng (Boston Medical Center) – COVID-19 disproportionately affects Black, Indigenous, People of Color (BIPOC) which highlights the health disparity/inequities and social injustice in public health. The pandemic also intersects with Black Lives Matter at a time when actions to support diversity, equity and inclusion are needed.

Dr. Tchou

Thank you, Dr Tseng for initiating the conversation on the topic of the Black Lives Matter movement. It will nicely segue into our next question for the panelists. We're going to ask the panelists about how the various organizations that they represent adjusted to the Black Lives Matter movement as well as how the organization is going to address systemic racism that we experience? Doctor Butler will you please start the conversation?

Reflections from medical leaders on embracing Black Lives Matter and systemic racism

Dr. Butler

Happy to and a great setup for us from Dr Tseng's comments. Rather than say "adjust" to the Black Lives Matter movement, I think it's "embrace". We're all aware that our challenges with race have been around for a long time and it has now further come to light. We now are having much more fervent and passionate conversations around this issue.

You literally can't go on a social media site without seeing some kind of reference to it in some capacity. As Jennifer (Tseng) nicely laid out, the recorded killing of George Floyd and the recorded racism showed toward Christian Cooper in NYC's Central Park, those things allowed us a kind of a platform to have further conversation in this state of disruption, and in the midst of the pandemic. As we attempt to "unpack" this racial civil unrest, in my opinion, it provides an opportunity for change, creativity, and innovation.

And the American Board of Surgery, to their credit, particularly our Executive Director, Jo Buyske and the ABS staff, they have fully embraced it. What have we done as an ABS board? First and foremost, Jo Buyske and the staff immediately placed a statement in the midst of the George Floyd protest, a statement on the ABS website that spoke to creating a US health system and a society that promotes antiracism culture, not only in words but in action. The American Board of Surgery staff now has mandated implicit bias training throughout. I received a call from Jo Buyske 2 mo before our scheduled retreat, which was going to be on how we carry out video-based assessment, and she asked if I would help her and Dr John Stewart, who is also a member of the ABS Council, to create a retreat specifically on racism and how it has impacted our black community.

As a result, we spent, and Jennifer Tseng and others were there as well, 4 1/2 h last week where we talked just about the impact of racism on America as a country but also more pertinently to American surgery. We had some phenomenal speakers inclusive of Drs. Andrea Hayes-Jordan, Selwyn Vickers and many others that were incredibly authentic, honest, and transparent. We broke out into small s groups where everybody voiced how they were impacted. There was conversation around allyship, as Jennifer previously alluded, but also upstandership, and how we can make a more diverse, equitable and inclusive surgical community.

Additionally, we are creating a task force within the American Board of Surgery, specifically aimed at diversity, equity and inclusion. We are hiring an external consultant to come in and help us figure out how we can ensure that our diplomates are equipped to serve the American public in the most appropriate way pertaining to race, ethnicity, LGBTQ status, gender, all forms of diversity. So that's what the ABS is doing. I could not be more proud of our response and how we are embracing it.

Dr. Tchou

Thank you, Dr Butler. Dr Nasca, I'm going to use the term embrace. How did the ACGME embrace the Black Lives, Matters movement and also systemic racism.

Dr. Nasca

Well, I think that I would go a little bit broader than the Black Lives Matter movement. It is a very important movement politically in the United States for justice. Our journey in this regard really started with our concern about disparities in clinical outcomes back in 2010 and 2011. If you remember, many of you may have been in training at that point, that's when we implemented the Clinical Learning Environment Review Program. And one of the four elements of the Clinical Learning Environment Review Program is reduction in disparities of care. To say that we have not been successful in completely ablating disparities in care would be an understatement. With the onset of the pandemic and the disparate outcomes that were being observed right from the start, it became clear to us that we had major challenges. Major challenges from a professions-wide standpoint, because we have some hand in those disparities and care, and we need to acknowledge that and take ownership of it.

In the course of thinking about diversity, equity, inclusion over the last decade, we looked at the outcomes of training of underrepresented minority groups in graduate medical education, and we found to our dismay, in about 2018, that there were disparate outcomes in graduate medical education for people of color, especially African Americans and especially African American males. I presented that data at the annual Education Conference to about 5000 individuals involved in graduate medical education. And we've begun efforts to try and understand the nature of those adverse outcomes. By adverse outcomes, I mean premature dismissal or noncompletion of training. And those outcomes have to have considered in them implicit or unrecognized bias in evaluation systems. We have begun educational programs starting about 2 y ago, that we sponsor from our diversity, equity and inclusion team headed by Dr Bill McDade and Dr Bonnie Mason. Bonnie Mason is an orthopedic surgeon, and Bill McDade is an anesthesiologist. And those programs obviously are met with tremendous engagement, and we hope to be able to demonstrate outcomes.

Now, we hosted at our June board meeting for the Board of Directors of the ACGME, a 2-d session exploring topics of diversity, equity, and inclusion, which have resulted in the creation of a number of programs, especially around inclusion that are absolutely essential. We have reached out to the AAMC to begin to work with them, to try and find ways to marshal the graduate medical education community in efforts to expand the pipeline, because we recognize that we cannot unilaterally expand the diversity of graduate medical education participants because of prerequisite participation at an earlier portion of the pipeline.

There is a striking statistic that you may or may not know, but we have had fewer than 300 African American males matriculate to domestic medical schools each year, and that number has not changed over the last 20 y. That number has not changed one iota in the last 20 y. African American females have more than doubled in number, but African American males are systematically being excluded for many reasons - from entrance into medical school and then entrance into graduate medical education. It is something that we as a profession need to take on with open arms in order to fix.

Obviously systemic racism has a hand in that, and it has a hand very early in the lives of these young people that preclude them from the opportunity to participate in medical education and then graduate medical education.

And finally, I issued a statement as did most other leaders in in the wake of the murder of George Floyd, and I think that all of us need to recognize that the outrage that we all feel will be attenuated over time, but then if we don't sustain these efforts, we will not make a dent in this problem. We need to consistently and persistently attack this problem if we are to become the society that we hope to become at least, most of us hope to become.

Dr. Tchou

Thank you, Dr Nasca. I think we all need to embrace Black Lives Matter, and we should all be addressing systemic racism in our own ways and thank you for your organization's efforts. We are going to move to Dr Mugiishi and ask him about how his insurance organization has adapted to embrace Black Lives Matter, especially health disparity and outcomes disparity, as well as how to address systemic racism in his organization?

Dr. Mugiishi

I did my medical education in Chicago, and when that was over, for my professional career, I came straight back to Hawaii. There are a couple of reasons for that. One is that it's warm but the second reason is that you know you've heard about the aloha spirit in Hawaii. And what that really means is that diversity, social equality, equal protection under the law-all of those things are the fabric of our society.

So here in Hawaii it's easy, right? Like this is who we are. And so embracing Black Lives Matter and all of the inequality, divisions that are happening in the rest of the country is easy here for us. I'll just say that it's kind of endemic to our DNA here, so it's not as hard an issue, but I can share for the Blue Cross Blue Shield Association, which are 36-member plans, many of which are in all kinds of different places. Each of the CEO's was part of a board, and so we do congregate and talk about these issues.

And the whole concept about equality and social opportunity as being the determinant of health outcome has become front and center of the conversation at all of our meetings. Everybody who knows about social determinants of health-related needs, all of the buzzwords that we use today about what actually determines the ability of somebody to be healthy and to live a good life when it comes to wellbeing, we all know that that's tied to your economic opportunities, your educational opportunities. The opportunities you're afforded to walk down the street without being discriminated against, all of those things, and it is for everybody who's part of a Health Organization. It really has become the central issue that defines how we move forward in improving the health of America.

So, I think there's no doubt about it that Black Lives Matters, and all of the conversation around health equity and social equity has become front and center. Just add one other piece about Hawaii which is just interesting is everybody now knows about the quadruple aim, which was physician wellbeing or physician burnout. Hawaii did that statutorily 5 y ago. They created a quadruple aim, and the 4th aim was health equity. So we kind of like jumped the line there. So now I guess we have the quintupling because we added a physician piece, but I just wanted to share that as something that is a shout-out to living in Hawaii and being part of Hawaii that this is who we are.

Dr. Tchou

Thank you Dr Mugiishi. Dr Tseng, you already started the conversation on Black Lives Matter. Tell us exactly what your Department has been doing to embrace Black Lives Matter as well as to adjust or address social injustice in your department.

Dr. Tseng

We are starting to take the blinders off in our Department. I want to use Hawaii as an example. I am so sad we were not in Hawaii because my parents have lived in Hawaii for two decades and even though I am not native Hawaiian, I am from California, Berkeley and San Jose, I did feel that way. In Hawaii, we often felt—even bragged-that color didn't matter. And you felt like that you were safe from being racist. Some of us, at least, felt we were safe from racism. I will challenge that a little bit but not about Hawaii, but about the rest of us that feel that we are in safe spaces and that we are postracist because we, at Boston Medical Center, serve a diverse population. Some sage person on Twitter said "just because you take care of minority patients doesn't actually make you antiracist." You're doing your job. I think at Boston Medical Center it's easy to get a little complacent and think "oh, we're on the side of light and goodness!" So at least for me. I have been re-examining my own assumptions and I'm charging my Department and our institution to re-examine our assumptions that we don't have more enlightenment to do.

Specifically, we've organized and we have beautiful Black Lives Matter/White Coats for Black Lives protests. Many individual faculty and staff have participated in various Black Lives Matter marches, voting registration, and voting drives. I think it is still ongoing how we as an institution address systemic racism in terms of faculty recruitment and hiring in our staff and these are like in American society. But I actually think it is like ripping the band aid off to say that we're not all postracist. In my view the election of 2008 made many of us feel overly great about ourselves, you know, like the Swedish when they gave President Obama the Nobel Prize. Basically, we're giving the United States the Nobel Prize for fixing racism after the election of the first Black president. We now know that racism was far from fixed.

At BMC we are finding our way like everybody. We have the advantage that we work and we take care of BIPOC patients every day, so it's not theoretical to us. That being said, if you look at the pictures of all the patients and I have slides but I won't show them, but 60%-70% of our patients are people of color and only 10 or 20% of those are Asian. Most of our patients are Black or Latinx, and if you look at the staff, our staff are also largely minority, but those are mostly the orderlies,

custodial staff, schedulers, some of the techs etc. If you get to the nurses at Boston Medical Center, they are largely white. And then you get to the doctors and the trainees and it gets whiter and whiter and whiter, with some Asians of course. We have a lot of work to do.

Vignettes from our medical leaders on Black Lives Matter:

- Dr Butler (ABS) – "Embrace" is the operative word. Conversation on diversity, equity and inclusion needs to be woven into the everyday fabric of American surgery.
- Dr Nasca (ACGME) – Fewer than 300 African American males matriculate to domestic medical schools each year, and that number has not changed over the last 20 y. We need to consistently and persistently attack this problem if we are to become the society that we hope to become at least, most of us hope to become.
- Dr Mugiishi (Hawaii BC/BS) – The whole concept about equality and social opportunity as being the determinant of health outcome has become front and center of the conversation at all of our meetings.
- Dr Tseng (Boston Medical Center) – On diversity, equity and inclusion, complacency is not an option. Once you think you're all good, you're in danger.

We should all read Dr Butler's paper from Annals of Surgery last year about leading from the front and how we increase racial and ethnic diversity in in-training programs and in this case, in surgery for all of us. (Leading from the Front: An Approach to Increasing Racial and Ethnic Diversity in Surgical Training Programs. Butler PD et. *Ann Surg*. 2019 Jun;269(6):1012-1015, PMID 31082895) How do we grow the pipeline and how do we look at our own selves and see not what who we are today, but how we can be better and more diverse tomorrow? That's what I'm trying to do at BMC and BU. And I'm trying to use my institutional leadership roles to do this as well. I know my CEO and Dean are in their different spheres on board. But it's a complicated lift and we're not as good as we think we are. Once you think you're all good, you're in danger. As the saying goes, don't start by correcting your neighbor's error and take the beam out of their eye, take the beam out of your own eye first. We're not perfect at BMC and BUSM but knowing we have work to do is the first step toward a better institution, and world.

Dr. Kim

Thank you. These are fantastic comments by the panelists, and we appreciate them. And, some really great questions have come through the chat, many of them share a common theme. I'm going to summarize some of those thoughts for a response from our panelists. We could probably talk about this for several hours, but unfortunately, I'm going to ask for a couple of minutes from each of you to perhaps give some advice. Many of our panelists, like many of us, we all sense microagressions. We work with people who don't share the same passion behind equity, whether that be with race and gender. These are people we work with in the operating room, and so how would you respond to these people? What kind of advice would you give them? How can we elevate the conversation at each of our institutions? Dr Butler, we will start with you.

Reflections from our medical leaders on microaggression

Dr. Butler

Great question, and you're right, each of us could spend many, many more minutes than just a couple I'm sure. I would say that 1) you're not going to reach everybody unfortunately, but I do think that we're in a position now that we can push the envelope and really encourage to have the uncomfortable conversations. I think we're in a place now where that is fair game. I would say whether it's in the operating theater, the OR lounge, during M&M, Grand Rounds, or Journal Clubs. I think there's opportunity to continue to talk about it.

I have commented repeatedly in the past that many diversity, equity, and inclusion programs from an education standpoint have been kind of tag-along programs, something that's simply added. We need to figure out a way to weave diversity, equity, and inclusion (DEI) into our cloth, into our fabric to what we do and how we carry out our work every single day.

So as an example, once a month, you know maybe there's a topic on DEI within our journal clubs, or within M&M. Maybe, we have a conversation looking at disparities pertaining everything from thoracic procedures to plastic surgery procedures. I think I saw someone in the chat comment on research endeavors. There's a fascinating study that came out of the University of Cincinnati a few years ago when we were having lots of conversations around the challenges with getting an adequate number of Black and Brown participants in clinical trials. In that particular study, they found that if you just had a single person from the Black and Brown community within the research team, then their rates of participation within the Black and Brown community went up exponentially. So, once again, this is an opportunity for us to be creative and innovative and have the conversations, because we currently have the platform to do it.

Dr. Kim

Thank you. Dr Nasca, any thoughts, particularly with your organization or if and when things like this occur, what would you recommend to some of our physicians who are struggling with this at their own institutions?

Dr. Nasca

Yeah, well I have a couple of thoughts. The first one, is in addition to what Dr Butler has said, is the second person needs to have the courage to speak up. In other words, when you are the recipient of microaggression or overtly racist behavior, it's very difficult to defend yourself. However, the person next to you has the ability to step in and intervene. We see this in all sorts of aggressions, whether it be sexual harassment or discriminatory behavior, it is the courage of the second person, the observer that makes the difference. I think I would just

amplify Dr Butler's comments about the opportunity for education and to try and use conversation to create a culture and gradually expand that inner circle to a larger and larger group that eventually becomes the dominant cultural theme of the Department or the Division. And it really has to happen at that level. It has to happen in smaller groups. You don't transform an institution.

In aggregate, you are transforming an institution by transforming its subunits and its subcultures one by one. And finally, you know I'm a disciple of Edmund Pellegrino (author of the Virtuous Physician), and he speaks about the Aristotelian virtues, and one of them is courage. Having the courage to stand up when something is going wrong either to you or to someone you see and calling it out and that's really at the core of professionalism. We need to recognize that and reward it when we see it. And I think if we all collectively commit to that and we do it in an educational and a collegial kind of fashion as opposed to a threatening fashion, I think we can change the culture and we will.

Dr. Kim

Thank you. Dr Mugiishi?

Dr. Mugiishi

Sure, I've always been a proponent of leading by example and letting actions speak louder than words. Perhaps so from an organizational standpoint, I'll say that I think our organization has always been committed to making sure that our actions are in support of all these things, and, for example, every year, we make sure that one of our corporate goals specifically addresses vulnerable populations and the integration of the delivery of care to health related social needs in order to show that the biggest Health Organization in the state is focused on this specific issue and this specific problem. And I think not everybody has the luxury, like I do luckily, of having the power of an organization behind you. Even as an individual, allow your actions and the way you put yourself out there personally behind you, I think we can. We can together start making inroads and societal change.

Dr. Kim

And with just the last few minutes, I think it's appropriate to hear from Department Chair Dr Jennifer Tseng, how you in a diverse faculty, how you deal with thoughts on racism and these issues.

Dr. Tseng

I think it's really important. Because especially now, the world has shown us that when some voices feel they are silenced, the results can be devastating. And obviously it's impossible not to talk about politics now though. But regardless of that, how do we talk about diverse opinions? I really think we need to not assume because somebody says something that they are "x". Like if somebody says not all cops are bad, I don't think we should immediately, we, at least I'm talking about Asians particularly, should immediately assume that that person is coming from a place of hate, that they're an evil person, and that they are saying that Black Lives (don't) Matter for instance.

And I think we should honestly listen to what people have to say and assume that they're good people. (Honestly, I exempt people that are in active pain over their identity and their groups being assaulted and murdered). But I do make the assumption that most people that we deal with on a day-today basis are good people and mean well. So I think we need to make sure that in this day and age that we just jump to label people that are raising a question, whether it's on whatever side or other side, and we're not going to listen, and we're going to yell at each other.

I am a huge admirer of Dr Pat Turner; just think about directing Member Services with the American College of Surgeons. She has to listen to all kinds of surgeons and from what little I see on the chat, it can be a doozy! The fact that Dr Turner has been able to navigate her position with grace and deal with the concerns of the ACS, teaches me one should listen first and not assume the person is coming from an unethical place. We don't want to suppress active discussion and then have it bubble up in a negative way in the future.

I don't have a good answer to the question, but I do want to make sure that we're not just PC in what we say and that our actions don't reflect what we say about social equity and justice and what's good. But also, that people that actually seek to do good may have a slightly different lens to have their voices heard. And that's an incredibly hard needle to thread. I think it has to be in the leaders having humility and saying "Listen to me", having one on one conversations where it's clear they're not being judged. We all judge, but you have to try to realize your own biases. So I think we need to all check our biases, I think the people who think they're really great and they are postracist need to check their biases and that they may be making some assumptions. That's what I'm trying to do as a leader in the Department and at BMC. Basically, to say, let's talk about this. Let's listen to each other. All the way down, and up, the leadership chain.

Vignettes from our medical leaders on microagression

- Dr Butler (ABS) – We are in a position now that we can push the envelope and really be encouraged to have the uncomfortable conversations.
- Dr Nasca (ACGME) – When you are the recipient of microaggression or overtly racist behavior, it's very difficult to defend yourself. However, the person next to you has the ability to step in and intervene. It is the courage of the second person, the observer that makes the difference.
- Dr Mugiishi (Hawaii BC/BS) – I've always been a proponent of leading by example and letting actions speak louder than words. Allow your actions and the way you put yourself out there personally behind you, I think we can. We can together start making inroads and societal change.
- Dr Tseng (Boston Medical Center) – One should listen first and not assume the person is coming from an unethical place.

This first session of the 5th Annual Society of Asian Academic Surgeons Virtual Meeting brought forth the platforms and goals from leaders of academic surgery, medical education, and health care insurance. In facing the unprecedented challenges from a worldwide pandemic due to the COVID-19 virus, each organization and leader described remarkable efforts to prioritize the safety of employees and faculty while continuing to strive to provide equitable health care as well as continue efforts to maintain graduate medical education and certification. In response to the second pandemic due to systemic racism in our society and the rise of the Black Lives Matter Movement, each leader thoughtfully and poignantly offered their thoughts about the need to improve and build the pipeline of students and trainees, as well as better support under-represented minorities in medicine to help develop and support diversity in medicine. As we slowly move toward the end of the COVID-19 pandemic, much work and collaboration at every level of medicine will be needed to continue our fight against the pandemic of racism.

Author contribution

ESK and JT transcribed the session, edited the transcript, added take home messages as well as introductory and concluding statements. PB, MM, TN, and JT are the subjects of the transcript, all of whom reviewed and edited the manuscript.

Disclosure

The authors reported no proprietary or commercial interest in any product mentioned or concept discussed in this article.

Acknowledgment

No grant funding supported this manuscript.