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Rethinking diversity, equity and inclusion in an acute care surgery setting

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ABSTRACT

N/A - This is the first place essay contest winner for the American Association for the Surgery of Trauma (AAST) Diversity, Equity, and Inclusion Committee's 2020 essay contest in response to the prompt 'How can diversity, equity, and inclusion be improved in acute care surgery/the AAST?' The essay does not have an attached abstract.

Shifts in the global population and a growing underrepresented minority (URM) community in America have increased the number of culturally diverse patients entering acute care surgery wards.[1] To properly treat the rising number of URM patients, at a standard equal to that of non-URM patients, new initiatives are desperately needed to maximize proficiency in URM care. Increasing the number of URM healthcare providers improves access to care for minorities, develops stronger lines of communication with patients and demonstrates commitment to patient-centered care. The American Association for the Surgery of Trauma (AAST) and member organizations need to adopt policies and plans that commit to increasing the proportion of URM physicians in the AAST, smooth their transition into the workplace and solidify their retention. Below are eight concrete policy goals to consider.

1. *Assess institutional culture for diversity and inclusion*. Before expanding organizational capacity for diversity, institutions need to understand the current state of URM inclusion and engagement in their respective settings. The Diversity Engagement Survey (DES) is a 22-question benchmarking tool used to determine organization participant activity, inclusive features and URM involvement.[2] AAST institution board members should use the DES to evaluate current diversity and inclusion gaps within the organization.
2. *Define diversity, equity and inclusion*. To educate the medical community on fundamental terminology and create a baseline of understanding, AAST institutions should use a cultural complications morbidity and mortality curriculum.[3] The longitudinal, data-driven modules are presented during hospital morbidity and mortality conferences and focus on topics ranging from URM patient–physician interaction to cases of workplace discrimination.[3] In addition to introducing basic concepts to hospital communities, the morbidity and mortality curriculum includes definitions of diversity, equity and inclusion that should be incorporated into new AAST institutional policies.[3] Clearly defining foundational equity and inclusion concepts will allow for proper communication and growth.
3. *Institute mandatory microaggression and implicit bias training*. Microaggressions and implicit bias directed towards URM colleagues lead to significant physical, mental and social health decline, and those directed toward URM patients lead to comparatively dismal health outcomes. To fight the effects of microaggressions and implicit bias, proper training throughout a physician's career should be required to maintain licensing status with the AAST. To introduce the concept of implicit bias, the Harvard Implicit Association Test (IAT) may be used explore a participant's microaggressions and implicit bias.[4] The IAT can be used to guide and personalize each physician's microaggression and implicit bias training.[5] Within microaggression and implicit bias training, it is imperative that dialogue frameworks are incorporated for URM who may be targets of unconscious and conscious physical and verbal insult.[5] Proper regulations and education for those found to cause physical and emotional injury should be created and approved by URM and a diversity council.[5] Furthermore, professional groups and support groups need to be properly created for the benefit of URM physicians and their non-URM counterparts to allow for successful microaggression identification and elimination.
4. *Diversify disease presentation and education material*. Preparing physicians to meet the needs of a diverse population requires elevated minority health disparity identification.[6] To aid in the expansion of current AAST curricula, diseases and symptoms need to be presented using a variety of skin tones and body types, fully representing the modern range of patients.[7] Proper training should also account for a patient's sexual orientation, especially if they are intersex or on hormone therapy, as such conditions may change treatment plans. Furthermore, standardized patient training should incorporate a range of clinical exposures, including, but not limited to, ethnicity, citizenship status, sexual orientation, disability and religion.
5. *Confront the minority tax*. The minority tax is defined as supplementary responsibilities and expectations assigned to URM to foster and stimulate diversity within institutions.[7] In addition to their clinical obligations, URM physicians are often mandated to mentor minority students and to develop inclusion initiatives without added pay or time.[7] Although these

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responsibilities are crucial to diversity, equity and inclusion in acute care surgery settings, they unfairly contribute to already disproportionate levels of pressure and anxiety within the URM AAST community.[7] To mitigate inequities, organizations should, at minimum, acknowledge added time commitments by introducing salary raises and decreasing clinical obligations.

6. *Support local businesses and speakers*. During AAST conferences and meetings, coordinators should be required to proactively partner with neighboring URM businesses to coordinate food-service contracts, catering and design. Furthermore, activists from local initiatives and non-profits should be invited to speak at these events to encourage AAST community involvement.
7. *Build scholarships*. Due to prevalent URM financial obstacles stemming from lower socioeconomic status and generational poverty, a minimum of 25% of educational grants should be allocated to prospective URM physicians. Overall, to help ease accruing debt, more awards, scholarships and programs are needed, and increased outreach about the availability of such opportunities should be directed toward URM students and trainees.
8. *Encourage feedback*. Although plans and programs can be implemented, without continuous assessment and adjustment, these initiatives cannot successfully develop and expand. Anonymous feedback forms should be sent to acute care setting staff and faculty and reviewed by an established organization diversity council. The compliments and criticism provided by institution staff may determine which programs are being respected and received well, which require additional support and which should be reimagined.

In conclusion, a wide variety of tools are available that promise to increase diversity, equity and inclusion within an acute care surgery setting. With support and guidance from all AAST team members, culturally diverse patients can receive the level of care that they are rightfully entitled to.

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