Disclosure Statement

• Dr. Railey has no relevant financial or nonfinancial relationships to disclose.
Presentation Objectives

• Review the benefits of inclusion and rationale for creating inclusive atmospheres in academic medical environments.

• Explore tools and resources to discuss implicit and explicit associations that negatively impact patient, provider, and personnel interactions.

• Explore methods to equip stakeholders with tools to enhance workplace climate, with a specific focus on inclusion as a strategy for excellence.
May the Force Be with Us: Achieving Inclusive Excellence in Academic Medicine

Kenyon Railey, MD
Duke Department of Community & Family Medicine
Grand Rounds
February 19, 2018
Not so long ago in a galaxy that isn’t very far away...
Episode IVIIIIXVII

It is a period of civil unrest. Turmoil has engulfed the Primary Republic of Health. The Family & Community Population Primary Health Rebel Alliance (the FCPPHRA for short), striking from a hidden dilapidated base at the edge of the Erwin system, has lead the battle against the evil Destructive Insurance Reactive Empire (or DIRE).

Unfortunately, the Republic of Health has crumbled after years of difference and disparities among the various planets in the system. Passage of legislation had eased the suffering of the many people under the ruthless rule of the EMPIRE, yet the old laws of governance still prevent change.

A brave warrior has arisen from the ranks of the FCPPHRA, who has plans to save the republic and restore freedom and health to the galaxy...
Meet Dr. Erin Wokowski
Dr. E. Wok
What happened to Dr. E. Wok?
Diversity & Inclusion

• Diversity
  – “Acceptance of difference, a lack of discrimination due to difference, and a presence of different kinds of people in organizations.”
  • Howard Ross Reinventing Diversity
  – Diversity = Invitation

• Inclusion
  – “Opportunities for people to be part of the fundamental fabric of the way organizations function. . . ”
  • Howard Ross Reinventing Diversity
  – Inclusion = Involvement
What is Inclusive Excellence?

• Concept developed by Association of American Colleges & Universities (AAC&U)

• 4 primary elements to achieve inclusive excellence:
  1. **Intellectual and social development**
     • Academically offering the best possible course of study
  2. **Purposeful development and utilization of organization resources to enhance learning**
     • Establishing an environment that challenges learners to achieve academically and challenges members to contribute to learning
  3. **Attention to cultural differences brought to the educational experience that enhance the enterprise**
  4. **Welcoming community that engages all of its members in learning**

What is Inclusive Excellence?

• “AAC&U endeavors to develop ‘equity-minded practitioners’ who are willing to engage in the necessary, and sometimes difficult, conversations and decision-making that can lead to transformational change.”

• Core principles of making excellence inclusive are diversity, inclusion, equity, and equity-mindedness.
What's at stake? What if we get this wrong?

- Attrition for faculty, staff, & students
- Personal and/or professional unhappiness
- Malignant working environment & Decreased productivity
  - Evidence suggests that members within a working environment perform better when they work within diverse areas while simultaneously experiencing a climate of belonging
  - Effects on recruitment & retention
  - Reduced mentorship/role modeling
  - Status quo continues. . . “we’ve always done it this way” or “I inherited this process.”.
- Healthcare disparities
A note about burnout...

- A 2015 Medscape survey reported 46 percent of physicians are experiencing burnout at any given time.
- Directly linked to a list of undesirable consequences
  - Lower patient satisfaction and care quality
  - Higher medical error rates and malpractice risk
  - Higher physician and staff turnover
  - Physician alcohol, drug abuse, and addiction
  - Physician suicide

SOURCE: https://www.aafp.org/fpm/2015/0900/p42.html
A note about burnout. . .

- Burnout originates from a disorder of energy metabolism.
- We all have an energy account, which can have a positive or negative balance.
  - Burnout is the constellation of symptoms that occur when your energy account has a negative balance over time.
- 3 energy accounts within us:
  - Physical energy account
  - Emotional energy account
  - Spiritual energy account
- Burnout is often characterized by
  - Exhaustion
  - Depersonalization
  - Lack of efficacy
  - Exclusion

SOURCE: https://www.aafp.org/fpm/2015/0900/p42.html
Connection between burnout and inclusion.

- Author suggests 5 main causes of burnout
  1. The practice of clinical medicine
  2. Unique stresses of the specific job
  3. Absence of life balance
  4. The conditioning of medical education
  5. Leadership skills of supervisors
     - “People don’t quit companies; they quit bosses.”
     - Work satisfaction and stress is directly correlated to the leadership skills of your immediate supervisor.

Inclusive excellence and inclusive leadership can be answers to burnout.

SOURCE: https://www.aafp.org/fpm/2015/0900/p42.html
Barriers to Inclusive Excellence

- Lack of racial/ethnic diversity
- Gender leadership disparity
- Pay disparity
- Hierarchy
- Bias
- Microaggressions
Barriers to Inclusion:
Lack of Racial/Ethnic Diversity

• US Census Data
  – US Population: ~325 million
  – White: ~199 million (61.3%) ***
  – Latin/Hispanic: ~54 million (17.8%) ***
  – African-Americans/Black: ~43 million (13.3%)
  – Asian: ~18.5 million (5.7 %)
  – Native-Americans: ~4.2 million (1.3%)
  – Native Hawaiian or other Pacific Islander: ~650,000 (0.2%)

***Hispanic is considered an ethnicity, total white (including those who report hispanic as an ethnicity is 78.9%)
# Barriers to Inclusion: Lack of Racial/Ethnic Diversity

## North Carolina Data

<table>
<thead>
<tr>
<th>TOTAL</th>
<th>10,273,419</th>
</tr>
</thead>
<tbody>
<tr>
<td>White-Americans:</td>
<td>71%</td>
</tr>
<tr>
<td>African-Americans:</td>
<td>22.2%</td>
</tr>
<tr>
<td>Latin/Hispanic</td>
<td>9.2%</td>
</tr>
<tr>
<td>Asian-Americans:</td>
<td>2.9%</td>
</tr>
<tr>
<td>Native-Americans:</td>
<td>1.6%</td>
</tr>
<tr>
<td>Native Hawaiian or other Pacific Islander</td>
<td>0.1%</td>
</tr>
</tbody>
</table>

- Female | 51.4% |
- Male | 48.6% |

**SOURCE**
https://www.census.gov/quickfacts/NC

## Durham Data

<table>
<thead>
<tr>
<th>TOTAL</th>
<th>306,212</th>
</tr>
</thead>
<tbody>
<tr>
<td>White-Americans:</td>
<td>53.1%</td>
</tr>
<tr>
<td>African-Americans:</td>
<td>38.3%</td>
</tr>
<tr>
<td>Latin/Hispanic</td>
<td>13.4%</td>
</tr>
<tr>
<td>Asian-Americans:</td>
<td>5.1%</td>
</tr>
<tr>
<td>Native-Americans</td>
<td>0.9%</td>
</tr>
<tr>
<td>Native Hawaiian or other Pacific Islander</td>
<td>0.1%</td>
</tr>
</tbody>
</table>

- Female | 52.3% |
- Male | 47.7% |

**SOURCE:**
https://www.census.gov/quickfacts/fact/table/durhamcountynorthcarolina/PST045216
Barriers to Inclusion: Lack of Racial/Ethnic Diversity

• United States (US) Census bureau projections suggest that the US population will become a “majority-minority” one by the year 2044
  – By 2060, 57% of the population will be non white and 1 in 5 Americans will likely be foreign born

• AAMC estimates that 8.9 percent of physicians identify as black or African-American, American Indian or Alaska Native, and Hispanic or Latino
  – 48.9 % White
  – 11.7% Asian
  – 4.4% Hispanic
  – 4.1% Black/African American,
  – 0.4% were American Indian or Alaska Native
Barriers to Inclusion: Lack of Racial/Ethnic Diversity

Medical School Data Faculty - 2016

Figure 20. Percentage of full-time U.S. medical school faculty by race and ethnicity, 2015.

- White: 63%
- Asian: 14.6%
- Black: 3%
- Latin/Hispanic: 2.1%
- Native Hawaiian or Pacific Islander: .2%
- Native Americans: .1%
- Multiracial: 3%

SOURCE:
http://www.aamcdiversityfactsandfigures2016.org/
Barriers to Inclusion:
Lack of Racial/Ethnic Diversity

- Physician Assistant (PA) Education Data

**TABLE 30. FIRST-YEAR CLASS: GENDER**

<table>
<thead>
<tr>
<th></th>
<th>n (P)</th>
<th>n (S)</th>
<th>%</th>
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<tbody>
<tr>
<td>Female</td>
<td>199</td>
<td>6,891</td>
<td>72.0</td>
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<tr>
<td>Male</td>
<td>199</td>
<td>2,672</td>
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<tr>
<td>Unknown</td>
<td>199</td>
<td>5</td>
<td>0.1</td>
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<tr>
<td><strong>Total</strong></td>
<td><strong>199</strong></td>
<td><strong>9,568</strong></td>
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**TABLE 31. FIRST-YEAR CLASS: ETHNICITY**

<table>
<thead>
<tr>
<th></th>
<th>n (P)</th>
<th>n (S)</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-Hispanic, Latino, or Spanish in origin</td>
<td>200</td>
<td>7,503</td>
<td>82.7</td>
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<tr>
<td>Hispanic, Latino, or Spanish in origin</td>
<td>198</td>
<td>592</td>
<td>6.5</td>
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<tr>
<td>Unknown</td>
<td>196</td>
<td>977</td>
<td>10.8</td>
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<tr>
<td><strong>Total</strong></td>
<td><strong>200</strong></td>
<td><strong>9,072</strong></td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>

**TABLE 32. FIRST-YEAR CLASS: RACE**

<table>
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<th></th>
<th>n (P)</th>
<th>n (S)</th>
<th>%</th>
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</thead>
<tbody>
<tr>
<td>American Indian or Alaskan Native</td>
<td>197</td>
<td>55</td>
<td>0.6</td>
</tr>
<tr>
<td>Asian</td>
<td>197</td>
<td>715</td>
<td>7.9</td>
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<tr>
<td>Black or African American</td>
<td>197</td>
<td>358</td>
<td>3.9</td>
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<tr>
<td>Multiracial</td>
<td>195</td>
<td>156</td>
<td>1.7</td>
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<tr>
<td>Native Hawaiian or Pacific Islander</td>
<td>195</td>
<td>16</td>
<td>0.2</td>
</tr>
<tr>
<td>White</td>
<td>198</td>
<td>6,671</td>
<td>73.5</td>
</tr>
<tr>
<td>Other</td>
<td>197</td>
<td>168</td>
<td>1.9</td>
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<tr>
<td>Unknown</td>
<td>192</td>
<td>939</td>
<td>10.3</td>
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<tr>
<td><strong>Total</strong></td>
<td><strong>198</strong></td>
<td><strong>9,078</strong></td>
<td><strong>100.0</strong></td>
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</tbody>
</table>

Barriers to Inclusion: 
Lack of Racial/Ethnic Diversity

• PA Demographics
  – 67.7 % of all PAs are female
  – 86.7 % white
  – 6.2% Latinx/hispanic
  – 5.4% Asian
  – 3.9% Black/African-American

Barriers to Inclusion: Gender Leadership Disparity

• Total enrollment in US Medical Schools in 2017-2018
  – 43,571 women
  – 46,315 men

• For the first time in 2017, there were more new women matriculants enrolled in medical school than men.
  – 39% of full time faculty are female
    – Proportion of women in the highest ranking leadership positions is relatively low
      • 46% of all assistant deans
      • 39% of senior associate deans
      • 16% of medical school deans

SOURCE:
## Barriers to Inclusion: Gender Leadership Disparity

### Table 2: Percentage of Full-time Faculty and Department Chairs by Department, Rank, and Gender, 2014

<table>
<thead>
<tr>
<th>Clinical Departments</th>
<th>Total Faculty % Women</th>
<th>Assistant Professor % Women</th>
<th>Associate Professor % Women</th>
<th>Full Professor % Women</th>
<th>Department Chairs % Women</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anesthesiology</td>
<td>36</td>
<td>38</td>
<td>27</td>
<td>19</td>
<td>13</td>
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<tr>
<td>Dermatology</td>
<td>49</td>
<td>58</td>
<td>43</td>
<td>31</td>
<td>19</td>
</tr>
<tr>
<td>Emergency Medicine</td>
<td>33</td>
<td>36</td>
<td>25</td>
<td>15</td>
<td>10</td>
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<tr>
<td>Family Practice</td>
<td>48</td>
<td>52</td>
<td>43</td>
<td>28</td>
<td>19</td>
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<tr>
<td>Internal Medicine</td>
<td>37</td>
<td>43</td>
<td>33</td>
<td>19</td>
<td>12</td>
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<tr>
<td>Neurology</td>
<td>36</td>
<td>44</td>
<td>33</td>
<td>18</td>
<td>11</td>
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<tr>
<td>Obstetrics &amp; Gynecology</td>
<td>57</td>
<td>67</td>
<td>46</td>
<td>28</td>
<td>22</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>34</td>
<td>43</td>
<td>32</td>
<td>18</td>
<td>8</td>
</tr>
<tr>
<td>Orthopedic Surgery</td>
<td>16</td>
<td>19</td>
<td>13</td>
<td>7</td>
<td>0</td>
</tr>
<tr>
<td>Otolaryngology</td>
<td>31</td>
<td>32</td>
<td>27</td>
<td>12</td>
<td>3</td>
</tr>
<tr>
<td>Pathology (Clinical)</td>
<td>38</td>
<td>48</td>
<td>39</td>
<td>24</td>
<td>14</td>
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<td>53</td>
<td>60</td>
<td>48</td>
<td>31</td>
<td>20</td>
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<td>Physical Medicine &amp; Rehabilitation</td>
<td>46</td>
<td>51</td>
<td>43</td>
<td>26</td>
<td>16</td>
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<tr>
<td>Psychiatry</td>
<td>47</td>
<td>54</td>
<td>42</td>
<td>27</td>
<td>13</td>
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<tr>
<td>Public Health &amp; Preventive Medicine</td>
<td>52</td>
<td>52</td>
<td>56</td>
<td>41</td>
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<tr>
<td>Radiology</td>
<td>28</td>
<td>31</td>
<td>26</td>
<td>18</td>
<td>16</td>
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<tr>
<td>Surgery</td>
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<tr>
<td>Other Clinical Sciences</td>
<td>37</td>
<td>41</td>
<td>33</td>
<td>25</td>
<td>24</td>
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<tr>
<td>Subtotal</td>
<td>39</td>
<td>45</td>
<td>34</td>
<td>21</td>
<td>12</td>
</tr>
<tr>
<td>Total</td>
<td>38</td>
<td>44</td>
<td>34</td>
<td>21</td>
<td>14</td>
</tr>
</tbody>
</table>

Source: AAMC Faculty Roster, May 2014

**SOURCE:**
Barriers to Inclusion: Pay Disparity

• In the United States, the average female annual salary is approximately 78% of the average male.
• For PA Education, in the 2012-2013 29th Annual Report:
  • male faculty members (M = $90,746, SD = $15,763) had higher average salaries than female faculty members (M = $88,392, SD = $17,128)
  • Male program director salaries were $118,226 compared to females at $109,595
  • Male medical director salaries were $138,960 compared to $125,126 for females
  • Black medical director salaries for PA Programs was $23,683, Asian $32,260, and white $38,374.

SOURCE: 29th PAEA Program Report
Barriers to Inclusion: Pay Disparity

- In the United States, the average female annual salary is approximately 78% of the average male.
- Among physicians with faculty appointments at 24 US public medical schools, significant sex differences in salary exist even after accounting for age, experience, specialty, faculty rank, and measures of research productivity and clinical revenue.
- Annual salaries of female academic physicians were 8.0% ($19,879) lower than those of male physicians.
- Female full and associate professors had adjusted salaries comparable to those of male associate and assistant professors.

SOURCE: https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2532788

The Gender Pay Gap In Medicine Is Abominable. Here’s Where It’s Worst.

By Christina Cauteruccio

- Durham has the country’s second-largest physician pay gap (31 percent).

Barriers to Inclusion: Hierarchy

- Chair
- Head of division
- Faculty
- Fellow
- Chief resident
- Senior resident
- Junior resident
- Intern
- Student

How has hierarchy affected program culture?
Barriers to Inclusion: **Bias**

- Stereotyping/Bias = **Cognitive Shortcut**
- Biases serve important functions.
  - Stereotypes organize and simplify complex situations in order to give confidence in order to understand, predict and potentially control situations.
  - The skill to perceive and learn from associations serves us well.
- Biases are often approximations of the truth; they are rarely applicable to every encounter.
  - Can be “self-fulfilling”.
  - They blind us to instances in which the associations are not accurate or when they don’t align with our expectations.
- Biases can exert a powerful influence on how information is processed and recalled.
Your brain on bias.

- **Pattern Recognition**
  - We look for and see patterns where they don’t exist.
  - Leads to confirmation bias: once we have formulated a theory, we pay more attention to items that support it and ignore evidence that disproves it.
  - *Example: Inconsistent evidence of GRE, MCAT, USMLE scores as predictors of success*

- **Emotional Tagging**
  - When the brain stores a memory of an event or action, it also stores an associated emotion with it.
  - *Example: Ethnic names on a CV or a bad encounter with a person of a particular background*

- **Availability Heuristic**
  - Mental shortcut that relies on immediate examples that come to a given person’s mind when evaluating a specific topic, concept, method or decision.
  - We give greater credibility to readily available information and overestimate probabilities in the future
  - *EXAMPLE: There are just so few minorities in the pool, we are unlikely to get any of them to come to our school*
Does medical training make us more biased?

- This disease is most common in...
- Men over 50 are at risk for...
- Women are more likely to...
- Obese patients are more at risk of...
- African-americans have the highest rates of...
- Patients with medicaid...
- Patients with back pain...
- Nurses are...
- Physician Assistants are...
- Family doctors are...
Barriers to Inclusion: Microaggressions

• Microaggressions
  – Brief and commonplace verbal, behavioral, or environmental indignities, whether intentional or unintentional, that communicate hostile, derogatory, or negative slights and insults toward a variety of groups.
  – Perpetrators of microaggressions are often unaware these indignities have real time implications.

• Patterns of exclusion and control
  – **Invalidation of sense of self**
    • Minority member viewed as member of group first, individual second
  – **Othering**
    • Being treated as an outsider (or excluded from decision making)
  – **Unequal treatment**
    • Unequal performance standards
    • Being “passed over”
Barriers to Inclusion: Microaggressions

- Perspective matters.
  - In other words, just because you didn’t experience it or feel it doesn’t make it not true.
What now? What can we do?

1. Beware the phantom menace.
2. Don’t trust your feelings, unlearn what you have learned.
3. Look for some different droids.
4. Two must always there be.
5. Don’t be a storm trooper.
6. Be a general, not an emperor.
7. Don’t be afraid.
8. Do or do not, there is no try.
Beware the phantom menace. . . ignorance.

- Open your eyes.
- Quantitative analysis
  - Get the demographic data for faculty, staff, students
  - Get granular
    - Asian?
    - Latino may equal white, white may equal latino
    - Black does not equal African-American, African-American does not equal African-American
- Qualitative analysis
  - Work culture surveys
  - Analyze by race/ethnicity, gender, sexual orientation
- Exit surveys/interviews
- Transparency
  - Share your data, don’t hide it.
Beware the phantom menace. . . isms.

- Racism
- Sexism
- Ableism
- Heterosexism
- Harassment
Beware the phantom menace...isms.

- Racism
- Sexism

<table>
<thead>
<tr>
<th>Mortality Rates, 2012-2016</th>
<th>Total</th>
<th>White, Non-Hispanic</th>
<th>African American, Non-Hispanic</th>
<th>American Indian, Non-Hispanic</th>
<th>Other Races, Non-Hispanic</th>
<th>Hispanic/Latino</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rate</td>
<td>Rate</td>
<td>Rate</td>
<td>Disparity Ratio</td>
<td>Rate</td>
<td>Disparity Ratio</td>
<td>Rate</td>
</tr>
<tr>
<td>Total Deaths, All Causes</td>
<td>781.8</td>
<td>775.6</td>
<td>694.3</td>
<td>1.2</td>
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<td>1.1</td>
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<td>Heart disease</td>
<td>161.3</td>
<td>159.0</td>
<td>187.1</td>
<td>1.2</td>
<td>182.0</td>
<td>1.1</td>
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<tr>
<td>- Acute Myocardial Infarction</td>
<td>31.4</td>
<td>31.2</td>
<td>36.2</td>
<td>1.2</td>
<td>42.5</td>
<td>1.4</td>
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<td>- Other Ischemic Heart Disease</td>
<td>62.7</td>
<td>63.6</td>
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<td>Cerebrovascular disease (Stroke)</td>
<td>43.1</td>
<td>40.6</td>
<td>56.0</td>
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<td>Total Cancer</td>
<td>166.5</td>
<td>165.0</td>
<td>190.7</td>
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<td>158.7</td>
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<tr>
<td>- Colon, Rectum, and Anus</td>
<td>14.0</td>
<td>13.3</td>
<td>18.9</td>
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<td>10.5</td>
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<td>1.3</td>
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<td>- Trachea, Bronchus, and Lung</td>
<td>47.5</td>
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<td>51.2</td>
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<td>- Breast</td>
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<td>28.3</td>
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<td>20.1</td>
<td>17.2</td>
<td>39.1</td>
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<td>23.0</td>
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<td>45.0</td>
<td>8.4</td>
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<td>18.3</td>
<td>17.1</td>
<td>0.9</td>
<td>13.3</td>
<td>0.7</td>
</tr>
<tr>
<td>Chronic lower respiratory diseases</td>
<td>45.6</td>
<td>50.7</td>
<td>27.6</td>
<td>0.5</td>
<td>43.8</td>
<td>0.9</td>
</tr>
<tr>
<td>Septicemia</td>
<td>13.1</td>
<td>12.3</td>
<td>18.6</td>
<td>1.5</td>
<td>12.4</td>
<td>1.0</td>
</tr>
<tr>
<td>Chronic liver disease/cirrhosis</td>
<td>10.3</td>
<td>11.4</td>
<td>17.4</td>
<td>0.6</td>
<td>14.8</td>
<td>1.3</td>
</tr>
<tr>
<td>Nephritis, nephrosis, and nephrotic syndrome</td>
<td>16.4</td>
<td>13.4</td>
<td>31.0</td>
<td>2.3</td>
<td>19.6</td>
<td>1.5</td>
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<tr>
<td>Alzheimer's Disease</td>
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<td>32.7</td>
<td>29.6</td>
<td>0.9</td>
<td>44.6</td>
<td>1.4</td>
</tr>
<tr>
<td>HIV Disease</td>
<td>2.2</td>
<td>0.8</td>
<td>7.5</td>
<td>4.9</td>
<td>9.4</td>
<td>1.3</td>
</tr>
<tr>
<td>Unintentional motor vehicle injury</td>
<td>14.1</td>
<td>14.0</td>
<td>15.3</td>
<td>1.1</td>
<td>27.5</td>
<td>2.0</td>
</tr>
<tr>
<td>Other Unintentional injuries</td>
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<td>37.3</td>
<td>27.8</td>
<td>1.1</td>
<td>40.8</td>
<td>1.1</td>
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<td>Suicide</td>
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<td>5.0</td>
<td>0.3</td>
<td>11.5</td>
<td>0.7</td>
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<tr>
<td>Homicide</td>
<td>6.2</td>
<td>3.1</td>
<td>15.3</td>
<td>4.9</td>
<td>16.7</td>
<td>5.4</td>
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</tbody>
</table>
Don’t trust your feelings . . . unlearn what you have learned.

- Trust that you have bias.
- Work against it.
- Priming
  - Exposure to one stimulus influences a response to a subsequent stimulus, without conscious guidance or intention.
  - Priming is happening all the time. . . we are constantly using past/previous information to process new information (and its automatic).
Look for some different droids.

“Welcome aboard! You are exactly the type of candidate that will fit in here.”
ORCHESTRATING IMPARTIALITY: THE IMPACT OF “BLIND” AUDITIONS ON FEMALE MUSICIANS

Claudia Goldin
Cecilia Rouse

Working Paper 5903

NATIONAL BUREAU OF ECONOMIC RESEARCH
1050 Massachusetts Avenue
Cambridge, MA 02138
January 1997
NBER WORKING PAPER SERIES

ARE EMILY AND GREG MORE EMPLOYABLE THAN LAKISHA AND JAMAL?
A FIELD EXPERIMENT ON LABOR MARKET DISCRIMINATION

Marianne Bertrand
Sendhil Mullainathan

Working Paper 9873
http://www.nber.org/papers/w9873

NATIONAL BUREAU OF ECONOMIC RESEARCH
1050 Massachusetts Avenue
Cambridge, MA 02138
July 2003
• Unconscious bias affects decisions in hiring and evaluation processes
  – People prefer males over females
  – People prefer White and Asian-American individuals over African-American and Mexican Americans in job positions

SOURCE: https://www.aamc.org/download/102364/data/aibvol9no2.pdf
These aren’t the droids you are looking for.

- Reexamine recruitment processes to reduce bias.
  - Processes should be open, transparent, and consistently applied
  - Create objective and structured processes
    - Utilize set criteria and objective measures to assess skills needed for job
    - Prior to initiating candidate interviews, the committee must agree on what they are looking for and the circumstances under which they would accept a lack of certain characteristics
  - Administer training to all involved in search and interview processes
    - Committee members should understand how implicit associations influence behavior
    - Take time in hiring processes, bias emerges under time pressure
    - Utilize non traditional networks
    - Minimum number of underrepresented candidate review

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Reducing Bias in Academic Search Committees

Faculty members are often called on to serve and participate on search committees for deans, department chairs, leaders of centers of excellence, and senior-level positions in medical schools, academic hospitals, and health systems. These search committees are generally charged not only to find qualified candidates but also to consider diversity and inclusion in the process.

The demographics of the US population are changing. Reports from census experts suggest that as many as 40 million immigrants have arrived in the United States since the origin of the Immigration Act of 1965. Further, the non-US-born population is projected to reach nearly 19% of the total US population by 2060. The Latino/Hispanic population is now 17.6% of the US population and together with the black/African American population accounts for nearly 31% of all US residents. Additionally, according to the Pew Research Center, Asian Americans are the fastest-growing and best-educated racial ethnic group entering the United States. These facts, coupled with continued challenges with health disparities and minority underrepresentation in key allied health positions, require specific actions and policies to ensure diversity, inclusion, and unbiased hiring practices.

In 2015, African Americans made up only 4.4% of faculty members of US medical schools who are listed as a single racial group. Concerns have also been raised that a proportion of those included in that number are not truly faculty members but practicing affiliated implicit or unconscious bias. Major private corporations are aware of this issue and are installing bias training coursework for top executives and key committee members, an innovation that leads to greater diversity and contribution to both financial and human capital.

The following 5 suggestions represent a rigorous attempt to formulate a new approach and address the concern of biased search committees.

1. Pretraining: After receiving the charge to join and serve on a search committee, invited members should participate in programmed pretraining. This should include provision of reading materials with appropriate references and accompanying presentations regarding the nature and definition of implicit bias, as this will be a critical starting place for establishing a foundational knowledge base and self-awareness of the team. All members should take an implicit bias self-assessment, such as implicit association tests offered by Project Implicit. Open discussion of the findings of these assessments will be beneficial for transparency and team building.

2. Outcome framework design: Prior to beginning the actual search and interview process, the research committee should construct a diagram or visual image of key characteristics that define ideal candidates and rejection criteria, with notation of suitable substitutes or allowable similarities. For example, if candidates with research background is sought, the type, quality, and quantity of research articles, collaborations, capabilities, and any acceptable substitutions enter the framework for the outcome design. In this manner, the committee becomes insulated against engaging on qualifications based on individual or group bias.
These aren’t the droids you are looking for.

- Get information on people within your organization and acknowledge them.
- Who are the people that make up your work environment?
  - Do you know their names?
  - How do you assess how they are doing?
- If we don’t ask, they won’t tell... they just leave.
Two must always there be.

• Mentorship matters.
Two must always there be.

• Mentorship matters.
  – Lack of quality mentorship has been identified as an impediment to a successful academic career.
  – Having a mentor has been associated with increased career satisfaction, academic productivity, and a sense of community.
  – In this study, junior faculty were disproportionately dissatisfied by lack of membership.

Don’t be a storm trooper.

- Silent and white is dangerous.
• Develop a core of dedicated faculty
  – Utilize opinion leaders and educationally influential colleagues who model appropriate behaviors

• Think beyond “The Usual Suspects”
  – i.e. doesn’t necessarily have to be women or URMs
Be a general, not an emperor.
Be a general, not an emperor.

• Practice inclusive leadership.
  – The inclusive leader is one whose words and deeds invite contributions from others and who demonstrate appreciation of those contributions.
  – Differences in status can influence beliefs about speaking up to offer ideas, discuss concerns, or ask questions.
  – Inclusive leadership creates a culture of psychological safety.
  – In psychological safe environments, people believe that if they make a mistake others will not penalize them or think less of them or their ability to do their job.
  – Team members who feel safe also feel open about asking for help.
Don’t be afraid.

• Fear leads to hate, hate leads to the darkside.
• “In the case of the United States, our three greatest fault lines-cracks that have grown and deepened due to willful neglect and a collective lack of courage—are race, gender, and class.” The fear and uncertainty flowing from collective trauma of all kinds have exposed those gaping wounds in a way that’s been both profoundly polarizing and necessary.”
  — Brene Brown “Braving the Wilderness”
• Be courageous enough to change.
Do or do not. There is no try.

• Align your actions with your intentions.
Do or do not. There is no try.

- **Institutional Curriculum Model**
  - A=Formal curricular elements we wanted to present, but couldn’t or didn’t
  - B=represents that which was spoken or acted out by “teachers” but was not intended as part of the curriculum or was even contradictory to the tenets of the multicultural curriculum on paper.
  - G=Things not taught, not intended, but nonetheless experienced by students
  - F=What we planned was also taught and learned
Do or do not. There is no try.

- Align your actions with your intentions.
  - Put your mission where your mouth is.
- Is diversity & inclusion included in your mission statement?
  - If so, then your actions should include diversity & inclusion
  - Mission = money = resources

Adapted from
originally from
Achieving Inclusive Excellence

1. Beware the phantom menace.
   – Ignorance and “isms.”

2. Don’t trust your feelings, unlearn what you have learned.
   – Trust you have bias and work against it.

3. Look for some different droids.
   – Reexamine recruitment practices.
   – See the people in your environment.

4. Two must always there be.
   – Mentorship matters.

5. Don’t be a storm trooper.
   – Silent and white is dangerous.

6. Be a general, not an emperor.
   – Practice Inclusive leadership.

7. Don’t be afraid.
   – Be courageous enough to change.

8. Do or do not, there is no try.
   – Align your actions with your intentions.
Outcomes of NOT belonging...

1. Live in constant pain and seek relief by numbing it and/or inflicting it on others;
2. Deny pain, and denial ensures that it is passed on to those around you and down to your children
3. Find the courage to own the pain and develop empathy and compassion for yourself and others
Imagine the institutions of the future...
THANK YOU!
QUESTIONS?

May the Force Be with Us: Achieving Inclusive Excellence in Academic Medicine

Kenyon Railey, MD
Duke Department of Community & Family Medicine
Grand Rounds
February 19, 2018