Leadership Education in Advancing Diversity: Diversity 3.0

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#LEADatStanford
Disclosure

• Presenters have no conflicts of interest

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Stanford Medicine
Leadership Education in Advancing Diversity
SAEM19

Las Vegas, NV • May 14-17, 2019
OBJECTIVES

1. Identify the prevalence and role of the imposter syndrome
2. Design strategies to overcome the imposter syndrome
3. Understand the impact of microaggressions and implicit bias on the learning and workplace climate
4. Organize a toolkit of strategies to address the imposter syndrome, microaggressions and implicit bias.

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CHANGING FACE OF AMERICA
Percent of total U.S. population by race and ethnicity, 1960-2060

1960
85%
10%

2010
12%
64%
16%

2060
31%
13%
43%
8%

SOURCE: PEW RESEARCH CENTER

SAEM19
LAS VEGAS, NV • MAY 14-17, 2019
Figure 10: U.S. Physicians by Graduation Year, Race, Ethnicity, and Sex, 1980–2012

- White Women
- White Men
- Asian Women
- Asian Men
- Black or African–American Women
- Black or African–American Men
- Hispanic or Latino Women
- Hispanic or Latino Men
- American Indian or Alaska Native Women
- American Indian or Alaska Native Men
How do you see loneliness and isolation manifest in your work?
• second victim/trauma phenomenon
• medical errors
• patient complaints

• implicit bias
• microaggressions

• imposter syndrome

How do you see loneliness and isolation manifest in your work?
second victim/trauma phenomenon
medical errors
patient complaints
microaggression
implicit bias
imposter syndrome
second victim/trauma phenomenon
medical errors
patient complaints
microaggression
implicit bias
imposter syndrome
Do I Belong Here?
Imposter Syndrome and its Impact on Diversity in the Medical Workforce

Daniel Hernandez MD, Nancy Rivera MD, Elana Feldman MD, Dimitri Augustin MD, Amanda Rigas MD, Taranjit Bains MD, Wendy Caceres MD, Hayley Gans MD, Rebecca Blankenburg MD
What is Imposter Syndrome?

“The term impostor phenomenon is used to designate an internal experience of intellectual phoniness”

“Self-declared impostors fear that eventually some significant person will discover that they are indeed intellectual impostors”

Pauline Rose Clance et al: 1978
Imposter Syndrome in Medicine
- Students

- **Female gender** was significantly associated with IS (49.4% female vs 23.7% male students)

- **Burnout** components significantly associated
  - Physical exhaustion, Cynicism,
  - Emotional exhaustion,
  - Depersonalization

- **4th year of medical school** significantly associated

All $p<0.05$

*Harris et. al 2016*
Imposter Syndrome in Medicine - Residents
Imposter Syndrome in Medicine - Attendings
- Self compassion
- Keep learning
- Find mentors
- Be a mentor

Strategies - Individual
Strategies - Interpersonal

- Peer support programs
- Openness about the issue among peers
- Supportive environment
- Give it a name
- Be authentic
- The power of storytelling
- Diversity 3.0
Imposter Syndrome is not uncommon!
JOHN IS CONFIDENT, JADA IS TOO ASSERTIVE: HOW TO RECOGNIZE AND MINIMIZE BIAS IN WRITTEN TRAINEE EVALUATIONS

Emily Earl-Royal MD MPH, Daniel Hernandez MD, Nancy Rivera MD, Al’ai Alvarez MD, Carmin Powell MD, Ripal Shah MD, Mike Gisondi MD

Hannah Keppler, MD, Kamaal Jones, MD, Maria de Lourdes Eguiguren, MD, Jonathan Updike, MD MPH, Xinshu She, MD, Quynh Dierickx, MD, Joseph Perales, DrPh LCSW, Lahia Yemane, MD
What is implicit bias?

Implicit bias “refers to the attitudes or stereotypes that affect our understanding, actions, and decisions in an unconscious manner.”

-Definition of implicit bias from Kirwan institute
The Effects of Bias in Evaluations

Leadership positions
Clerkship Grades¹

Underrepresented minorities were more likely to have lower grades in all clerkships when controlling for other factors.
Racial disparities in MSPEs²

<table>
<thead>
<tr>
<th>Word Categories</th>
<th>Black</th>
<th>Hispanic</th>
<th>White</th>
<th>Asian</th>
<th>Multi</th>
<th>Other</th>
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<tr>
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<td>52%</td>
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<td>54%</td>
<td>64%</td>
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<td>44%</td>
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<td>49%</td>
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<td>58%</td>
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<td>84%</td>
<td>86%</td>
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<td>88%</td>
<td>&lt;0.001*</td>
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<tr>
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<td>32%</td>
<td>38%</td>
<td>36%</td>
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<tr>
<td>Stellar</td>
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<td>10%</td>
<td>8%</td>
<td>9%</td>
<td>13%</td>
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<tr>
<td>Excellent</td>
<td>91%</td>
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<td>93%</td>
<td>95%</td>
<td>97%</td>
<td>0.050</td>
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<tr>
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<td>5%</td>
<td>8%</td>
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<tr>
<td>Ability</td>
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<tr>
<td>Intelligent</td>
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<tr>
<td>Bright</td>
<td>43%</td>
<td>44%</td>
<td>57%</td>
<td>54%</td>
<td>54%</td>
<td>52%</td>
<td>&lt;0.001*</td>
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</tbody>
</table>
Gender Disparities in Resident Milestone Achievement

Figure.
Frequency Distribution of Milestone Levels for Postgraduate Year (PGY) 1 and PGY3 Attending and Resident Physicians
Gender Disparities in Resident Feedback

Discordant Personality-focused
  - Autonomy
  - Assertiveness

Consistent Specific
Gender Disparities in Resident Feedback

“seemed to respond negatively to my input on her plans last shift . . . I know she’s late in the third year and needs progressive autonomy, but she seemed to have a negative attitude toward supervision.”

“sometimes argumentative, but he is trying to assert his confidence”
Impact on Leadership

US Medical School Faculty Trends: Female Faculty by Rank

<table>
<thead>
<tr>
<th>Year</th>
<th>% of Faculty</th>
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<tbody>
<tr>
<td>2009</td>
<td>20%</td>
</tr>
<tr>
<td>2010</td>
<td>22%</td>
</tr>
<tr>
<td>2011</td>
<td>24%</td>
</tr>
<tr>
<td>2012</td>
<td>26%</td>
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<tr>
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<td>28%</td>
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<td>32%</td>
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<tr>
<td>2016</td>
<td>34%</td>
</tr>
<tr>
<td>2017</td>
<td>36%</td>
</tr>
<tr>
<td>2018</td>
<td>38%</td>
</tr>
</tbody>
</table>

- Instructor
- Assistant Professor
- Associate Professor
- Professor
Impact on Leadership

US Medical School Faculty Trends: Male Faculty by Race/Ethnicity

- White
- Asian
- Other/Unknown race
- Hispanic/Latino
- Multiple race, non-Hispanic
- Black or African American
- Native Hawaiian
- Multiple race – Hispanic
- American Indian / Alaskan Native
Best Practices for Challenging Bias
3 Levels of Change

Individual

Interpersonal

Institutional
Recognizing Individual Bias

Implicit Association Test: Harvard Medical School

https://implicit.harvard.edu/implicit/takeatest.html
Train Evaluators to Challenge Bias

<table>
<thead>
<tr>
<th>Strategy</th>
<th>Application</th>
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</thead>
<tbody>
<tr>
<td>Stereotype replacement</td>
<td>Avoid stereotypic language</td>
</tr>
<tr>
<td>Counter stereotypic imaging</td>
<td>Minorities in leadership positions</td>
</tr>
<tr>
<td>Individuation</td>
<td>Be detailed, use specific examples</td>
</tr>
<tr>
<td>Increasing opportunities for contact</td>
<td>Know the person well</td>
</tr>
</tbody>
</table>
Train Evaluators to Challenge Bias

1. Focus on **specific skills** rather than personality traits
2. Vet your criticisms to job applicability and universality
3. Balance positive and negative feedback
Reducing Bias on an Institutional Level

- Important to create **transparency** and **accountability** throughout the evaluation process

- **Cultural change** on an institutional level

- Periodic review of own evaluation practices over years to **notice trends**

- GME review of milestones
Summary

- **Implicit bias negatively impacts** medical trainee evaluations resulting in less diversity among medical providers and leaders in medicine

- **Strategies exist** to reduce biased evaluations at the individual, programmatic and institutional level
  - Standardized, objective evaluation process
  - Implicit bias training for evaluators
CEASE AND DESIST: Addressing and Debriefing Biases and Microaggressions in the Clinical Setting

Carmin Powell, MD and Ripal Shah, MD
• **60%** of female medical residents reported gender based discrimination by families/patients

• **35%** of African American/Hispanic/Native American medical residents reported discrimination

• **60%** of Middle Eastern medical residents reported discrimination
Definitions

- **Bias**
  - *Implicit* - A positive or negative mental attitude towards a person, thing, or group that a person holds at an *unconscious level*
  - *Explicit* - A positive or negative mental attitude towards a person, thing, or group that a person is aware of and is under *conscious control*

- **Microaggressions** - *Brief and commonplace daily verbal, behavioral, or environmental indignities, whether intentional or unintentional, that communicate hostile, derogatory, or negative slights and insults that potentially have harmful or unpleasant psychological impact on the target person or group*
Why is this so hard?

Embarrassment

Uncertainty

Therapeutic alliance/collegiality
To Address or Not to Address?

- **Adaptive** → Does not change relationship with offender
- **Generative** → Potential to change the relationship with offender

“You can choose courage or you can choose comfort, but you cannot have both” – Brené Brown
Goals of Tool

1. Provide a safe and supportive environment to discuss biases
2. Create a guide for providers to address biases with their learners
3. Help change the culture at institutions
The 5 S of Debrief

- Solutions
- Space
- Self Reflection
- Situation
- Support
What can you do next?

- **Individual** (ex. interrupt microaggressions, use micro-affirmations)

- **Interpersonal** (ex. faculty development, communication workshops)

- **Institutional** (ex. learning climate survey, chain of command)
Take Home Points

▪ Bias and Microaggressions occurs frequently in medicine and in everyday life

▪ These tools are guides that can help people debrief biases and microaggressions in a safe and supportive way

▪ Having an open dialogue can be the first step in raising awareness and changing a culture

What questions are you leaving with?
"Self-compassion is simply giving the same kindness to ourselves that we would give to others."
self-kindness
common humanity
mindfulness
Shame in medical education
What it is, what it can cause, and why we need to be talking about it

SHAME (n.) Shame occurs when a person attributes a failure to reach a standard or ideal to something global and stable about themselves. Shamed individuals assess themselves to be globally flawed, deficient, and/or unworthy.

What the outside world may see:

SHAME “I am bad”

GUILT “I did a bad thing”

SHAME can be caused by events related to

Patient Care
- e.g., making a medical error, showing emotion in a patient

Learning
- e.g., answering questions wrong in public, undergoing remediation

Personal Goals
- e.g., failing to become a chief resident

These factors can contribute to shame

- high focus on performance
- perfectionism
- difficulty with subjective standards
- comparisons to others
- fear of judgment

These negative effects can occur with shame

- social isolation & impaired belonging
- disengagement from learning
- diminished psychological & physical wellness
- impaired empathy

WE NEED TO...

- Recognize shame in ourselves & others
- Normalize shame through honest & open conversation
- Confront shame through self-compassion & reaching out
- Understand shame through further study

Sentinel Emotional Events: The Nature, Triggers, and Effects of Shame Experiences in Medical Residents
William F. Byrne Jr, MD, Anthony R. Azran, MD, Sebastian Uchitelle, PHD, Albane M.P. Webb, MD, and Lax Varghese, PHD
Diversity is being invited to the party. Inclusion is being asked to dance.

Verna Myers
Diversity is being invited to the party.

Inclusion ends with being asked to dance.

Somewhere in between, you have to cultivate, and teach to dance. - Modified by LEAD Team 4

LEAD’19 Team 4: Alexander Ball, Julia Chandler, Anju Goyal, Rebecca Saenz, Omar Sahak, Ripal Shah, Irene Loe, AJ Fletcher, Michelle Brooks, Al’ai Alvarez
Belonging
Psychological Safety
Retention

Minority Resident Physicians’ Views on the Role of Race/Ethnicity in Their Training Experiences in the Workplace
Diversity + mentorship + + + → Inclusion and Belonging

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Why It Matters

50% of underrepresented faculty members report having no formal academic mentorship.

Challenges
Marginalization
Overt and covert racism
Activities that do not advance careers
Higher burden of clinical care

Consequences
Less likely to obtain grants
Less likely to be promoted

Ginther et al, Science 2011; Liu et al, AAMC Brief 2010
“Appreciating diversity and practicing diversity are not the same.”

Teresa Smith, MD
SUNY-Downstate
“Appreciating wellness and practicing wellness are not the same.”

Teresa Smith, MD
SUNY-Downstate
Diversity Operating System → DOS 3.0

**DOS 1.0**  (Diversity as an end to itself)
Racial and ethnic diversity important, but not critical to an institution’s primary functions

**DOS 2.0**  (Diversity as educationally additive)
Diversity of trainees enhances the educational environment for all, and teaching diversity enhances the intellectual development, service orientation, self-awareness, and cultural competency for all students. But still not integrated into the whole academic system.

**DOS 3.0**  (Diversity as a vehicle to excellence)
Diversity linked with inclusion builds innovative, high-performing organizations; diversity becomes a strategic imperative.

Diversity and inclusion is used to frame all academic activities.

**Faculty and Academic Leaders key to achieve Diversity 3.0**

Dr. Marc Nivet (Diversity 3.0: A Necessary System Upgrade, Acad. Med., Vol86, no12, Dec. 2011)
"We are people responding to a calling. All of us can be part of the effort. We are brothers and sisters in Medicine."

--Vivek Murthy, MD
19th Surgeon General of the United States
Make a Change!

Our community needs to promote inclusion, and you can be part of that.

Pick **ONE goal** that you personally want to focus on.

Write down **YOUR goal** in an email and send it to yourself.

Pick **ONE need** that your institution should address.

Write down **the need** in an email and commit to working on it when you get back home.
LEAD Steering Committee, Scholars and Mentors
Office of Pediatric Education
Stanford Pediatrics
Stanford Emergency Medicine
Stanford Vice Provost for Faculty Development and Diversity
Stanford Teaching and Mentoring Academy
Leadership Education in Advancing Diversity (LEAD) Program


The LEAD Program

Background
The pediatric patient population is rapidly becoming more diverse, yet the healthcare workforce has remained static in reflecting the patients we serve across diverse backgrounds. Pediatric leadership needs more representation of racial, ethnic, sexual and gender minorities. Building leadership and scholarship capacity for improving diversity and inclusion efforts should begin early during residency and fellowship training. This will strengthen the faculty pipeline in academic medicine and ensure that our core values of diversity and inclusion are reflected in our medical programs, leadership, and culture.

Program Outline
The LEAD Program, funded through a grant from the