Hey my name is Pamela Koons. I'm a GI medical oncologist and the vice chief of diversity, equity and inclusion for this section of medical oncology. It is my great pleasure to introduce Doctor ABBA Black who will be our speaker for today's Cancer Center grand rounds and I had the pleasure to get to know Doctor Black in the course of our work. She's also a vice chief for the section of general internal Medicine for Diversity, Equity and inclusion.
We have a wonderful committee that. We’ve gotten to know each other through that effort and but just by way of background, I’d like to share with all of you. I’m about Doctor Black, so she is an assistant professor and associate program director for Diversity and inclusion in the Department of Internal Medicine. She received her bachelors from Princeton and went on to graduate from medical school at the University of Rochester. She completed her residency at the Yale Primary Care Internal Medicine program, and she also served as chief resident. She currently works as a faculty
Many of Doctor Black’s career and research interests focus on enhancing workplace diversity and inclusion, including participating in minority recruitment efforts, facilitating workshops on bias of which I attended, one that was fantastic and researching the effects of race on minority physicians. Her clinical work is devoted to working with underserved, patient populations in the primary care setting and in her role as a clinician educator.
She also works towards supporting residents who identify with minority affinity. Groups and developing curricula design to enhance cross cultural knowledge, skills and attitudes, and I have truly been so impressed with Doctor Black’s efforts through these workshops that she’s really developed and spearheaded. And I’m really think that we can all learn a great deal. So doctor black. Welcome and thank you. Thank you so much and that introduction is incredibly kind. I’m so thrilled to have the opportunity to come and chat with the group,
00:02:04.820 --> 00:02:06.476 so thank you all so much for having me.

00:02:06.480 --> 00:02:08.208 I’m going to go ahead and share my slides

00:02:08.208 --> 00:02:09.976 and then we’ll go ahead and get started.

00:02:14.650 --> 00:02:16.904 OK great so I have no disclosures

00:02:16.904 --> 00:02:19.368 today and as far as the learning

00:02:19.368 --> 00:02:21.790 objectives for the next hour or so,

00:02:21.790 --> 00:02:23.494 I hope that we can touch

00:02:23.494 --> 00:02:24.990 upon three major points here.

00:02:24.990 --> 00:02:26.478 First, anytime I do a talk like this,

00:02:26.480 --> 00:02:28.541 you know, I hope that we begin to expand

00:02:28.541 --> 00:02:30.796 our scope in terms of what we understand

00:02:30.796 --> 00:02:32.899 to be unconscious bias and how it plays

00:02:32.899 --> 00:02:34.386 a role in our healthcare workforce.

00:02:34.386 --> 00:02:36.674 This is less a patient facing talk and

00:02:36.674 --> 00:02:38.531 more thinking about our own culture
and our structure in terms of what it looks like for healthcare professionals.

I also hope that some of what I share will enhance awareness of personal blind spots, of which we have many myself very much included and lastly, thinking about some steps that we can take to promote equity, both in terms of our personal spheres of influence but also thinking more broadly in terms of institutions and organizations. So I hope to leave you with some inspiration in that regard.

I will say just to put it out there in the beginning that you know.
diversity inclusion is a very large umbrella term and there are many lived experiences and identities that are important in terms of what that. EI umbrella really looks like most of my work and initiatives have focused on race and ethnicity, so I just want to be clear about that. Beyond that, a lot of examples in the literature all relate to underrepresented groups in terms of race and ethnicity, but of course that’s by no means a form of diversity that in fact really
make up that important Umbrella DEI.

So first of all,

talk about some background and hopefully some interesting contextualizing information for you all,

and then we’ll go into some of the work that’s been done around workplace experiences of those underrepresented in medicine.

We’ll chat a little bit about why this is something that’s important for all of us, regardless of how we spend our time and academia.

And lastly, we’ll end this promise with thinking a little bit more broadly.
around steps to move forward, and how we can actually take some of this work and make it more concrete. I’m sure many of you are familiar with some of these common deiters. I do just want to spend a few minutes going over some common terminology because I think it’s important to develop a shared mental model and make sure that you all are clear about what I mean when I do use these terms throughout the talk. So implicit bias, also known as unconscious bias. One definition that I like is
thinking about this term as relatively unconscious and relatively automatic features of prejudice, judgment and social behavior. So really. That predisposition, that mindset that’s not intentional. That’s not about, you know, Antagonistic views or feelings towards any particular group but nonetheless operate at a level that we’re not fully aware of and then thinking about microaggressions, so implicit bias is the attitude or the predisposition. Then microaggressions are really
these behavior based manifestations of such and it’s actually a really old term tester Pierce, an African American psychiatrist dubbed the term way back in the 1970s, which I was surprised to learn because they feel like it’s a term that’s only more recently. Have come into academia as a more of a buzzword and something that people think about more often and initially. When he conceptualized with the term, he really was only thinking about it as applying to African American physicians and trying to describe
some of their experiences.

However, since that time, we’ve really expanded microaggressions to be relevant to a whole host of identity groups that may be marginalized or underrepresented. And it's definition that I've written here brief everyday exchanges that sending meaning messages to people because of their group affiliation. I think really encapsulates that concept that these again are not obvious in your face. Hateful ways of behaving towards people, but they nonetheless can make people feel otherwise outside of the mainstream,
disrespected, or demeans. Even without that lack of conscious intent.

Importantly, you know when we both, when we think about implicit bias and then microaggressions as the outdrove, what binds it all together? Is that these really are things that are unconscious, subtle and automatic. And so oftentimes people have consciously held egalitarian views in regards to any kind of people group, right? They and I think that would say
that that’s very much true of our culture here at Yale that people see themselves as those who really embody ideals of justice and equity. For all people, so this is again not about casting labels on anyone talking about anyone who’s explicitly racist or sexist, but nonetheless thinking about the ways in which those automatic connections that are happening inside each and every one of us, myself included, can end up causing a lot of harm. And so micro and micro
I think it’s really important to separate intent versus impact. People can have good intentions or neutral intentions, but nonetheless cause a lot of harm and negative impact. So that’s an important point to keep in mind as we go through some discontent here. In terms of the literature on unconscious bias, you know a lot of what we know really comes from the social psychology literature and a lot of the studies support that unconscious bias.
is also going to very early age. You know, as early as age 5 or 7, they’ve done experiments where they’ve asked children to rate the pain score of individuals who experience a painful stimulus, such as getting one Ted or biting one’s tongue right and they find is that children will for very same stimulus children will actually say that an African American child experiences less pain compared to a white child. That, of course is highly through beneficiant. Knowing what we know about disparities
NOTE Confidence: 0.733406051666667
00:07:53.866 --> 00:07:55.780 in terms of adequately treating
NOTE Confidence: 0.733406051666667
00:07:55.780 --> 00:07:57.740 pain across race, ethnicity lines.
NOTE Confidence: 0.733406051666667
00:07:57.740 --> 00:08:00.110 The second point here is about
NOTE Confidence: 0.733406051666667
00:08:00.110 --> 00:08:02.202 thinking that unconscious bias also
NOTE Confidence: 0.733406051666667
00:08:02.202 --> 00:08:04.662 has real world effects on behavior.
NOTE Confidence: 0.733406051666667
00:08:04.670 --> 00:08:06.370 So sometimes people think if
NOTE Confidence: 0.733406051666667
00:08:06.370 --> 00:08:08.070 this is happening underneath the
NOTE Confidence: 0.733406051666667
00:08:08.130 --> 00:08:10.083 skull and it’s just all this very
NOTE Confidence: 0.733406051666667
00:08:10.083 --> 00:08:11.590 abstract kind of processing,
NOTE Confidence: 0.733406051666667
00:08:11.590 --> 00:08:13.290 what does this actually mean?
NOTE Confidence: 0.733406051666667
00:08:13.290 --> 00:08:14.660 And I think it’s important
NOTE Confidence: 0.733406051666667
00:08:14.660 --> 00:08:16.370 to note that there are some.
NOTE Confidence: 0.733406051666667
00:08:16.370 --> 00:08:19.296 Studies that show that in terms of,
NOTE Confidence: 0.733406051666667
00:08:19.300 --> 00:08:20.180 for example,
NOTE Confidence: 0.733406051666667
00:08:20.180 --> 00:08:22.380 a pro White implicit association,
not explicit racism, but it’s just an automatic kind of implicit bias that’s happening that automatically favors white over black people. For example, if you take those healthcare providers who do have that pro white bias, as demonstrated on the implicit association test, those same providers will also have observable behavior such as decreased eye contact engaging, small talk. That’s often with their patients who are black or brown, so just important to highlight
that then sociation can’t go into

the decisions that we’re making,

which is of course very important

when we think about HealthEquity

from a broader standpoint.

On a more hopeful note,

there are some studies that do suggest

that unconscious bias can be malleable,

particularly if you spend a lot of

time engaging with people around there

by it and showing counter stereotypic

images over prolonged period.

You can actually attenuate,

to some degree.

The level of implicit bias folks have,
and one example of that was taking college students who had an implicit association of women having less high powered careers. This is a implicit bias. I have myself around women and career and over time, if you if you expose those people to a number of different people who challenge the implicit association, those same college students were found to actually improve their scores on the Implicit Association test. So hopeful note in terms of what we can actually do about some of our implicit association.
I always like to point out, particularly to a group of health care providers that you know, the things that make implicit bias source are things that we have in spades in our profession, right? No matter what you do in health care. More broadly, chances are you’ve experienced some elements of cognitive overload, sleep deprivation, and stress, right? So just kind of being extra aware that in our field those sort of quick fast brain impulses associations that are going on are much more likely to
happen when we’re not getting adequately.

I could sleep,

have high levels of stress,

and constantly have a lot to
deal with cognitively.

Some of you have made me have
seen this depiction before.

I think it’s important to highlight
because I think it really helps to
demonstrate what the goal is when
we talk about these larger goals
and aspirations for diversity,
and equity and inclusion work and on
the left upper side of your screen,
you’ll see inequality.
And I think that’s a pretty intuitive
term for most people that the tree is obviously slanted towards the left has a lot more fruit on the left and the right side. But clearly that person on the right has unequal access, and I think that that’s pretty clear. No, no one wants that. And then moving along on the right upper side. Now we have this equality question and what that means is now you can evenly distributed tools and assistance as depicted here. Now both individuals have the
same size and color ladder,
so presumably you know you might
think that that was the goal,
and for a long time and DI work we
did talk a lot about equality
and evenly distributing these
tools and assistance.
But as this graph is a nice job of showing
the trees still slanted towards the left.
And the apples are still
congregated on that left side,
and so even though you give both,
you’ve given both people the same
sized ladder that person on the
right still doesn’t have that
same access to opportunities.
00:11:44.971 --> 00:11:48.850 And then we moved to the left bottom hand

00:11:48.936 --> 00:11:51.610 at the the EDI and this is the idea

00:11:51.610 --> 00:11:54.054 of customizing tools and assistance in

00:11:54.054 --> 00:11:56.670 order to address the existing inequality.

00:11:56.670 --> 00:11:58.637 So now, even though that tree is

00:11:58.637 --> 00:12:01.430 still planted, the person on the

00:12:01.430 --> 00:12:03.621 right has been given a taller ladder.

00:12:03.621 --> 00:12:05.830 So is in a better position to

00:12:05.830 --> 00:12:07.942 actually reap the fruit of the tree.

00:12:07.942 --> 00:12:10.365 But ultimately, and I think this is what

00:12:10.370 --> 00:12:11.721 What we really have is justice and

00:12:11.721 --> 00:12:13.357 by now you probably picked up on the

00:12:13.357 --> 00:12:14.986 fact that the tree in fact represents

00:12:14.986 --> 00:12:16.714 the systems and the structures of

NOTE Confidence: 0.887258889090909
our organizations and our societies.

Right, and so now both people have the same size bladder and actually do for the first time have equal access and opportunity because the fruit has now been distributed throughout the tree and the tree is actually upright. So thinking about what the larger vision I think is can be really important to censure us around what our goals are for DI work.

The term underrepresented medicine is probably not a new term for most people, probably not a new term for most people, and the way that the AA and C defined this is as those racial ethnic populations that are underrepresented.
In the medical profession relative to their numbers in the general population. So for the purposes of terminology, what that really includes is Hispanic, Latin, African American, American Indian or Alaskan Native origin, as is depicted by the double AMC. But I will say here. So I think this is important. That race is a social construct, right? The way that we decide to create boundaries around different people groups is more reflection on society than it is necessarily around genetic similarity. And of course we can think of many races.
For example, the Asian race that encompasses so many different kinds of cultures and people from multiple kinds of lineages. So the way that we think about race to begin with is problematic, and so I just want to say that even though you know there's an effort here to just designate. Those who are underrepresented. It's not a perfect thing, right? There's a lot of heterogeneity even within one racial group that them back to our society's way of trying to group people and homogenize them. But I will use that term underrepresented.
because it is how we have tried to track how we’re doing in terms of diversifying our workforce.

Now on the left side of your screen coming up here, you’ll see a pie chart that represents the racial ethnic breakdown of the US population,

and now you’ll see a similar graph, this time on the right that’s depicting the resource and breakdown of our physician workforce,

and even though this data is a few years old, it actually hasn’t changed significantly unfortunately,
so,

but I'll draw your attention to is

that on the left you'll see that

Hispanic or Latinx individuals comprise

approximately 18% of our population.

We want it comes.

To the percentage of the physician workforce,

there are only 5% similarly for

African American individuals,

13% of our population is only 4%

of our of our workforce.

We also know that if you think

about the various aspects of the

you know academic trajectory,

that that we all go through

to become a physician.
Not only is there this drop off when we go from you, the overall population to practicing positions, but those steps in the middle to go to medical school then to pursue residency or fellowship. We’re losing people along the way, and there’s increased attrition rates. There’s actually a paper that came out in the New England Journal of Medicine recently that was looking at the diversity of US training. Programs from 2011 to 2019 and in many cases the numbers have stayed the
same in terms of the representation

of underrepresented individuals

and some specialties in some of the

surgical specialties are actually

a drop off in that period,

which is disheartening considering

that there's a lot more attention

paid these days to the importance of

diverse recruitment and retention.

So something is happening along

the trajectory that I think is

important for us to pay attention to,

and that brings us to this next topic.

Found workplace experiences of

those underrepresented in medicine.

There are multiple studies and
a lot of this work has been done by Yale Bone Marcelina Snitch, who many of you probably know in terms of her work both locally and on the national stage, and the pursuit of equity and a lot of this work has consistently showed that physicians who are considered underrepresented in medicine have very adverse experiences in the healthcare workforce and site. Things such as lower career satisfaction, patrons refusing their care or feeling like there's racial bias in the academic environment.
Not feeling supported or adequately recognized on, on and on and on.

So what we were interested in, and we meaning a research team as part of a few years ago, was thinking about how underrepresented medicine residents experience their training. Because there was certainly some resource to help us understand those experiences at the faculty level, as well as some literature at the medical student side, but not a lot in terms of that grade zone, which we felt like was a really important part of training to understand it’s a vulnerable time where people are,
in some ways being kind of initiated into this new. Difficulty of their choice and and learning a lot about professional identity and what their place is within a larger institution and a larger profession. So we wanted to understand how black and brown residents really felt about their experiences and residency. So towards that end we conducted some semi structured interviews or used an interview guide. But also we're free to kind of deviate and probe on themes as they were identified.
by our group of residents.

We interviewed people who met the double AMC criteria for Kind of represented medicine. Primarily African American people.

And then we conducted interviews until we reach any kind of thematic saturation where we no longer felt like there were new things that were arising.

And then we just took a look at our data. We had a group of 3/3 of us on the team who looked at the subsequent interviews to really find recurrent themes that we could identify.

The overarching narrative and this is a little bit of our interview guide.
so a lot of it was fairly open ended.

Asking people to share about their experiences, what they feel like it might be to be underrepresented in medicine and to give some examples of how race was relevant to their experience.

We ended up publishing this study back in 2018. We talked to 27 residents who represented 21 different institutions, 56% identified as female, 40%, 4% identified as male.
The majority, as I noted, were African American and we had a good group of specialties represented to all medical specialties across the folks that we talked to. And for the next session here, I just want to talk a little bit about what we learned when we spoke with these residents. Our team ultimately boiled it down to three teams that could really populate the experiences of these folks. The first was common racial bias. The second was role of race ambassador, which I'll explain and then thirdly, the pressure to cover racial identities.
will also go into in more detail.

I think by far the most common theme was around bias, both implicit and explicit, but primarily implicit bias, and there are a few sub themes that kind of shed light on what that meant for these trainees. First was what we call the assumptions of lower status, whereby the black and brown residents were very frequently mistaken to be any member of the team, so they were called food transport workers.
You know, medical assistants, people who are supporting the team, people who have integral. Goals of course to the whole healthcare team, but despite attempts to really assert their identity into where you know, stethoscope around their neck badge with the MD label very prominent, it seems that patient families in some cases other members of the care team really had a hard time seeing me. Black and brown residents at physicians and as leaders of the team. And you seen that that those quotes there I’ve never been called transport so many times in my life.
I’ve been confused for janitors, food service worker. Even when I go in a room, I introduce myself like always when I first walk in a room. Hello, I’m doctor so and so and it’s like they don’t hear that. So really the sense of cognitive dissonance, which was very disheartening for our residents and made them feel like they didn’t belong in the environment. Another form of implicit bias is what we termed alien ones on land, so these were generally people from
Hispanic or Latin next background.

Who had names that were not common Anglo-Saxon names in the States and so you know.

People often from patients making comments.

Hey, can I just call you Bob or saying things like wow, that last name is different?

How do I say where is that from doing this?

Your first language?

Where are you from?

And this resident who is actually Mexican American whose family had been in the US for four generations and was very proud of his culture.

Also,
you know very much identified as an American.

And this is really sharing how they would not just access Texas when he says I’m from Texas,

they always kind of following up with with more questions and making it seem like because he had a Hispanic last name he could not be American and in other forms of bias like that.

We also saw what we called assumptions of similarities of similarity,

and this was the idea that for many of our black and brown residents, they found that they were confused for other residents of the program.
who are also black and brown. Even if they didn’t look very similar in this quote, this is on a surgical resident who says six of us are black women. They’re constantly interchanging our names, constantly interchanging people that don’t even look alike. People that it’s like I was in your surgery. I was in your 8 hours surgery the other day. Your eight hour surgery. And you do not know my name. So again, another theme that really made folks feel like they did not belong at the institution that people around many
00:22:03.936 --> 00:22:07.100 cases were even sometimes you know the

00:22:07.188 --> 00:22:09.434 program leader who program director

00:22:09.434 --> 00:22:11.702 who was engaged engaging this kind

00:22:11.702 --> 00:22:14.109 of behavior to not know the names

00:22:14.109 --> 00:22:17.047 and really added to that sense of isolation.

00:22:17.050 --> 00:22:18.760 And I might commonly there

00:22:18.760 --> 00:22:20.470 were forms of explicit bias.

00:22:20.470 --> 00:22:22.228 For example this resident who said

00:22:22.228 --> 00:22:24.519 someone like who had a patient statement.

00:22:24.520 --> 00:22:24.982 Excuse me,

00:22:24.982 --> 00:22:26.137 Someone Like You should go

00:22:26.137 --> 00:22:27.520 back to where you came from.

00:22:27.520 --> 00:22:29.242 You people come and you take our

00:22:29.242 --> 00:22:31.149 places and you take our jobs and

00:22:31.149 --> 00:22:32.539 you don’t even have citizenship

45
and you don’t even speak English,
so you know clearly nothing,
nothing implicit or unconscious about this,
just hateful language.
And the resident described having to
continue on to go through their day
despite having an encounter like this,
which was.
Work very challenging.
We also found that despite the
relative frequency of these episodes,
very few residents actually did
anything to share this with their
program or to arc it up the chain,
and oftentimes they either would
kind of go home and perhaps talk to
00:23:04.471 --> 00:23:06.452 a partner or friend about what was
00:23:06.510 --> 00:23:09.390 going on, or have an internal support
00:23:09.390 --> 00:23:11.783 system among other residents who
00:23:11.783 --> 00:23:13.226 identified as underrepresented.
00:23:13.230 --> 00:23:15.174 And when we asked why there is no follow
00:23:15.174 --> 00:23:17.373 up and why they didn’t share that these
00:23:17.373 --> 00:23:19.460 kinds of incidents with program leadership.
00:23:19.460 --> 00:23:21.364 A lot of it came down through
00:23:21.364 --> 00:23:22.180 these three reasons.
00:23:22.180 --> 00:23:23.650 One was fear of repercussions
00:23:23.650 --> 00:23:25.842 and just the fear that there is
00:23:25.842 --> 00:23:27.497 a tuition was very hierarchical.
00:23:27.500 --> 00:23:29.228 One in turn, said when you’re
00:23:29.228 --> 00:23:31.160 at a certain level of training.
00:23:31.160 --> 00:23:32.917 You don’t have clouds really stick out
your neck and say you’re totally out of line.

There’s also some skepticism that speaking up would actually lead to any kind of measurable change.

Someone said I brought up in the past and just kind of puts aside. So sort of the mindset of why bother and then time and energy expenditure,

which I found really moving.

This idea, that residency in general requires a lot of emotional bandwidth and so to kind of fit with the program.

Director, director talk to someone and ombudsman about what’s going on.
Just it just felt like an additional expenditure of emotional energy as well as time, and I think the resident put it very well in this last quote. That’s the hottest piece of currency that I own in residency is my time. I don’t want to spend it reliving something. Our second theme was around the World Race ambassador and some of you may be familiar with the term minority tax, particularly in academic settings, what can happen is that for folks who are racially underrepresented.
there’s an increased burden to do things like join a diversity Committee, help recruit and retain certain individuals from diverse backgrounds, mentor and advise students or trainees of color. So all these sort of added tasks, or. Our efforts that historically haven’t been compensated have that haven’t come with time, collective time or compensation, right? And so thinking about how that task can actually downstream really affect things like promotion and and recognition. And what we thought was interesting is that while that phenomenon
00:25:08.772 --> 00:25:10.962 has been well described in the literature for faculty members,

00:25:10.962 --> 00:25:12.710 we actually thought that the residents themselves were vocalizing a lot of these same themes.

00:25:12.710 --> 00:25:14.270 Entirely developing and running a HealthEquity curriculum at their institution.

00:25:14.270 --> 00:25:15.518 Because there was no faculty member who felt comfortable with that material who are leading diversity committees who are felt like they had increased responsibilities to educate their peers around diversity.

00:25:15.518 --> 00:25:17.048 Entirely developing and running a HealthEquity curriculum at their institution.

00:25:17.050 --> 00:25:19.342 We talked to residents who are, you know.

00:25:19.342 --> 00:25:21.422 Entirely developing and running a HealthEquity curriculum at their institution.

00:25:21.422 --> 00:25:23.800 Because there was no faculty member who felt comfortable with that material who are leading diversity committees who are felt like they had increased responsibilities to educate their peers around diversity.

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00:25:25.726 --> 00:25:27.403 We talked to residents who are, you know.

00:25:27.403 --> 00:25:29.063 material who are leading diversity committees who are felt like they had increased responsibilities to educate their peers around diversity.

00:25:29.063 --> 00:25:31.185 committees who are felt like they

00:25:31.185 --> 00:25:32.661 had increased responsibilities to

00:25:32.661 --> 00:25:34.434 educate their peers around diversity,

00:25:34.434 --> 00:25:35.316 equity, and inclusion.
So a lot of work that was being done that again wasn’t given time or or compensation, and one resident put it this way. The black people are asked to fix the black black problem, but we also noticed was that there was really a lack of. The long term plan when it came to DI work, and in many cases we felt that there was this institutional abdication of responsibility when it came. To having a strategic plan or vision for improving the issues, and it was made it very vulnerable because in many cases there would be one attending or one resident.
00:26:08.577 --> 00:26:09.864 who was really passionate about

00:26:09.864 --> 00:26:11.932 the work and who would be doing it.

00:26:11.932 --> 00:26:13.708 Then when that person would leave,

00:26:13.710 --> 00:26:15.518 as you can see in that second quote,

00:26:15.520 --> 00:26:17.704 a black attendant who was very involved

00:26:17.704 --> 00:26:19.383 in recruitment left to another.

00:26:19.383 --> 00:26:21.388 Is the 2000 and since he’s left

00:26:21.388 --> 00:26:22.810 without that voice on the table,

00:26:22.810 --> 00:26:24.575 there’s few and everything sort

00:26:24.575 --> 00:26:25.634 of falls apart,

00:26:25.640 --> 00:26:28.550 so not not very sustainable in

00:26:28.550 --> 00:26:31.020 terms of prioritizing DI work.

00:26:31.020 --> 00:26:32.290 And then it’s glass beam.

00:26:32.290 --> 00:26:34.276 Thirdly, is around pressure to cover.

00:26:34.280 --> 00:26:36.740 And this is a term that was
That legal scholar and he talked about covering as this attempt to play down identities that are outside the mainstream in order to blend in. And we definitely found that theme with the residents that we spoke to where they felt like predicting when it came to external factors such as hair or clothing or speech. There’s this attempt to be very mindful of how they were. With that team, oftentimes that hypervigilance was related to experiences that they had in that first quote.
This is a biracial resident who one parent is black and one parent is white and he wears his natural hair in an Afro and oftentimes pulled in a ponytail and he had one of his clinic attendings come up to him and say, you know, there’s people who you’re going to see in clinic who probably would not feel comfortable with your hair being like that. And you know if you found it shocking, that someone would say that to him, but didn’t really know what to do about it and ended up just kind of changing his hairstyle and not letting anyone else in the program know about this.
comment and the hypervigilance that resulted was often around feeling like a race representative that any action, good or bad, would somehow cause others in the program to extrapolate that as a characteristic of the entire race, and this was particularly predominant in low diversity environments where there were very few residents of color. Institution and one resident told us just want to make sure that what you’re doing is top notch because they may use your mistakes and then kind of pair that with your race, which of course it was not a comfortable feeling.
Outside some of this quality of that, I also just wanted to spend a few minutes talking about bias and professional opportunities and advancement on some of you may be familiar with this study the Alpha Honor Society selection that made a big splash when it came out a few years ago was led up by a team here at Yale and the bottom line is that both black and Asian students were less likely to be inducted into Alpha Omega Alpha even after controlling for what you might think of as those common offenders that might play a role.
As you can see there, and it's like I said, really need waves and actually caused several medical schools to temporarily or permanently suspend, affirming to alpha Honor Society selections and to take a look at their internal process to understand what was driving those inequities. There's also some literature around racial, ethnic, and gender bias and medical student evaluation, so I'm sure a lot of you remember the MPE that large kind of Dean's letter that contains a lot of language.
To summarize, the medical students' performance as they go on to their next step of training.

Terms of the racial bias. What they found is that, again, even after controlling for step one, scores or leadership experiences, community outreach experiences and so forth.

White applicants were more likely to be described with those standout keywords that reviewers are often looking for at the other. On the other side of the application, words like exceptional, best, outstanding and black applicants were.
This resident was competent, and then the gender piece interesting. Not surprising, but I think women were more likely to be described with nurturing words like carrying empathetic, commented on their organizational skills instead of using again those standout keywords that really tend to make an impact in terms of who's reviewing that application. What we also know is that when we take a look at the distribution of US medical faculty by race and ethnicity.
Now if you look at the X axis here we have the different groups. Here, white, African American, Asian, Hispanic, gladness and then the blue stand for assistant professor, blue stand for assistant professor, associate professors in orange, and then Gray full professor and. What I want to draw your attention is that even for Asian groups who are not underrepresented in medicine faculty members really have this same pattern where the majority of the physicians are clumped in the assistant professor category.
But then that level of diversity really trails off as you move up to associate and full professor, and there's an interesting study done about 10 years ago by Marcel Nunez Smith, looking at that variation and promotion. On the bottom line is that most institutions displayed lower rates of promotion for black and Hispanic faculty despite controlling for characteristics that you might think of as germane to how that decision is made. Interestingly, there are 13% of institutions do not promote any Hispanic faculty over the course of this study period,
NOTE Confidence: 0.842764516538461
00:31:22.290 --> 00:31:24.066 almost a quarter to promote any
NOTE Confidence: 0.842764516538461
00:31:24.066 --> 00:31:25.250 black faculty at all.
NOTE Confidence: 0.842764516538461
00:31:25.250 --> 00:31:26.710 But there was this third,
NOTE Confidence: 0.842764516538461
00:31:26.710 --> 00:31:28.108 the third of their sample size,
NOTE Confidence: 0.842764516538461
00:31:28.110 --> 00:31:30.665 that those somewhat equal rates of promotion,
NOTE Confidence: 0.842764516538461
00:31:30.670 --> 00:31:31.870 which I think is encouraging.
NOTE Confidence: 0.842764516538461
00:31:31.870 --> 00:31:34.462 In terms of thinking about what the best
NOTE Confidence: 0.842764516538461
00:31:34.462 --> 00:31:36.857 practices might be that are associated there.
NOTE Confidence: 0.842764516538461
00:31:36.860 --> 00:31:38.932 The next election will we’ll talk about
NOTE Confidence: 0.842764516538461
00:31:38.932 --> 00:31:41.340 is the case for why this all matters.
NOTE Confidence: 0.842764516538461
00:31:41.340 --> 00:31:43.910 Highest relevant to us as
NOTE Confidence: 0.842764516538461
00:31:43.910 --> 00:31:44.938 healthcare professionals.
NOTE Confidence: 0.842764516538461
00:31:44.940 --> 00:31:45.378 You know.
NOTE Confidence: 0.842764516538461
00:31:45.378 --> 00:31:47.861 I think a lot of the the case for this
NOTE Confidence: 0.842764516538461
00:31:47.861 --> 00:31:49.883 really comes from the business literature
NOTE Confidence: 0.842764516538461
and certainly in academia as well. There's a great study in the 1990s from Anne McLeod around diversity and creativity, and this experiment was done there. They're all college students I believe, and they're randomly assigned to two groups and have this brainstorming task to solve the torus problem, and essentially they were. Has to come up with as many ideas as possible to improve American tourism, and then blinded judges assess the performance based on the feasibility of the ideas and also the effectiveness.
and what they found is that for the groups that were made up of people from a variety of different backgrounds, they had ideas that were much more feasible and more effective compared to those groups that were homogeneous, this is often thought of as a landmark study to think about why diversity is important in terms of creative thought and giving an organization. From the business side of things, I think also certainly applies to our medical organization.
thinking about how diversity leads to a competitive advantage when you have a heterogeneous group,

better market performance,

increased productivity,

higher return on equity.

All these things have been associated with organizations that are not made of people who have the same lived experiences or the same identity group.

So something that’s important,

I think, thinking about it from an organizational optimization point in addition to of course the moral.

Argument that I hope we all care about.
I think this is an important point, although it’s important to be careful about it, the method certainly shouldn’t be that people of color should only be treated by physicians who are also of color. But it is true that the literature supports that race.

Concordant care improves access, so particularly for providers who are black and brown, they often will go practice in areas where there are a higher number of underrepresented individuals who we all know unfortunately experienced worse.
Outcomes in our country.

In terms of thinking about Medicaid patients, uninsured patients who are high utilizers of accused health services, and the Ed and in urgent care centers and patients who self report as fair or poor health status.

Providers of color much more likely to work with that group. So again, I say with a grain of salt because I don’t want to send the message that our solution is to make sure that providers and physicians all have the same.
patients have the same race,

but I do think it’s important to

note that diversifying our health care workforce is likely to make inroads in terms of this HealthEquity issue that we we constantly face.

So for the remainder here,

then I hope to leave a good amount of time for for questions here.

At the end is thinking about how we can move forward and some of the work that I’ve been doing and the DI space and other things to think about is as you chew on some of what we’ve been talking about during this talk.
So I think something that’s become very clear to me in the time I’ve been doing this work is how important it is to protect time for DI leadership efforts. As you saw in the data that I showed, unfortunately has become way too common. For folks to think of TDI leadership as an extracurricular activity that doesn’t get much recognition or much support, and I think there’s really something about giving that protected time and funding to make sure that the message is being sent, that DI is something that’s prioritized in the department and the larger institution.
NOTE Confidence: 0.875673660344828
00:35:21.680 --> 00:35:23.660 whatever the the sphere of
NOTE Confidence: 0.875673660344828
00:35:23.660 --> 00:35:24.848 influence might be.
NOTE Confidence: 0.875673660344828
00:35:24.850 --> 00:35:26.644 And I feel really fortunate that
NOTE Confidence: 0.875673660344828
00:35:26.644 --> 00:35:28.672 I have had time and support to
NOTE Confidence: 0.875673660344828
00:35:28.672 --> 00:35:30.208 do the work that I do.
NOTE Confidence: 0.875673660344828
00:35:30.210 --> 00:35:32.485 So if Pam mentioned at the beginning
NOTE Confidence: 0.875673660344828
00:35:32.485 --> 00:35:35.487 I have a few roles in DI leadership.
NOTE Confidence: 0.875673660344828
00:35:35.490 --> 00:35:37.374 One is as the associate program
NOTE Confidence: 0.875673660344828
00:35:37.374 --> 00:35:39.799 director for DI and Yale Primary Care,
NOTE Confidence: 0.875673660344828
00:35:39.800 --> 00:35:41.155 and then the vice chief
NOTE Confidence: 0.875673660344828
00:35:41.155 --> 00:35:42.510 for DUI in the section
NOTE Confidence: 0.739737229047619
00:35:42.571 --> 00:35:44.101 General Medicine and then as
NOTE Confidence: 0.739737229047619
00:35:44.101 --> 00:35:45.990 as most of you probably know,
NOTE Confidence: 0.739737229047619
00:35:45.990 --> 00:35:47.831 that hitting Hanal left us this spring
NOTE Confidence: 0.739737229047619
00:35:47.831 --> 00:35:49.787 to become the the Dean of Diversity,
NOTE Confidence: 0.739737229047619
equity and belonging at Penn State.

This is such a wonderful opportunity for her.

And in that transition, I'm now helping with the DI by chief development across different sections and partnering with bonding kamdar, who's taking on other engineer responsibilities on an interim basis.

And I made this a sort of a Venn diagram because I just wanted to note that I think it’s so important for diversity and equity and inclusion work that it doesn’t happen in silos, and I think there are many ways in which all these roles help to inform each other.

You know, certainly.
Both the app role and the Vice Chief and GIM role are under the larger GIM section, right?

And so our trainees are very integral. Part of how we function overall, the section of general medicine and doing the work in terms of thinking about how we help develop our our DI Vice chief across the Department of Medicine is also going to have downstream effects in terms of what’s happening in the individual section. In terms of thinking about the DI development, I think we’ve really had this kind
of try part vision and I think in
any did such a wonderful job in
terms of developing infrastructure
for DIF administration,
because a few years ago certainly
I came to residency here,
so I’ve been here for about 9
years and when I first came,
there really wasn’t much in the way
of leadership positions or people
who were really taking their time
and energy to work on various DI.
To do and so even having a DI
vice chief in each section in
the Department of Medicine,
is just such a wonderful development.
And I’m really so grateful to have the support of the department in that. I think in terms of the things that we’ve been focusing on, team building has been a huge component of the work that we’re trying to do because it’s been very clear that there’s been a little bit of TDI work done in, one section, perhaps, but then no one else in the department may know about it. And there may be multiple people who are working towards the same goal.
It's unclear who's doing what, and so you know part of it is developing a really good team model so that we can support one another and collaborate and make sure that we're really effective in the work that we're doing. Secondly, the goal of the I knowledge and skill building, and there's a ton of passion or group for social justice, and it's such a wonderful group to be part of. And so a lot of what we're thinking about now is how do we just hone our skills to make
And DI leaders and understand the strengths that people are bringing to enhance the content that we can can then bring back to our individual sections, and then a huge piece as well has been leadership development and I'm really grateful to be partnering with Doug McKinley. Approved announced external consultant who comes in and works with us to help us understand our leadership styles. To understand how to be more effective and the work that we do is to really kind of hardness our our
individual personalities to make sure that we are going into this work. To really make sure that we are thinking of ourselves as just as worthy as other vice chiefs and affection and getting that kind of voice to to make us effective leader. So it’s it’s been fun to have him work. Alongside as we’re sort of doing a DI content piece to also think about, how do I understand myself as a leader? And what does that mean in terms of how I want to optimize the work that I’m doing? And then in terms of Vice chief role as the sector general medicine, specifically, this is a year,
a role I've had for about a year now, and so really the focus that I've been having this first year plus has been around education and doing a lot of faculty development. Something that I'm really excited about that are our section has committed to is having an annual DI themed retreat which we had in February was our first one since the pandemic, so it was virtual, but at least we were able to go through the content. We did things like have a virtual privilege walk, talk about what,
what privilege means in terms of what it looks like for our lived experiences, doing some small group activities, and having external speaker come in and talk about resistance and advocacy. So really great ways to keep the conversation going. Think sometimes in the I can feel like a you know one off kind of thing where, uh, someone has a training but we don’t want it to be a check with the kind of initiative we really want to think about how to create it to be a thread. Neurocrine theme that comes into people’s minds. I’ve also enjoyed being the director.
of the race bikes and advocacy and medicine distinction pathway and working alongside a great group of faculty and resident coli.

And these are for residents in any of our three internal medicine programs, so the traditional internal medicine program, the primary care program that I work primarily in and then the medicine pediatric program, so it’s open to all all residents in any of those three tracks, and the idea is for it to be a deeper dive. To some of these social justice kinds of issues for people who want to
00:40:58.085 --> 00:41:00.402 engage more so they attend various
NOTE Confidence: 0.673880409615385
00:41:00.402 --> 00:41:02.530 forms of interactive didactic.
NOTE Confidence: 0.673880409615385
00:41:02.530 --> 00:41:04.690 In order to at the end of their
NOTE Confidence: 0.673880409615385
00:41:04.690 --> 00:41:06.030 tenure as a resident,
NOTE Confidence: 0.673880409615385
00:41:06.030 --> 00:41:08.718 they kind of graduate with distinction
NOTE Confidence: 0.673880409615385
00:41:08.718 --> 00:41:10.510 in this particular field,
NOTE Confidence: 0.673880409615385
00:41:10.510 --> 00:41:11.637 and it’s similar to the way that
NOTE Confidence: 0.673880409615385
00:41:11.637 --> 00:41:12.570 we think about distinction,
NOTE Confidence: 0.673880409615385
00:41:12.570 --> 00:41:15.230 pathways and other aspects.
NOTE Confidence: 0.673880409615385
00:41:15.230 --> 00:41:18.186 So we have investigations pathway.
NOTE Confidence: 0.673880409615385
00:41:18.186 --> 00:41:21.054 We have a clinical educator pathway.
NOTE Confidence: 0.673880409615385
00:41:21.060 --> 00:41:23.148 We have a global health and equity pathway.
NOTE Confidence: 0.673880409615385
00:41:23.150 --> 00:41:25.537 So really great as the most recent
NOTE Confidence: 0.673880409615385
00:41:25.537 --> 00:41:27.190 of these distinction pathways.
NOTE Confidence: 0.673880409615385
00:41:27.190 --> 00:41:29.005 To really elevate the importance
NOTE Confidence: 0.673880409615385
00:41:29.005 --> 00:41:30.820 of thinking about things along
the lines of race and bias.
On a large piece of that too,
is thinking about how we can provide
mentorship and professional develop
opportunities for for these residents.
Because a fair number of them are are
underrepresented in medicine themselves.
Looking forward,
I think somebody would love to
focus on in the Vice chief role in
the next year or two is thinking
about recruitment and retention.
I think we’ve certainly made some inroads
in terms of diversifying our trainees,
so it’s kind of work to do there.
But you know the the faculty level as I showed you in some earlier data, tends to be a really challenging. A kind of trend to shift, and so you know, thinking about what it looks like to to make sure that we're positioning ourselves in a position to diversify our faculty, and even to think about the experiences of those who are underrepresented in medicine to make sure that we're addressing any potential barriers. And then as a PD for DI and the primary care residency, I have a number of roles,
some of which are traditional APD rolls administratively, but also in education recruitment. Thinking about climate, I have a curriculum with the residents that runs three years in our ambulatory didactic curriculum where we dive into a lot of different interactive small group activities to help them understand the experiences of other people in the training program who may or may not look like them. And we always have incredibly rich conversations to think about our own identities and what that means.
Not only personally, but professionally. What that means when we interact with patients, so that’s always a really fun thing to work on. I’m grateful that we’ve done quite well when it comes to recruiting a diverse group of residents and that’s been a really integral part of our ethos. As a program with something that we very much prioritize. And of course, it’s not just recruitment.
the retention and making sure that the climate that these trainees are in one is one that actually encourages other folks to come and feel at home here and experience that sense of belonging. And I, I really enjoy that mentoring and advising peace, and that helping to advocate for people. That’s me so that they do feel like they belong. So as I wrap up here in the next few minutes, the thing about institutional next steps, you know, I think I always like to
emphasize that each of us,

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whatever our particular rules might be,

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there’s something that we can do

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as a next step in terms of

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adding our voice to this long term

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road to equity and to justice,

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and I think something that’s very

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clear to me is that institutions

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and sections and departments we all

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have to take ownership of diversity.

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You know,

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can’t be this thing where it’s relegated.

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The only people who have official

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DI position because diversity

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as we talked about is something

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that really benefits everyone.
It’s not just for underrepresented groups and so everyone has to be a part of the effort to really make sure that we’re meeting the challenges and improving ourselves consistently. I think in a lot of ways that we talk about institutional standard of excellence and in many things like patients safety and quality, we really need to have a similar mindset. A similar framework. When it comes to the EI, I also think that some of that racial burden that we talked about
where there’s that tax to
underrepresented individuals can be
minimized. If there’s more resources and
support to diversity initiatives and making
sure that people who may not feel like
they themselves have personally been the
recipients or bias for microaggressions.
They also of course have a very important
role to play in all of this too.
As an organization, I think some of the
things that come to mind is importance
of mandatory unconscious bias training.
Paris, Florence, who recently came to speak with our
Vice Chief DI Vice Chief Group,
is the inaugural director of DI Training
and development underneath Darren Lattimore and Darren Lattimore's, office of Diversity and inclusion at the Med School, and I think that's going to be really great. It's not mandatory yet, but I do think sometimes when these DI circles we kind of get to the this concept of preaching to the choir. The people who show up and engage in the topic are people who already bought in. So thinking about what it looks like to implement structures so that everyone can engage in these issues and ultimately helps
to cultivate our environment.

I think open forum to discuss these topics are really important sometimes with our residents will do town halls where we just have people reflect on what’s going on in the world.

Things would have happened in their own lives because it was clear to me in the study we did with those residents.

Oftentimes there aren’t adequate venues.

For people to process their feelings and their experiences, I also think it’s incredibly important to survey our trainees about their experiences because oftentimes they’re not coming forward unless being asked,
and so I think that needs to become a regular part of our culture. We talked about a strategic plan to increase diversity. I think that’s part of hiring those roles so people can build out those plans. Mentorship of underrepresented groups not only a faculty who look like them, but people who can be really informative. Allies and support folks who else to achieve their personal bests and then making sure, as I mentioned, that we support colleagues who do engage in diversity work and do in a way that’s not going to be a
detriment to their career advancement. On an individual level, I think there are a number of practices that we can also engage in. I think having awareness of our personal biases is something that’s extremely important. I mentioned in the Implicit Association test earlier, which I’m sure some of you have done in the past. I think it’s not a perfect test, but it’s a good way to think about some of that unconscious bias that might be lurking underneath the service, and I think that awareness was really
important first step and then helping to make sure that we’re changing our behavior when it comes to. Evaluations is something I hear a lot from the trainees who come and talk to me and debrief as as not always feeling like the feedback they get is is as fair and equitable as it could be, and wondering, you know, they do something or say something. Is it perceived in the same way as another trainee who does the same thing who looks differently from them and part of the majority?
And because of the data that we do know that shows those differences and how we're evaluating trainees, I think it's really important. When we are on the side of evaluating someone else to be clear about what the performance metrics are to be really specific in terms of behavior based language and not just say things like oh this person was a good fit or you know this person did a good job like what? Why are we saying someone does well or doesn’t do well?

Mindfulness is an interesting
00:48:15.396 --> 00:48:17.490 point at actually read a study

00:48:17.549 --> 00:48:19.089 about how mindfulness can help

00:48:19.089 --> 00:48:21.271 to disrupt some of the fast brain

00:48:21.271 --> 00:48:23.301 connections that we that we make and

00:48:23.301 --> 00:48:25.560 so engaging in mindfulness can do.

00:48:25.560 --> 00:48:27.015 Some ways help to attenuate

00:48:27.015 --> 00:48:27.888 that implicit bias,

00:48:27.890 --> 00:48:30.014 which is really important in the

00:48:30.014 --> 00:48:31.430 complex cognitive environment that

00:48:31.492 --> 00:48:33.476 we all live and work in and then

00:48:33.476 --> 00:48:35.514 thinking about how you can stand the

00:48:35.514 --> 00:48:36.994 diversity work in your department.

00:48:37.000 --> 00:48:38.771 I know from Pam that there’s some

00:48:38.771 --> 00:48:40.372 great things that are that are

00:48:40.372 --> 00:48:41.950 happening already and maybe if if

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you’ve been on the sidelines and you don’t feel like the expert. The room is 5.
Still something that you can contribute, and doing that having that effort of increasing your personal growth and stepping out of your comfort zone and joining in the work can only yield good things.
The last thought here, I really think a lot of the what I talked about today is ultimately a Wellness issue.
I think representation and experience are very much interdependent.
You know,
00:49:08.038 --> 00:49:09.433 for making all these efforts
00:49:09.433 --> 00:49:11.059 to recruit and retain people,
00:49:11.060 --> 00:49:13.308 but we’re not doing the work that
00:49:13.308 --> 00:49:15.942 we need to do to create a kind of
00:49:15.942 --> 00:49:17.680 climate where people feel welcome.
00:49:17.680 --> 00:49:18.316 Then of course,
00:49:18.316 --> 00:49:19.800 it’s not going to be successful.
00:49:19.800 --> 00:49:21.844 So we really need to think about
00:49:21.844 --> 00:49:23.799 those efforts as very much linked.
00:49:23.800 --> 00:49:24.844 I would also encourage you before
00:49:24.844 --> 00:49:26.139 we get to the questions here,
00:49:26.140 --> 00:49:27.967 just to take a moment of silent
00:49:27.967 --> 00:49:29.417 reflection and think about how
00:49:29.417 --> 00:49:30.957 you can do something differently.
00:49:30.960 --> 00:49:31.542 Moving forward,
you know maybe it’s a simple step like a book you want to read, or a colleague you want to talk to about their experience joining us Diversity Committee. You know, doing something different, but I think there’s constantly something to do in this larger journey towards justice and we we all can make those decisions to move forward. A few resources, but I’ll leave you with some books that I’ve read that I think are give a nice lens to thinking about some of these issues. The double AMC that second
00:50:01.255 --> 00:50:02.600 bullet bear has great portal

00:50:02.657 --> 00:50:04.029 on physician workforce data,

00:50:04.030 --> 00:50:05.398 so if you are interested in

00:50:05.398 --> 00:50:06.869 some of those trends or wanted

00:50:06.869 --> 00:50:08.381 to look up how the healthcare

00:50:08.381 --> 00:50:10.126 profession is doing in terms of

00:50:10.126 --> 00:50:11.314 diversity and inclusion efforts,

00:50:11.320 --> 00:50:13.348 there’s some really great

00:50:13.348 --> 00:50:15.376 resources there as well.

00:50:15.380 --> 00:50:18.656 And with that I will stop sharing my screen.

00:50:18.660 --> 00:50:20.740 I think you found my free time and

00:50:20.740 --> 00:50:22.620 I’m happy to take any questions.

00:50:25.340 --> 00:50:27.264 Thank you so much,

00:50:27.264 --> 00:50:29.555 that was wonderful to hear a little

00:50:29.555 --> 00:50:31.370 bit more about your research and some

101
action items that I think we can all take. So what I thought I would do is turn.

There’s actually a great first question we can take from the chat, so this is the question is what is the approach to addressing patients bias and aggression? It seems we have strong efforts in place in regards to faculty development, but how do we approach patients? It’s difficult to speak back to patients and that’s a great question. And in fact, I’ll just editorialize a little bit I. I have personally found and observed that we’ve seen more patient bad
00:51:03.290 --> 00:51:05.666 behavior in the era of COVID, and I think it’s a struggle.

00:51:08.790 --> 00:51:10.694 I’d love to hear your thoughts on this.

00:51:12.040 --> 00:51:13.942 Yeah, this is such an important question and it’s something that I love to talk to people about as well, because, you know, some of you might be familiar with the term of bystander response training, or more recently, we call it upstander response training because we want to make it more proactive.

00:51:19.159 --> 00:51:20.949 but there is really such an important role when it is the patient who is being something inappropriate and I’ve had, you know, in our program as a graduate.
00:51:35.120 --> 00:51:37.227 of our Yale Primary care program
NOTE Confidence: 0.83095670985
00:51:37.227 --> 00:51:39.408 who was actually called the N word
NOTE Confidence: 0.83095670985
00:51:39.408 --> 00:51:40.828 on our inpatient General Medical
NOTE Confidence: 0.83095670985
00:51:40.828 --> 00:51:42.029 service by a patient.
NOTE Confidence: 0.83095670985
00:51:42.029 --> 00:51:42.727 And literally,
NOTE Confidence: 0.83095670985
00:51:42.727 --> 00:51:45.170 no one in the room said anything,
NOTE Confidence: 0.83095670985
00:51:45.170 --> 00:51:46.843 even though there are about five or
NOTE Confidence: 0.83095670985
00:51:46.843 --> 00:51:48.104 six other health care professionals
NOTE Confidence: 0.83095670985
00:51:48.104 --> 00:51:49.586 in the room at the time.
NOTE Confidence: 0.83095670985
00:51:49.590 --> 00:51:51.786 So I think this is critical in terms of,
NOTE Confidence: 0.83095670985
00:51:51.790 --> 00:51:54.280 you know,
NOTE Confidence: 0.83095670985
00:51:54.280 --> 00:51:57.370 can really make or break anyone’s experience.
NOTE Confidence: 0.83095670985
00:51:57.370 --> 00:51:59.044 But of course,
NOTE Confidence: 0.83095670985
00:51:59.044 --> 00:52:00.922 this is that it’s very important
to be direct with patients.

I think you can be both direct and respectful. Oftentimes.

What I’ll do is I’ll employ strategies that encourage the person who made a comment to reflect.

So I’ll say something. For example, you know what did you mean by that, or what made you say that, and I think that signals that what was said is not OK and put that person in the position of explaining why they made it.
00:52:27.712 --> 00:52:29.500 can lead to a teachable moment.
NOTE Confidence: 0.83095670985
00:52:29.500 --> 00:52:31.474 Sometimes you know you can have a
NOTE Confidence: 0.83095670985
00:52:31.474 --> 00:52:33.295 strategy where you acknowledge that the
NOTE Confidence: 0.83095670985
00:52:33.295 --> 00:52:35.423 person may not have had bad intent,
NOTE Confidence: 0.83095670985
00:52:35.430 --> 00:52:36.900 but there’s still a bad impact,
NOTE Confidence: 0.83095670985
00:52:36.900 --> 00:52:37.660 and so you know.
NOTE Confidence: 0.83095670985
00:52:37.660 --> 00:52:39.296 I mean, I know you may not have meant harm,
NOTE Confidence: 0.83095670985
00:52:39.300 --> 00:52:40.626 or you may not have realized
NOTE Confidence: 0.83095670985
00:52:40.626 --> 00:52:42.010 that your words were offensive,
NOTE Confidence: 0.83095670985
00:52:42.010 --> 00:52:43.658 but that was actually really hurtful to me.
NOTE Confidence: 0.83095670985
00:52:43.660 --> 00:52:44.140 Or really.
NOTE Confidence: 0.83095670985
00:52:44.140 --> 00:52:44.860 Bothersome to me,
NOTE Confidence: 0.83095670985
00:52:44.860 --> 00:52:47.968 and here’s why I’m hoping to engage.
NOTE Confidence: 0.83095670985
00:52:47.970 --> 00:52:49.510 There are many other states you’ve got,
NOTE Confidence: 0.83095670985
00:52:49.510 --> 00:52:50.370 I’ll leave it at that.
NOTE Confidence: 0.83095670985
00:52:50.370 --> 00:52:53.652 I think sometimes if a patient’s
particularly antagonistic, something something I’ll do if they don’t seem open to education is just remind them of our sort of institutional values. Saying something like an institution like, yeah, it’s very important. We all embody this these ideas of respect and accountability and compassion our team is treating you that way. We very much expect those same kinds of values and return. So please respect every member of our team and then transition to talking about you know the blood pressure.
or whatever the situation might be.

NOTE Confidence: 0.71838246

Thank you, I’d love to turn

NOTE Confidence: 0.71838246

to Doctor Barbara Burtness,

NOTE Confidence: 0.71838246

who’s serving as our interim associate

NOTE Confidence: 0.71838246

director for DI for the Cancer Center.

NOTE Confidence: 0.71838246

So Barbara and I partner on a

NOTE Confidence: 0.71838246

lot of these efforts so Barbara,

NOTE Confidence: 0.71838246

any comments or questions.

NOTE Confidence: 0.83919742625

First of all, I want to thank you for

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coming and and sharing with us.

NOTE Confidence: 0.83919742625

And for the work that you do,

NOTE Confidence: 0.83919742625

what I particularly loved was.

NOTE Confidence: 0.83919742625

You you know your your message that

NOTE Confidence: 0.83919742625

implicit bias is not cast in stone,

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that this is something that over

NOTE Confidence: 0.83919742625

time you can see progress on you know.
Obviously you brought forward an example with college students in the same way it gets harder to learn a new language when you get older. It's probably harder to let go of these habits that people have had over the years. But I wanted to and I loved your emphasis on repeated exposure to counter stereotypic examples. And obviously representation is part of that.
NOTE Confidence: 0.83919742625

I think is is one of the reasons we like to do this, but I I guess I. I struggle with issues like to what extent can you require people to do implicit bias training? What’s the backlash and the resentment that that creates. And you know, I just took a quick look at who the attendees are for today’s grand rounds. And it’s a lot of people who already work on these issues. So apart from working on our artwork,
working on who we invite is speakers.

Do you have any concrete strategies for kind of?

Breaking across to groups where these biases are more solidified I guess.

Yeah, I mean it’s completely resonates with me because it’s tough and I, as many of these workshops as the first that I do it. Oftentimes the people in the audience are people who are already very much bought in, and so we have the same, you know, problem in general medicine. I think there are few things right, I think.
Even though it can be a little uncomfortable to mandate training, I do think you know there is precedent for it. You know, we all have to undergo sexual harassment training. We all have to go, you know, go through training on how to decrease certain infections in the hospital and know the response to a code. And you know all those kinds of things that we’re required to do. I do think there’s a way in which the training that we decide are mandatory for any employee are.
can send a message about what we think is really important. Umm?
That aside, you know I think this, like larger question is,
how do you engage individuals who who may not be particularly excited about doing the equity and inclusion?
One size that I often use with the residence is. Trying to engage in as many small group activities as possible because I find that for people who may be a little bit resistant to the topic, it’s a lot easier for them to learn if they hear their peer talk.
about something that happened to them personally because they care about their peer right and so. Oftentimes in my the curriculum I mentioned that I do feel primary care residents very little of it is didactic. You know, I'm not here. The residents I'm not talking for an hour, but I'm doing is. I'm creating structured opportunities for them to reflect and then share. So, for example, you know we'll do an activity where we write down our name on a piece of paper, and then we think about 7 identities.
That means something to us that can be raised, gender, ability, religion, whatever. Defined it for an individual and I just asked two simple questions. One is described, you know, a time that you were proud to be part of one of these identities and describe the time that it was painful for you to be part of these identities. So I'm always amazed by the richness of the conversation that comes from such a simple activity. And I've witnessed,
like people sort of light bulbs go off when you know someone, for example, shares a painful time when they were members of certain community, and what that means and what you know the things that they have to think about is it creates an opportunity for someone to be in someone else’s shoes, and I think that’s a the more accessible way to engage in DI issues. For someone who you know is not going to attend the grand rounds or something on the topic. Ava, thank you. We are at time.
So I we could go on probably for a while longer with questions, but I’m certainly leaving feeling inspired, motivated and really hopeful about this work that can be hard and slow going. So thank you for sharing kind of your vision with us, and I’m sure I certainly learned a lot and I’m sure our audience did too. So thank you so much for joining us. Great, thank you so much for having the opportunity. Thank you. Have a great afternoon everyone.