Advancing Health Equity through Well-Being and Inclusion

Yue-Yung Hu, MD, MPH
Associate Professor
Ann & Robert H. Lurie Children's Hospital
Northwestern University

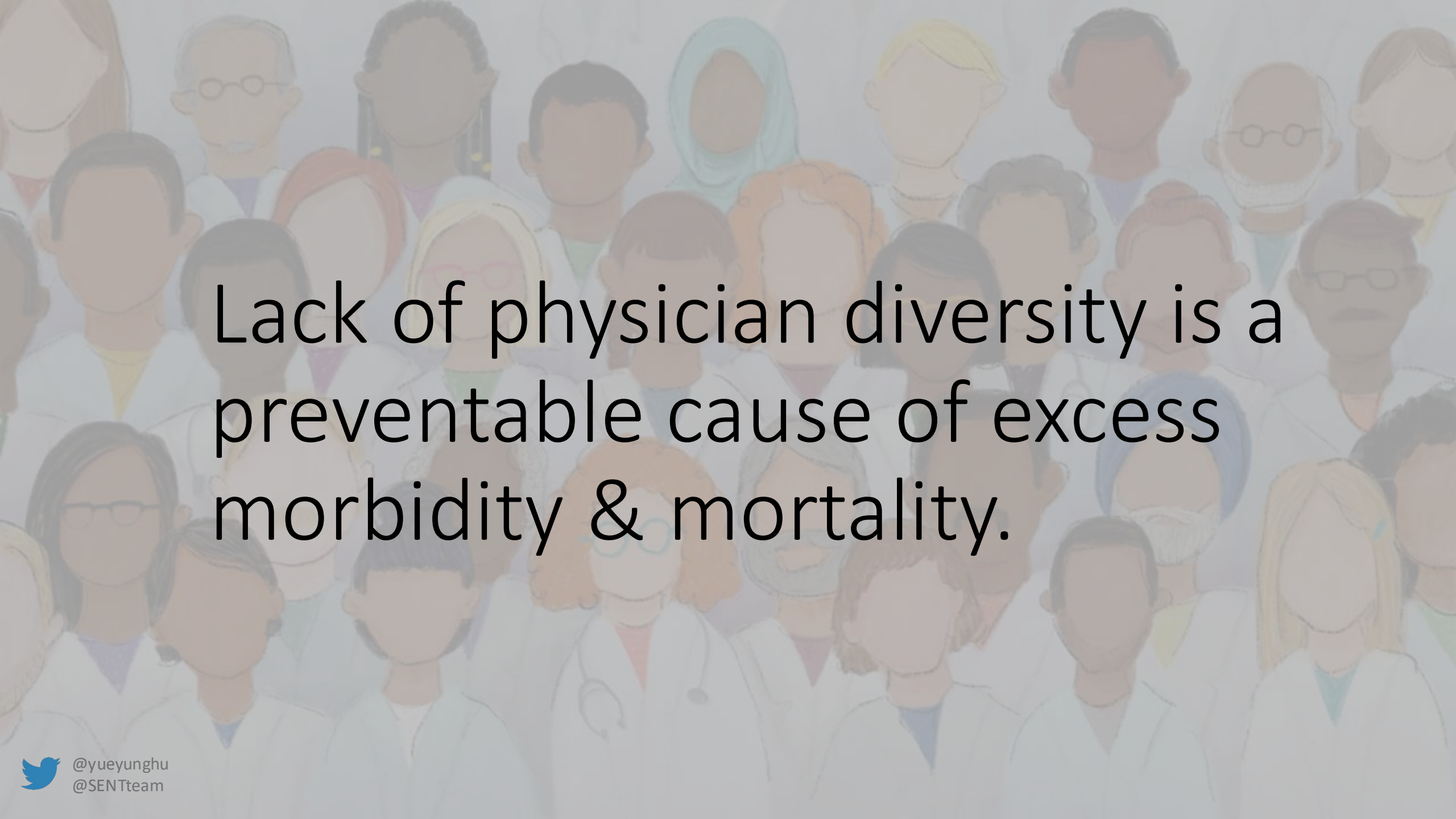
Disclosures

- Funders

K08 HS029532

- Collaborators

@yueyunghu
@SENTteam



Lack of physician diversity is a preventable cause of excess morbidity & mortality.

Diversity Improves Access to Care for Underserved

JAMA I

February 2014

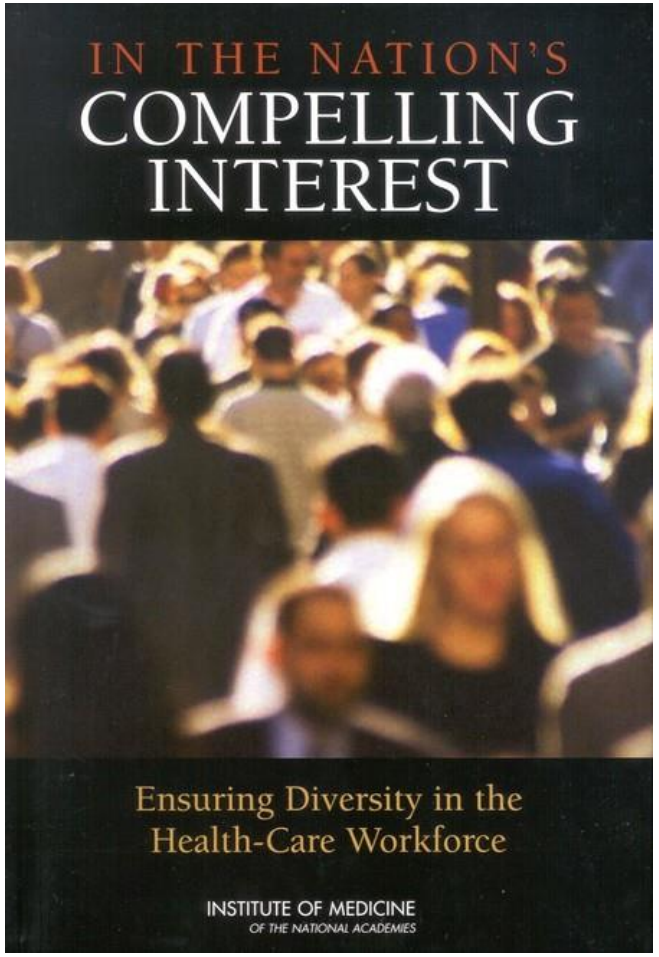
Minority Phy
Underserve
Diversifying
Be Key in Ad

Lyndonna M. Marrast, MD[1]; Le

Patient Characteristic	No. (%) Millions of Patients With a White Physician	Millions of Patients With a Black Physician	Unadjusted Odds Ratio (95% CI)[a]	Millions of Patients With a Hispanic Physician, No. (%)	Unadjusted Odds Ratio (95% CI)[b]	Millions of Patients With an Asian Physician, No. (%)	Unadjusted Odds Ratio (95% CI)[c]
All patients	62.2 (100.0)	3.3 (100.0)		5.9 (100.0)		9.8 (100.0)	
Non-Hispanic whites	53.2 (86.8)	1.1 (34.7)	1 [Reference]	2.4 (41.5)	1 [Reference]	5.2 (53.7)	1 [Reference]
Minorities	9.0 (13.2)	2.2 (65.3)	12.30 (8.30-18.00)	3.5 (58.5)	8.20 (5.98-11.23)	4.6 (46.3)	5.40 (4.16-6.99)
Black, non-Hispanic	4.1 (7.1)	1.9 (63.9)	23.24 (16.28-33.17)	0.5 (16.8)	2.65 (1.81-3.87)	1.0 (16.3)	2.56 (1.90-3.44)
Hispanic	3.1 (5.5)	0.1 (5.3)	0.96 (0.49-1.88)	2.7 (52.6)	19.04 (13.47-26.93)	1.1 (17.7)	3.68 (2.62-5.18)
Asian	0.9 (1.7)	0.1 (5.1)	3.06 (1.15-8.17)	0.3 (9.0)	5.63 (2.67 -11.86)	2.3 (31.2)	25.73 (16.92 -39 .13)
Other	0.9 (1.7)	0.1 (7.4)	4.60 (1.78-11.94)	0.02 (1.1)	0.61 (0.17 -2.15)	0.2 (3.8)	2.25 (1.19-4.25)
Income							
High/middle	48.9 (78.5)	2.1 (64.5)	1 [Reference]	3.9 (65.5)	1 [Reference]	7.0 (70.9)	1 [Reference]
Low	13.4 (21.5)	1.2 (35.5)	2.03 (1.46-2.75)	2.1 (34.5)	1.92 (1.44-2.55)	2.8 (29.1)	1.49 (1.23-1.81)
Medicaid							
None	54.8 (93.2)	2.5 (78.4)	1 [Reference]	4.4 (81.8)	1 [Reference]	7.9 (85.2)	1 [Reference]
Medicaid	4.0 (6.8)	0.7 (21.6)	3.75 (2.72-5.18)	1.0 (18.2)	3.04 (2.29-4.04)	1.4 (14.8)	2.38 (1.85-3.06)
Any health insurance	58.8 (94.3)	3.1 (95.2)	1 [Reference]	5.4 (90.1)	1 [Reference]	9.3 (94.0)	1 [Reference]
Uninsured	3.5 (5.7)	0.1 (4.8)	0.83 (0.49-1.41)	0.6 (9.9)	1.83 (1.30-2.57)	0.6 (6.0)	1.07 (0.78-1.47)
English home language	60.6 (97.3)	3.2 (96.8)	1 [Reference]	3.9 (66.7)	1 [Reference]	7.9 (80.4)	1 [Reference]
Non-English home language	1.7 (2.7)	0.1 (3.2)	1.18 (0.51-2.69)	2.1 (33.4)	17.83 (12.80-24.82)	1.9 (19.6)	8.69 (6.19-12.19)

@yueyunghu
@SENTteam

Patient-Provider Concordance Improves Care Processes



2004

ASA PAPER

Ensuring Equity, Diversity, and Inclusion in Academic Surgery

An American Surgical Association White Paper

Michaela A. West, MD, PhD, FACS, Shelley Hwang, MD, MPH, FACS,† Ronald V. Maier, MD, FACS,‡ Nita Ahuja, MD, FACS,§ Peter Angelos, MD, PhD, FACS,¶ Barbara L. Bass, MD, FACS,|| Karen J. Brasel, MD, FACS,** Herbert Chen, MD, FACS,†† Kimberly A. Davis, MD, FACS,§ Timothy J. Eberlein, MD, FACS,‡‡ Yuman Fong, MD, FACS,§§ Caprice C. Greenberg, MD, MPH, FACS,¶¶ Keith D. Lillemoe, MD, FACS,|||| Mary C. McCarthy, MD, FACS,*** Fabrizio Michelassi, MD, FACS,††† Patricia J. Numann, MD, FACS,‡‡‡ Sareh Parangi, MD, FACS,|||| Jorge D. Reyes, MD, FACS,‡ Hilary A. Sanfey, MB, BCh, MHPE, FACS,§§§ Steven C. Stain, MD, FACS,¶¶¶ Ronald J. Weigel, MD, PhD, FACS,|||||| and Sherry M. Wren, MD, FACS*****

Objective: The leadership of the American Surgical Association (ASA) appointed a Task Force to objectively address issues related to equity, diversity, and inclusion with the discipline of academic surgery.

Summary of Background Data: Surgeons and the discipline of surgery, particularly academic surgery, have a tradition of leadership both in medicine and society. Currently, we are being challenged to harness our innate curiosity, hard work, and perseverance to address the historically significant deficiencies within our field in the areas of diversity, equity, and inclusion.

Methods: The ASA leadership requested members to volunteer to serve on a Task Force to comprehensively address equity, diversity, and inclusion in academic surgery. Nine work groups reviewed the current literature, performed primary qualitative interviews, and distilled available guidelines and published primary source materials. A work product was created and published on the ASA Website and made available to the public. The full work product was summarized into this White Paper.

Results: The ASA has produced a handbook entitled: Ensuring Equity, Diversity, and Inclusion in Academic Surgery, which identifies issues and challenges, and develops a set of solutions and benchmarks to aid the academic surgical community in achieving these goals.

Conclusion: Surgery must identify areas for improvement and work iteratively to address and correct past deficiencies. This requires honest and ongoing identification and correction of implicit and explicit biases. Increasing diversity in our departments, residencies, and universities will improve patient care, enhance productivity, augment community connections, and achieve our most fundamental ambition—doing good for our patients.

Keywords: bullying, discrimination, diversity, equality, equity, faculty recruitment, inclusion, LGBTQ, medical ethics, microaggression, surgery faculty, surgical education

(*Ann Surg* 2018;268:403–407)

From the *Department of Surgery, University of Minnesota, North Memorial Health, Minneapolis, MN; †Department of Surgery, Duke University, Durham, NC; ‡Department of Surgery, University of Washington, Seattle, WA; §Department of Surgery, Yale School of Medicine, New Haven, CT; ¶Department of Surgery, University of Chicago, Chicago, IL; ||Department of Surgery, The Methodist Hospital, Houston, TX; **Department of Surgery, University of Oregon Health Sciences University, Portland, OR; ††Department of Surgery, University of Alabama, Birmingham, AL; ‡‡Department of Surgery, Washington University School of Medicine, St. Louis, MO; §§Department of Surgery, City of Hope Cancer Center, Duarte, CA; ¶¶Department of Surgery, University of Wisconsin, Madison, WI; ||||Department of Surgery, Massachusetts General Hospital, Boston, MA; ***Department of Surgery, Wright State University School of Medicine, Detroit, MI; †††Department of Surgery, Weill Cornell Medical College, New York, NY; ‡‡‡Department of Surgery, Upstate Medical University, Syracuse, NY; §§§Department of Surgery, Southern Illinois University, Springfield, IL; ¶¶¶Department of Surgery, Albany Medical College, Albany, NY; ||||||Department of, University of Iowa, Iowa City, IA; and ****Department of Surgery, Stanford University School of Medicine, Palo Alto, CA.

Drs Hwang and West contributed equally to the primary authorship of this document.

The authors report no conflicts of interest.

Reprints: Michaela A. West, MD, PhD, FACS, 3300 Oakdale Blvd, Minneapolis, MN 55422. E-mail: westmichaela@outlook.com.

ISSN: 0003-4932/18/26803-0403
DOI: 10.1097/SLA.0000000000002937

In October 2017, the leadership of the American Surgical Association (ASA) identified increasing diversity in the surgical workforce as a priority of the Association and approved the preparation of a handbook to aid departments of surgery in achieving this aim. A call for volunteers was extended to the ASA membership, and a roster of contributing authors was selected, led by Dr Ronald Maier. Over 3 months, the committee compiled a comprehensive document entitled: Ensuring Equity, Diversity, and Inclusion in Academic Surgery. The aim of this document is to serve as a practical reference for surgical departments and institutions as they work to address this critical issue. The following is a summary of the handbook, which can be downloaded in full at: http://www.americansurgical.org/equity/.

Ensuring Equity, Diversity, and Inclusion: An Academic Surgery Imperative

The demographics of the United States are changing and the country is becoming more racially and ethnically diverse.[1] In 2003, the Association of American Medical Colleges (AAMC) adopted the following definition: "Under-Represented in Medicine (URiM) means those racial and ethnic populations that are under-represented in the medical profession relative to their numbers in the general population."[2] Evidence from the AAMC and the Accreditation Council for Graduate Medical Education (ACGME) shows far fewer women and URiM faculty in surgery departments than in the general population.[3] Women and racial/ethnic minorities have had fewer opportunities to enter academic surgery and they encounter more academic career challenges than their white male counterparts. Less data are available for the lesbian, gay, bisexual, transgender (LGBT) community or disabled surgeons, but few success stories can be identified.

2018

- Patient satisfaction
- Participatory decision-making
- Use of services
- Treatment adherence

…and Outcomes

Original Investigation

August 30, 2023

JAMA Surgery

Surgeon Sex and Long-Term Postoperative Outcomes Among Patients Undergoing Common Surgeries

PNAS RESEARCH ARTICLE | ECONOMIC SCIENCES

Patient–physician gender concordance and increased mortality among female heart attack patients

Brad N. Greenwood[a,1], Seth Carnahan[b], and Laura Huang[c]

MSc[1]; et al

PNAS RESEARCH ARTICLE | ECONOMIC SCIENCES

Physician–patient racial concordance and disparities in birthing mortality for newborns

Brad N. Greenwood [a,2,1], Rachel R. Hardeman [b,1], Laura Huang [c,1], and Aaron Sojourner [d,1]

- Surgical complications
- Mortality
- Not just due to trust or communication

Diversity Improves Care Beyond Concordance

- Exposure to diverse colleagues in med school reduces implicit & explicit bias expression in residency

Onyeador, Psychol Sci 2020

- Patients treated by women physicians may have better outcomes
  - Readmission
  - Mortality
  - Surgical complications

Tsugawa JAMA Intern Med 2017
Wallis, BMJ 2017

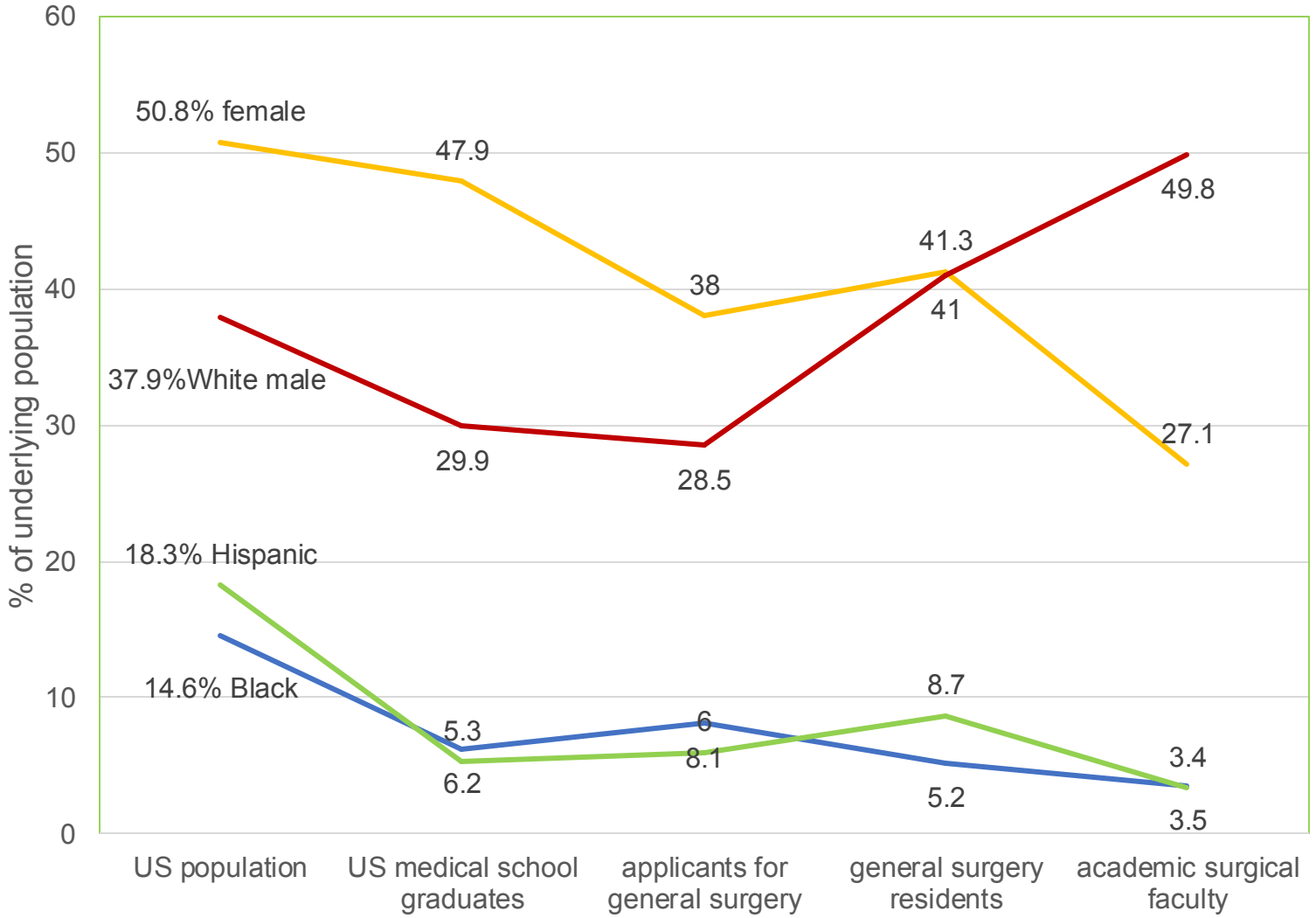
Failure to Retain Diversity

- Majority of DEI efforts in surgery around recruitment
- AAMC surgical residency programs' resident censuses x 18y
  - Recruitment
    - Women increased by 31.5%
    - URiMs decreased by 2.1%
  - All-cause attrition in gen surg
    - Women RR 1.33 (95% CI 1.24-1.42)
    - URiM RR 1.13 (95% CI 1.04-1.23)
  - Unintended attrition (dismissal) in gen surg
    - Women RR 1.31 (95% CI 1.17-1.47)
    - URiM RR 1.54 (95% CI 1.35-1.76)

Rajaguru, JACS 2022

Haruno, JAMA Surg 2023

Failure to Retain Diversity



US Census Bureau 2019
Choinski, JAMA Surg 2020
Brotherton, JAMA 2019
AAMC 2020

@yueyunghu
@SENTteam

How do we retain talent?

Surgical Education Numbered Trials

Data Sources

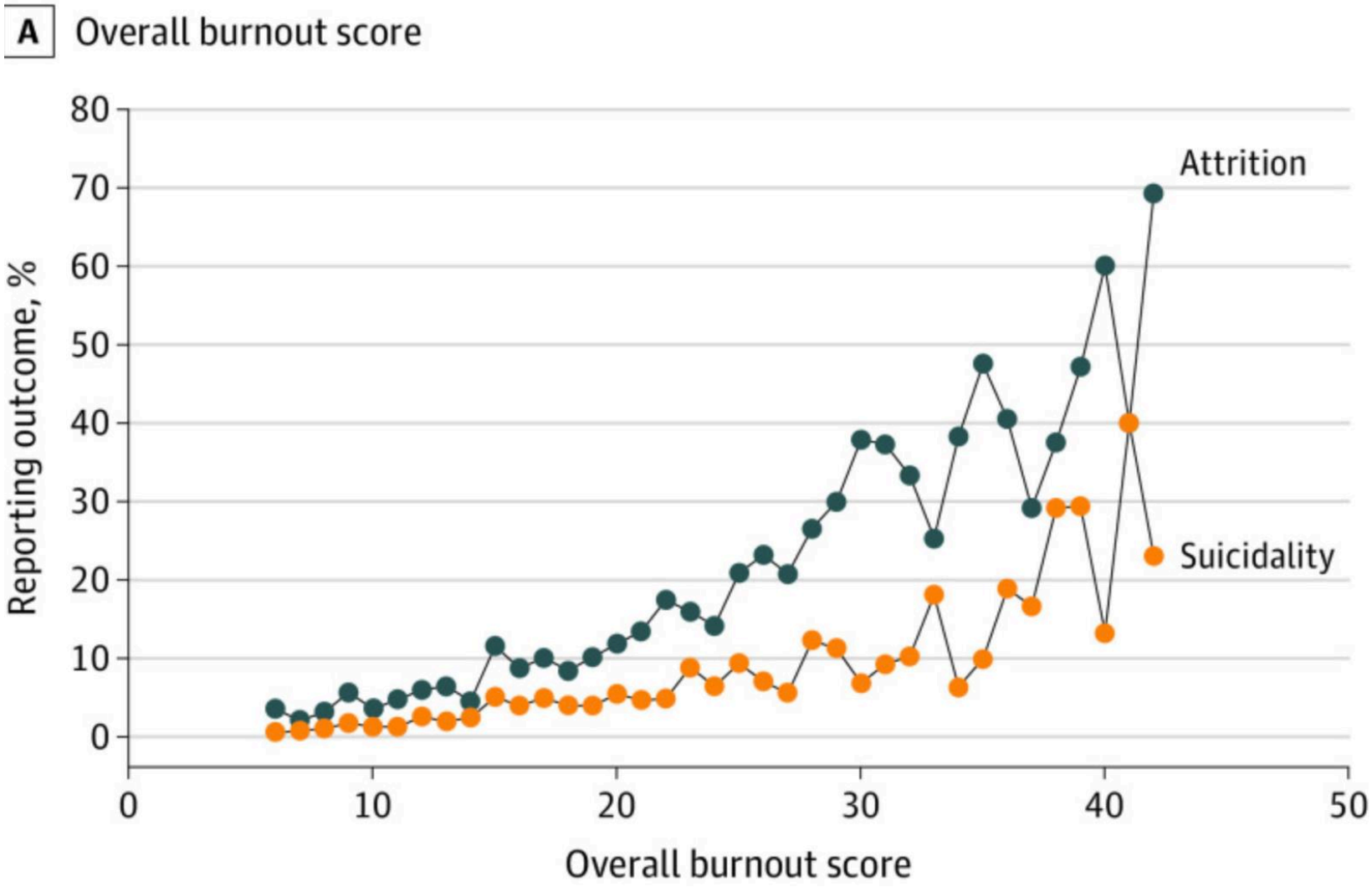
- Quantitative
  - Survey after the American Board of Surgery In-Training Exam (ABSITE)
  - All clinically active residents training in ACGME-accredited programs
  - Elective, confidential
  - N=6826-7415
  - Response rate 77-99%

- Qualitative
  - 15 general surgery program tours
  - 398 interviews & focus groups
  - Deductively & inductively coded

  - Recent PD & VC DEI (Zoom)

@yueyunghu
@SENTteam

Burnout Drives Attrition



Brock Hewitt, MD MPH
JAMA Surg 2020

@yueyunghu
@SENTteam

What drives burnout?

FIRST Trial

The NEW ENGLAND JOURNAL of MEDICINE

ESTABLISHED IN 1812 FEBRUARY 25, 2016 VOL. 374 NO. 8

National Cluster-Randomized Trial of Duty-Hour Flexibility in Surgical Training

Karl Y. Bilimoria, M.D., M.S.C.I., Jeanette W. Chung, Ph.D., Larry V. Hedges, Ph.D., Allison R. Dahlke, M.P.H., Remi Love, B.S., Mark E. Cohen, Ph.D., David B. Hoyt, M.D., Anthony D. Yang, M.D., John L. Tarpley, M.D., John D. Mellinger, M.D., David M. Mahvi, M.D., Rachel R. Kelz, M.D., M.S.C.E., Clifford Y. Ko, M.D., M.S.H.S., David D. Odell, M.D., M.M.Sc., Jonah J. Stulberg, M.D., Ph.D., M.P.H., and Frank R. Lewis, M.D.

ABSTRACT

BACKGROUND

Concerns persist regarding the effect of current surgical resident duty-hour policies on patient outcomes, resident education, and resident well-being.

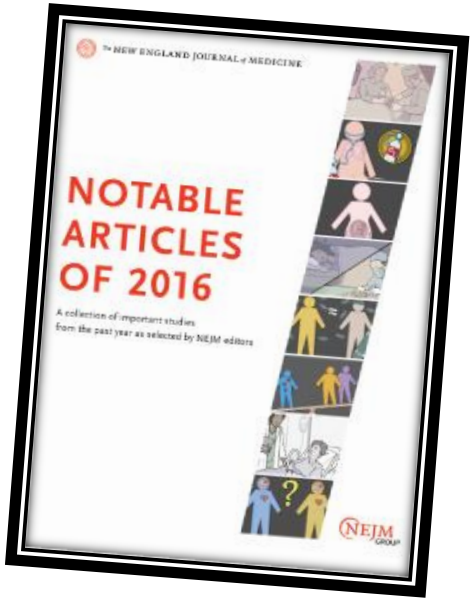
METHODS

We conducted a national, cluster-randomized, pragmatic, noninferiority trial involving 117 general surgery residency programs in the United States (2014–2015 academic year). Programs were randomly assigned to current Accreditation Council for Graduate Medical Education (ACGME) duty-hour policies (standard-policy group) or more flexible policies that waived rules on maximum shift lengths and time off between shifts (flexible-policy group). Outcomes included the 30-day rate of postoperative death or serious complications (primary outcome), other postoperative complications, and resident perceptions and satisfaction regarding their well-being, education, and patient care.

RESULTS

In an analysis of data from 138,691 patients, flexible, less-restrictive duty-hour policies

From the Surgical Outcomes and Quality Improvement Center (SOQIC), Department of Surgery and Center for Healthcare Studies, Feinberg School of Medicine and Northwestern Medicine, Northwestern University (K.Y.B., J.W.C., A.R.D., R.L., A.D.Y., D.M.M., D.D.O., J.J.S.), and the American College of Surgeons (K.Y.B., M.E.C., D.B.H., C.Y.K.), Chicago, the Department of Statistics, Northwestern University, Evanston (L.V.H.), and the Department of Surgery, Southern Illinois University, Springfield (J.D.M.) — all in Illinois; the Department of Surgery, Vanderbilt University, Nashville (J.L.T.); the Department of Surgery and the Center for Surgery and Health Economics, Perelman School of Medicine, University



Karl Bilimoria, MD MS

@yueyunghu
@SENTteam

Intervention = Eliminating Duty Hours Restrictions

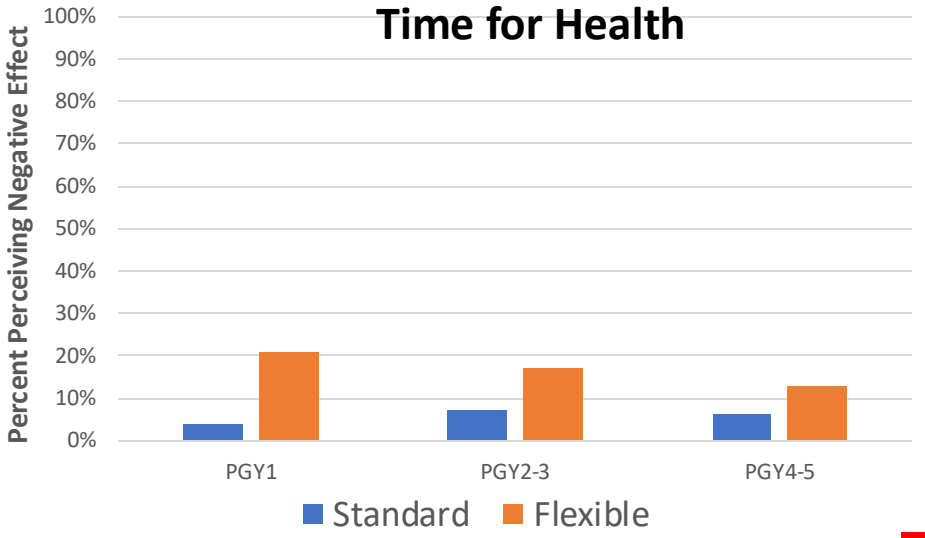
YEAR	STANDARD POLICY	FLEXIBLE POLICY
2003	Maximum of 24 hours duty with an additional 4 hours for transitions in care	Eliminated
2003	At least 8-10 hours off after a regular shift	Eliminated
2011	PGY-1 resident duty periods must not exceed 16 hours	Eliminated
2011	Residents must have 14 hours off after 24 hours in-house duty	Eliminated

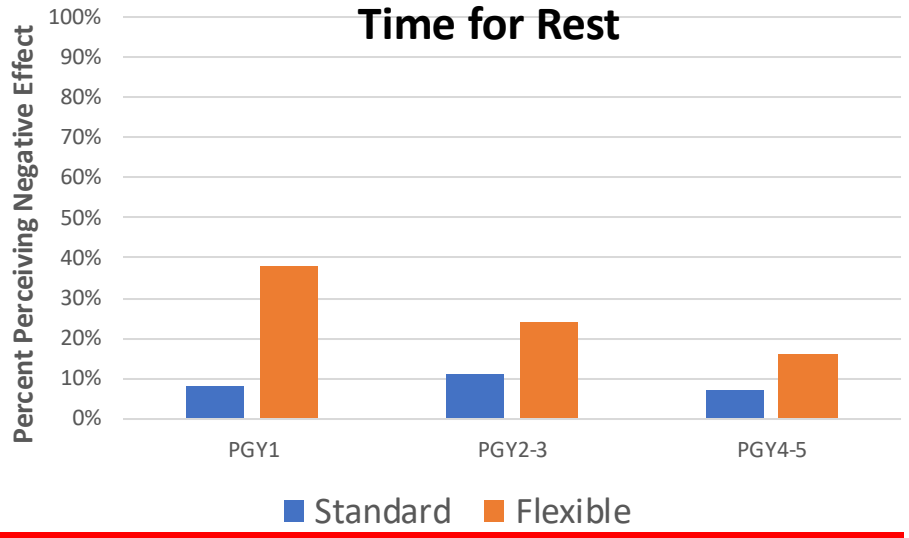
Better Well-Being Despite Less Time Off

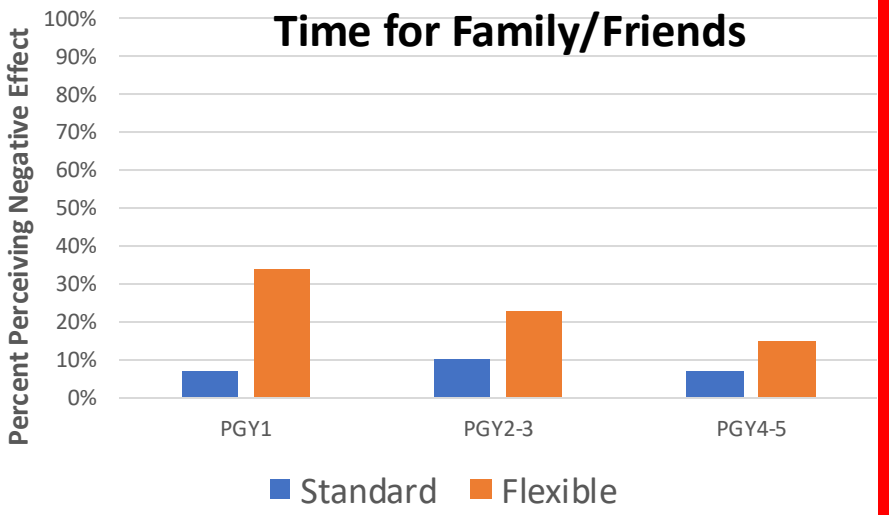
Tony Yang, MD MS

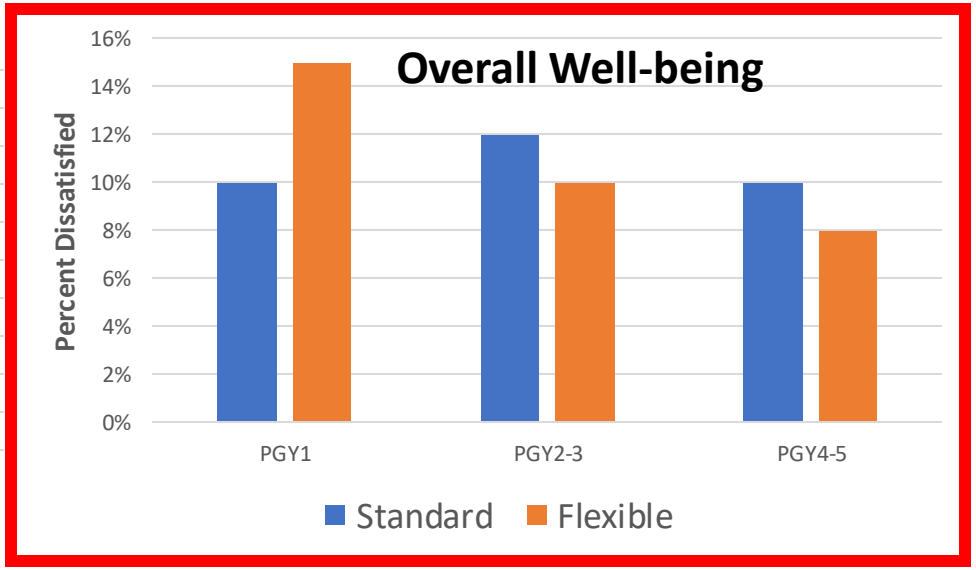
JACS 2017

@yueyunghu
@SENTteam



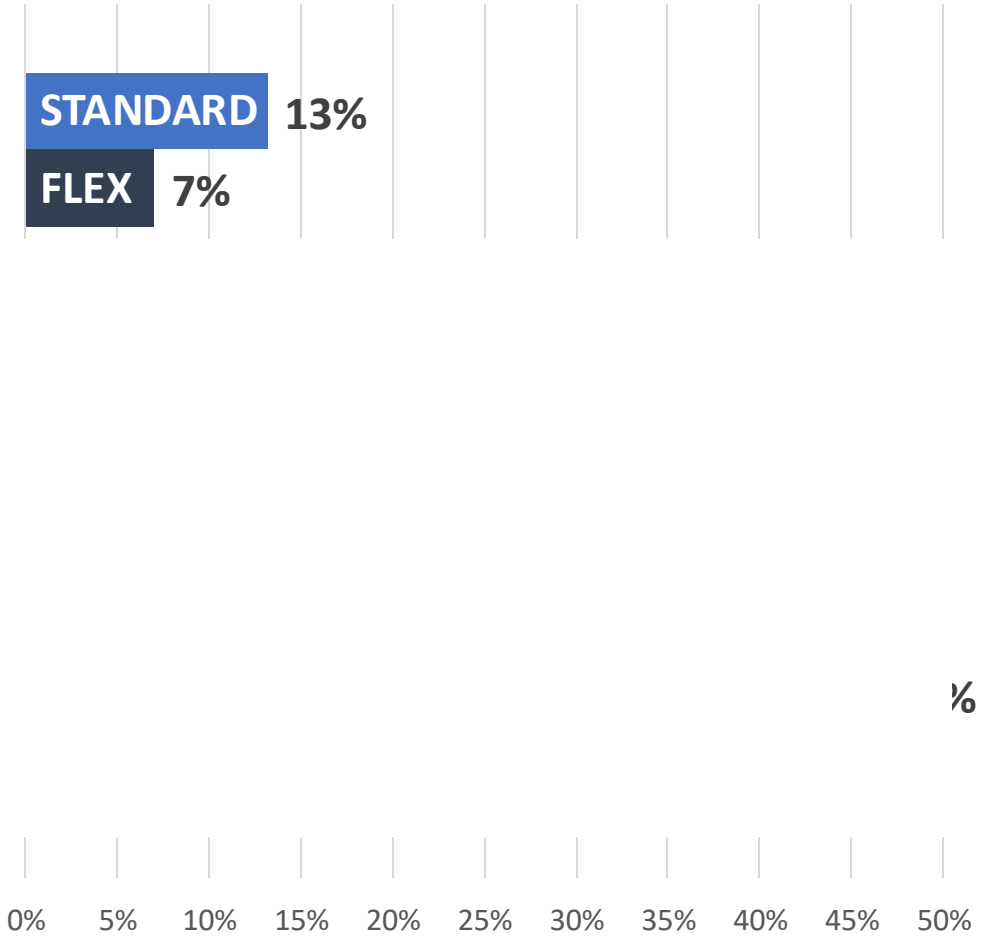






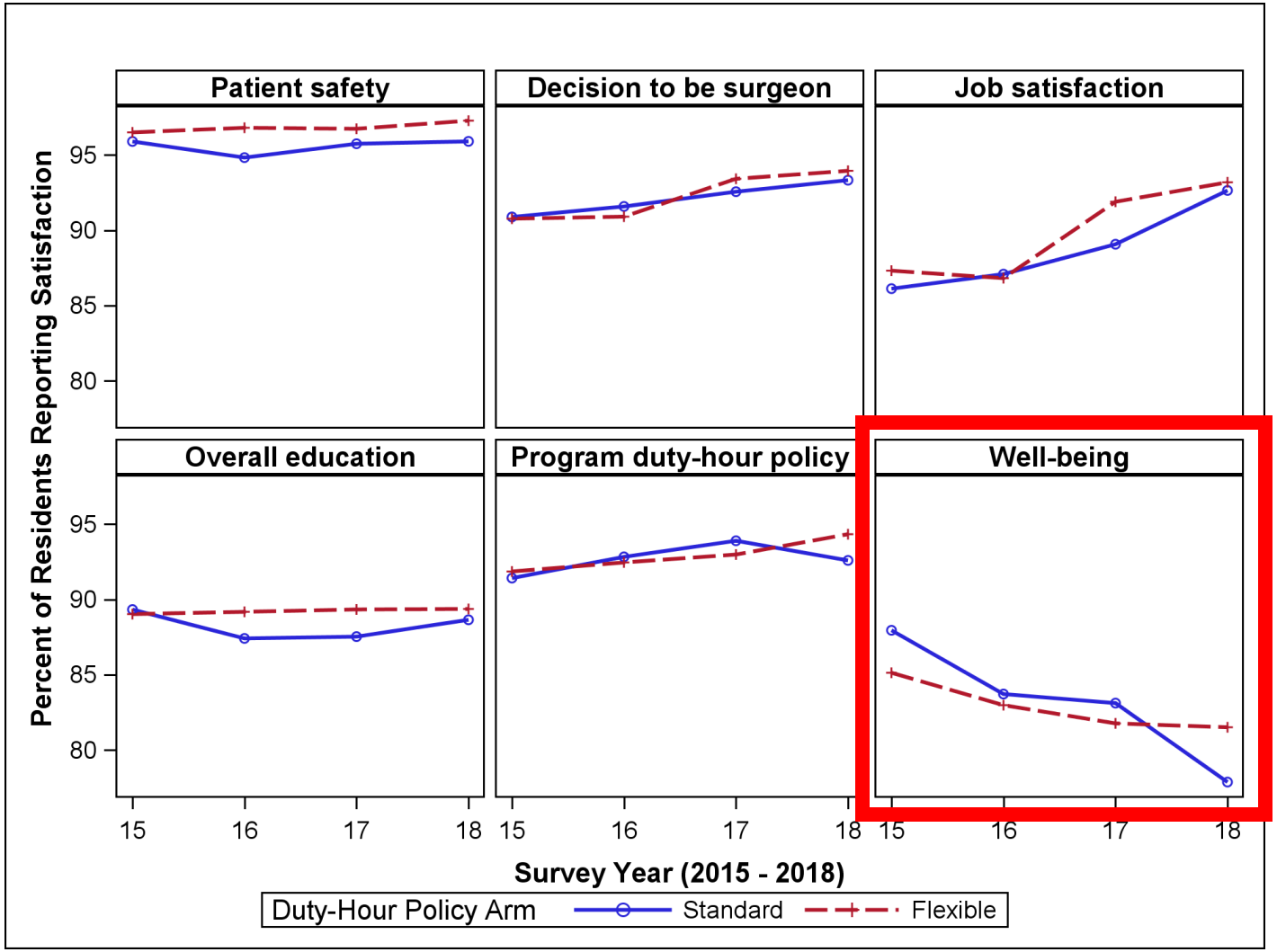
Improved Continuity

Leave During an Operation
Due to Duty Hour Regulations



@yueyunghu
@SENTteam

4 Years After FIRST, Worse Well-Being for All



Rhami Khorfan, MD MPH

Ann Surg 2020

@yueyunghu
@SENTteam

Lessons Learned about Well-Being

1. It’s about meaning, not hours

Worse Well-Being in Women

- FIRST: women more likely to endorse 9/12 measures of poor psychological well-being

Dahlke, Ann Surg 2018

- Higher burnout in women in multiple prior studies

Dyrbye, JAMA 2018
Elmore, JACS 2016
Lindeman, JSE 2017

Identity-Based Mistreatment

The NEW ENGLAND JOURNAL of MEDICINE

SPECIAL ARTICLE

Discrimination, Abuse, Harassment, and Burnout in Surgical Residency Training

Yue-Yung Hu, M.D., M.P.H., Ryan J. Ellis, M.D., M.S.C.I., D. Brock Hewitt, M.D., M.P.H., Anthony D. Yang, M.D., Elaine Ooi Cheung, Ph.D., Judith T. Moskowitz, Ph.D., M.P.H., John R. Potts III, M.D., Jo Buyske, M.D., David B. Hoyt, M.D., Thomas J. Nasca, M.D., and Karl Y. Bilimoria, M.D., M.S.C.I.

Ryan Ellis, MD MS

ABSTRACT

BACKGROUND

Physicians, particularly trainees and those in surgical subspecialties, are at risk for burnout. Mistreatment (i.e., discrimination, verbal or physical abuse, and sexual harassment) may contribute to burnout and suicidal thoughts.

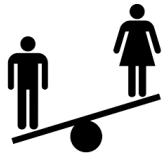
METHODS

A cross-sectional national survey of general surgery residents administered with the 2018 American Board of Surgery In-Training Examination assessed mistreatment, burnout (evaluated with the use of the modified Maslach Burnout Inventory), and suicidal thoughts during the past year. We used multivariable logistic-regression mod-

From the Surgical Outcomes and Quality Improvement Center (SOQIC), Department of Surgery, Feinberg School of Medicine, Northwestern Medicine (Y.-Y.H., R.J.E., D.B. Hewitt, A.D.Y., K.Y.B.), the Division of Pediatric Surgery, Ann and Robert H. Lurie Children's Hospital (Y.-Y.H.), the American College of Surgeons (R.J.E., D.B. Hoyt, K.Y.B.), the Department of Medical Social Sciences, Northwestern University (E.O.C., J.T.M.), and the Ac-

@yueyunghu
@SENTteam

Identity-Based Mistreatment



	All N=7409	Men N=4438	Women N=2935
Gender discrimination	31.9%	10.0%	**65.1%**
Sexual harassment	10.3%	3.9%	**19.9%**
Racial discrimination	16.6%	15.1%	**18.6%**
Verbal/emotional abuse	30.2%	28.3%	**33.3%**
Any	49.9%	36.1%	**70.6%**

@yueyunghu
@SENTteam

Hu & Ellis, NEJM 2019

Mistreatment Drives Gender Differences in Well-Being

	% Residents	Excluding Mistreatment
BURNOUT	38.5%	
Gender		
Female	42.4%	1.33 (1.20 – 1.48)*
Male	35.9%	1.0 (ref)
SUICIDALITY	4.5%	
Gender		
Female	5.3%	1.31 (1.03 – 1.67)*
Male	3.9%	1.0 (ref)

Adjusted for PGY, relationship status, program size, program type, program location, and duty hour violations

@yueyunghu
@SENTteam

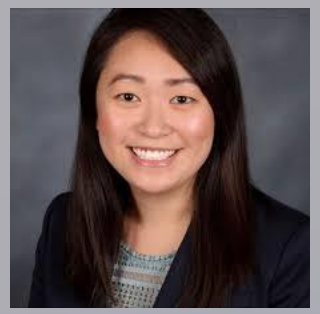
Hu & Ellis, NEJM 2019

Research Letter

May 26, 2020

Prevalence, Types, and Sources of Bullying Reported by US General Surgery Residents in 2019

Lindsey M. Zhang, MD, MS[1]; Ryan J. Ellis, MD, MS[1]; Meixi Ma, MD, MS[1]; et al



Lindsey Zhang, MD MS

N=6956	Prevalence
Repeated reminders of mistakes	42.3%
Shouting	39.3%
Gossiping	32.7%
Withholding important information	31.8%
Exclusion	31.2%
Persistent criticism	30.3%
Hostility	24.3%
Offensive remarks	23.4%
Unwanted jokes	9.1%
Occasional Bullying	**43.8%**
Frequent Bullying	**18.1%**

Experiences of Gender Discrimination & Sexual Harassment Among US General Surgery Residents

Cary Schlick, MD MS

6,956 responses (85.6% response rate) after 2019 ABSITE

79.9% Gender Discrimination

42.5% Sexual Harassment

Specific Behaviors

77.4% mistaken for non-physician

43.2% different standards of evaluation

29.7% advised not to have children

37.3% crude, demeaning, explicit comments

17.5% offensive body language

6.1% unwanted physical sexual attention

Associated Factors

	Discrimination	Harassment
Men	Low ABSITE scores	Seniority
	Children	
Women	Pregnancy	Seniority
	High ABSITE scores	High ABSITE scores
		Female faculty

@yueyunghu
@SENTteam

JAMA Surgery

Racial/Ethnic Discrimination

N=6956	Black	Hispanic	Asian	NH White
Mistaken for nonphysician	62.4%	13.7%	15.6%	1.5%
Mistaken for another person of same race	55.8%	15.4%	37.5%	8.7%
Different standards of evaluation	38.0%	10.8%	14.2%	2.9%
Slurs or hurtful comments	24.8%	8.3%	13.4%	7.3%
Denied opportunities	16.1%	5.6%	6.1%	2.0%
Socially isolated	11.6%	5.4%	3.8%	1.9%
Any	**70.7%**	**25.3%**	**45.9%**	**12.6%**

Tarik Yuce, MD MS

JAMA Surg 2020

@yueyunghu
@SENTteam

LGBTQ+ Mistreatment

N=6956	Non-LGBTQ+ Men	LGBTQ+ Men	Non-LGBTQ+ Women	LGBTQ+ Women
Bullying	63.0%	**71.8%**	72.6%	**77.6%**
Gender/LGBTQ+ discrimination	15.9%	**33.3%**	80.1%	**82.5%**
Sexual harassment	20.7%	**34.9%**	41.6%	**59.0%**

Evan Heiderscheit, MD

JAMA Surg 2022

@yueyunghu
@SENTteam

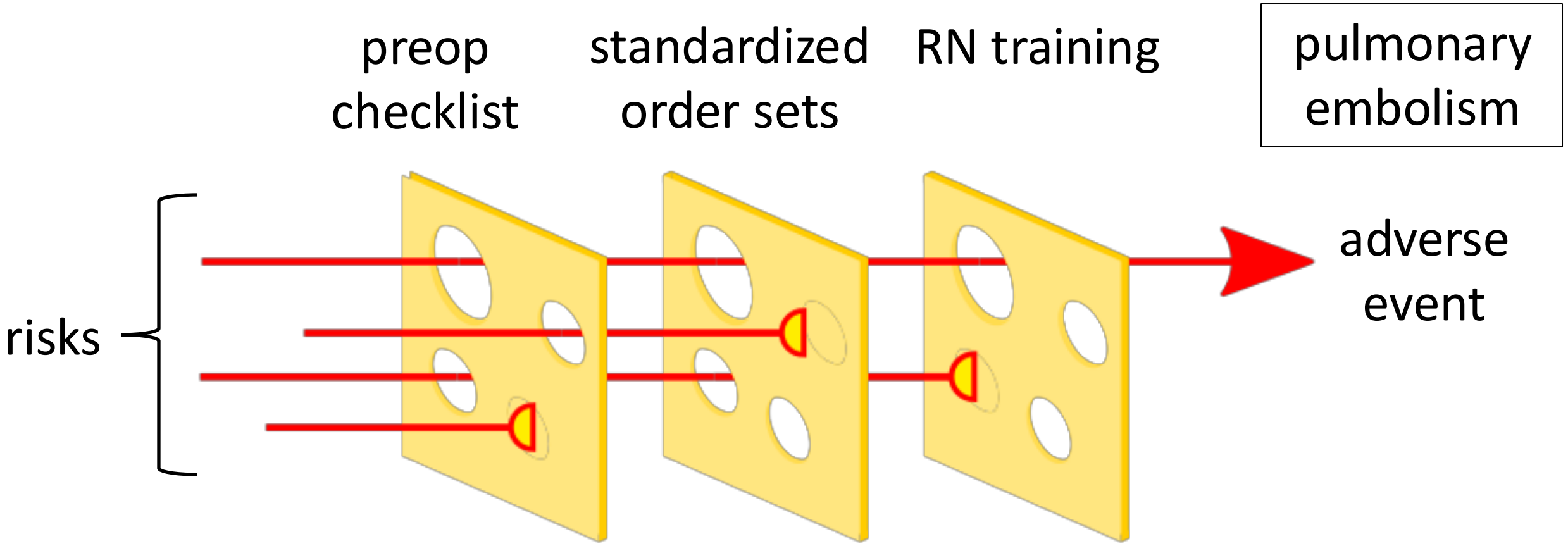
Lessons Learned about Well-Being

1. It’s about meaning, not hours
2. No wellness without inclusion

@yueyunghu
@SENTteam

Surgical Education Culture Optimization based on National comparative Data

Quality Improvement: A Systems Approach



multiple layers of defenses

@yueyunghu
@SENTteam

Wellness: A Systems Approach?

pick resilient physicians

emphasize self-care

pizza parties

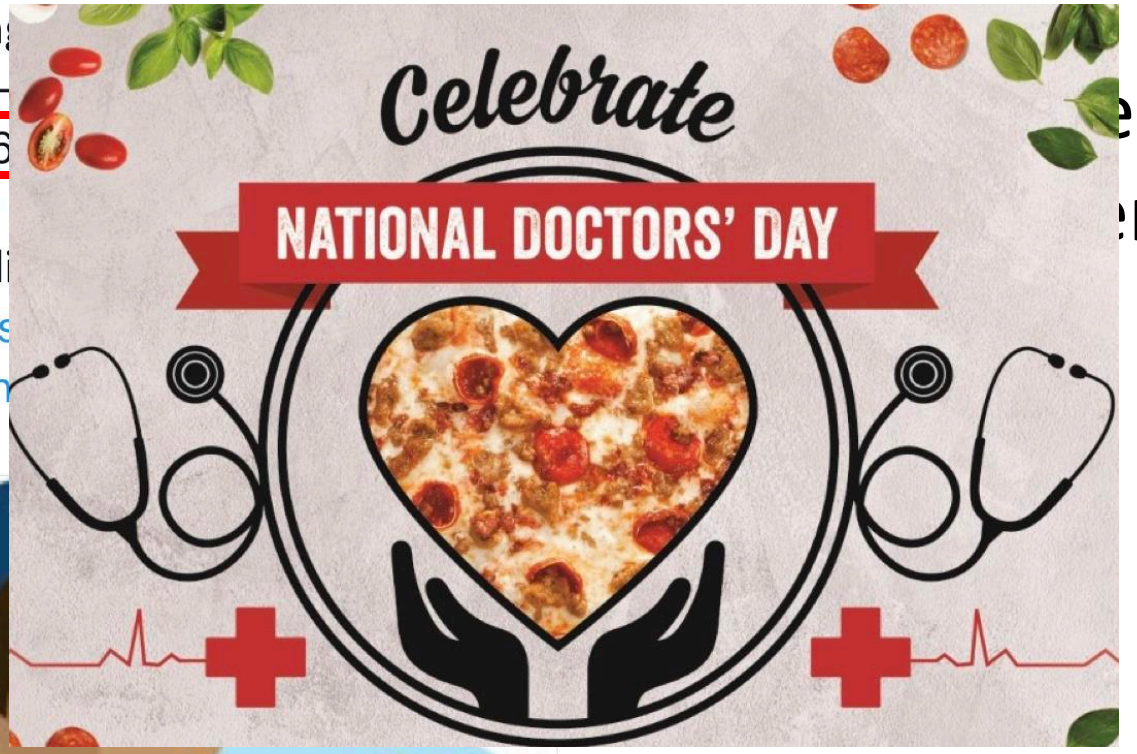
burnout

risks -

AmJSurgery
@AmJSurgery

Burnout and perceived s
efficacy, depression and
support in surgery reside
research is needed for se
trainees and increase res
our trainees to reduce bu
#SoMe4Surgery @herbc
@pferrada1 @Cirbosque

Physician Well-Being
and Encourage Self-
alignment with our 6
Provider Health and
I tweeted about earli
out. edhub.ama-ass
@AmerMedicalAssn

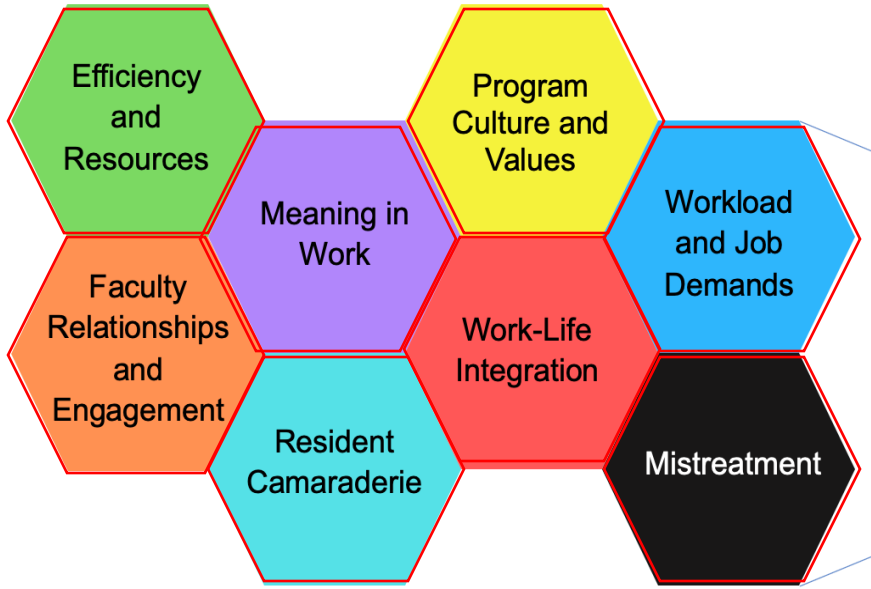


@yueyun
@SENTte

erse

ent

SECOND Conceptual Model



Learning Environment Factors

Individual Mediating Factors

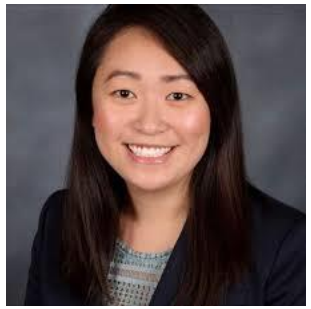
SURGERY RESIDENT OUTCOMES

Well-being

Burnout

CONSEQUENCES FOR

- Patients
- Clinicians
- Healthcare Organizations
- Society



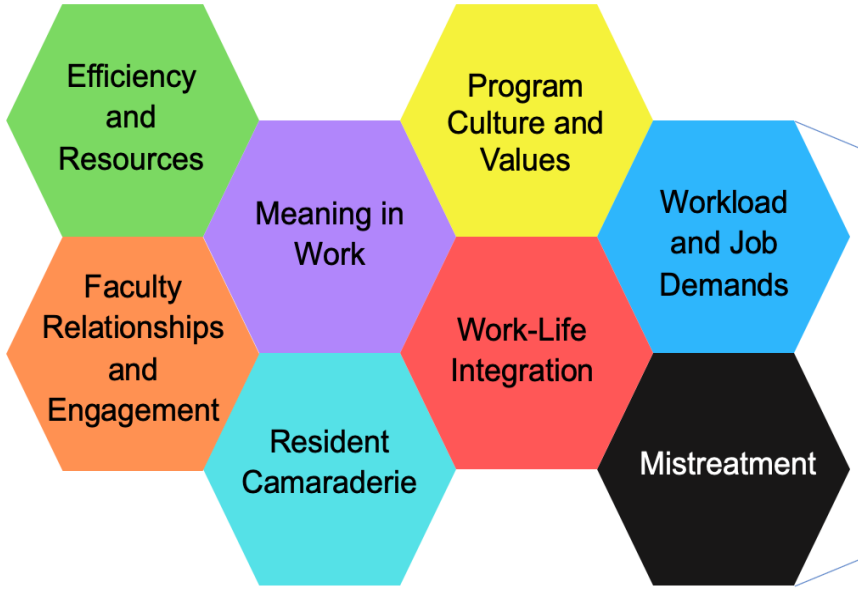
- [illegible] adverse events
- [illegible] opportunities
- [illegible] discrimination
- Bullying

Lindsey Zhang, MD MS

Am J Surg 2020

@yueyunghu
@SENTteam

SECOND Conceptual Model



Learning Environment Factors

Individual Mediating Factors

SURGERY RESIDENT OUTCOMES

Well-being

Burnout

CONSEQUENCES FOR

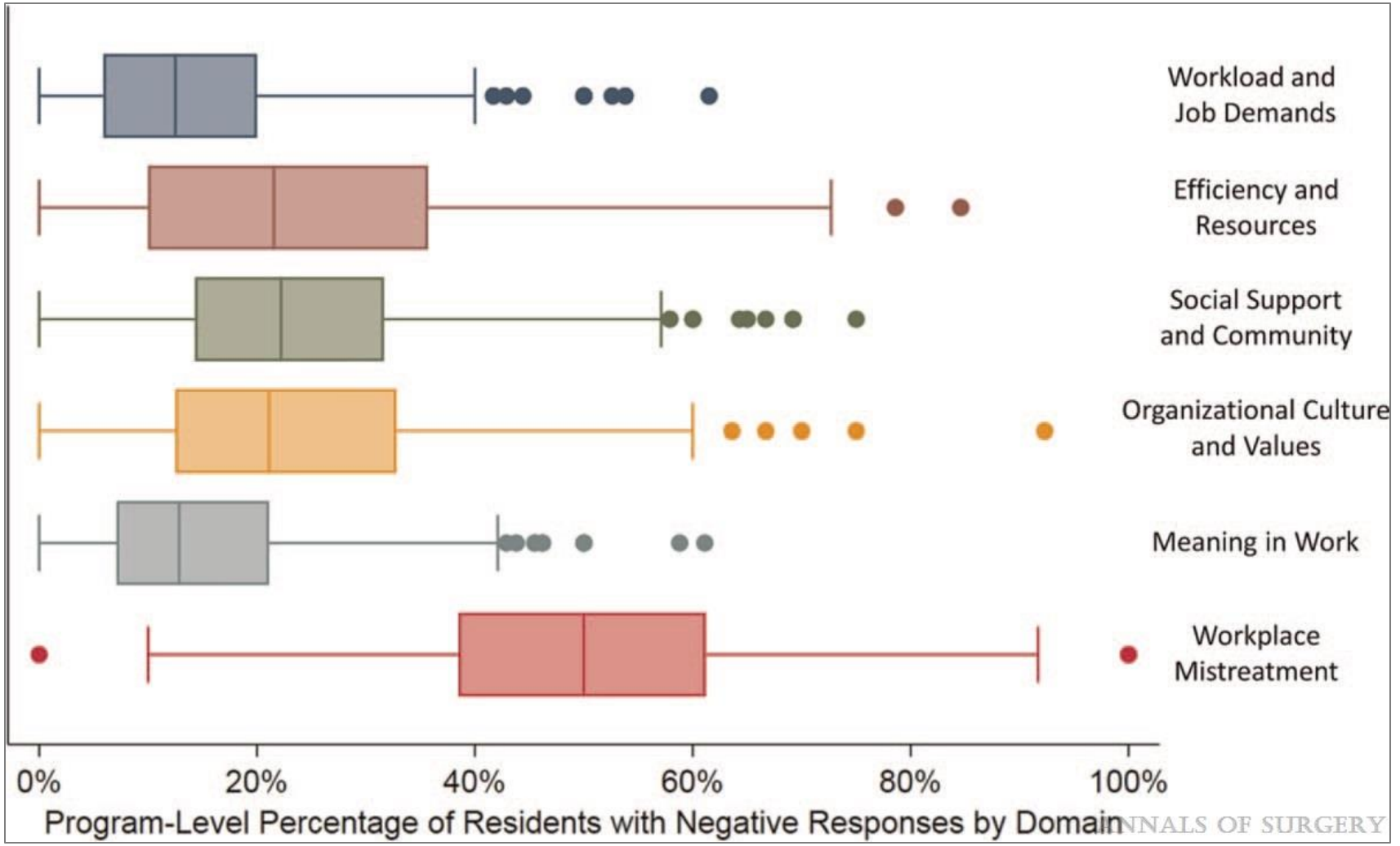
- Patients
- Clinicians
- Healthcare Organizations
- Society

Ryan Ellis, MD MS
Lindsey Zhang, MD MS
Am J Surg 2020
Ann Surg 2021

- Confirmatory factor analysis: acceptable fit
- Logistic regression: all domains independently associated with burnout

@yueyunghu
@SENTteam

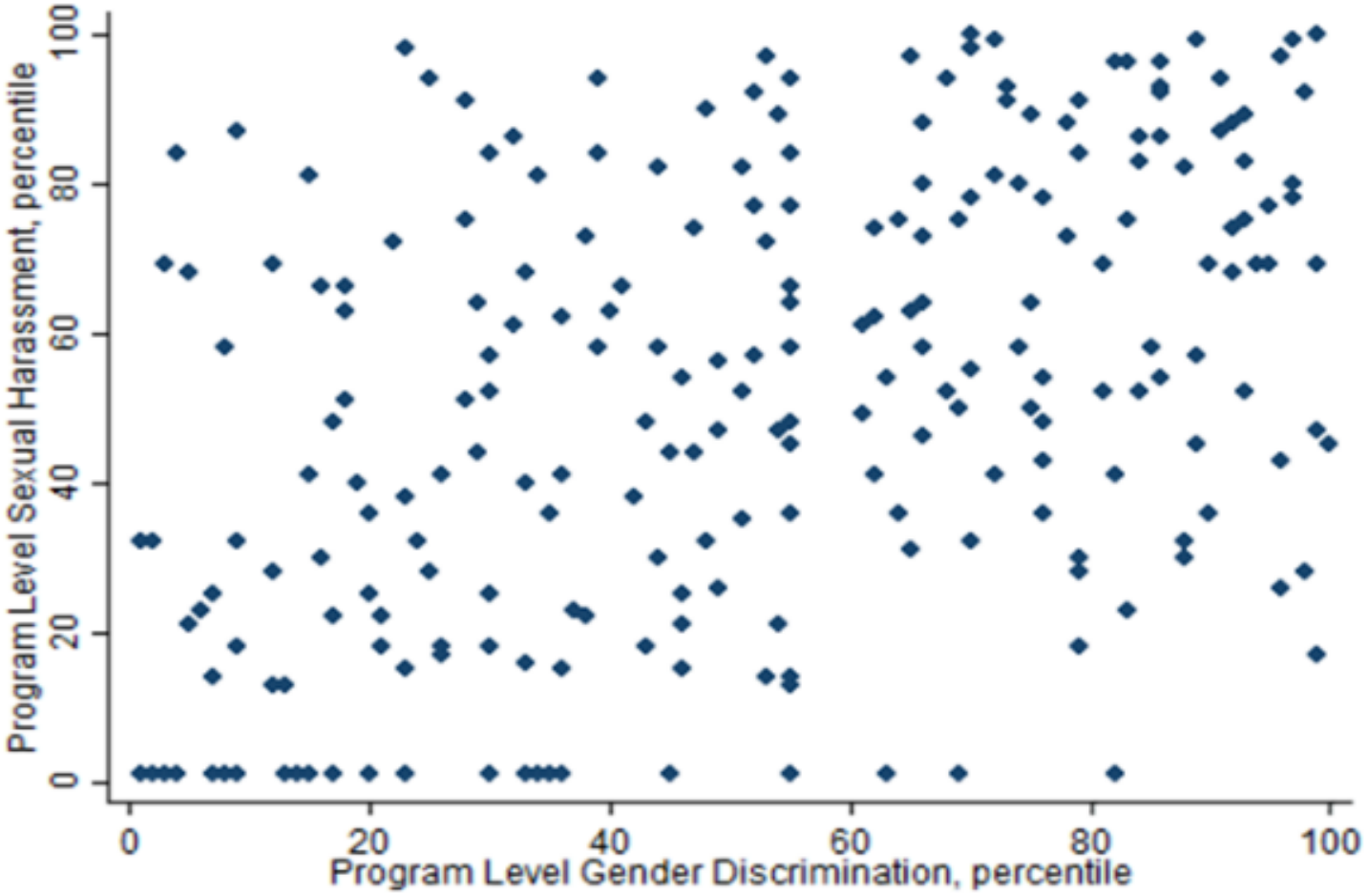
Considerable Program-Level Variation



@yueyunghu
@SENTteam

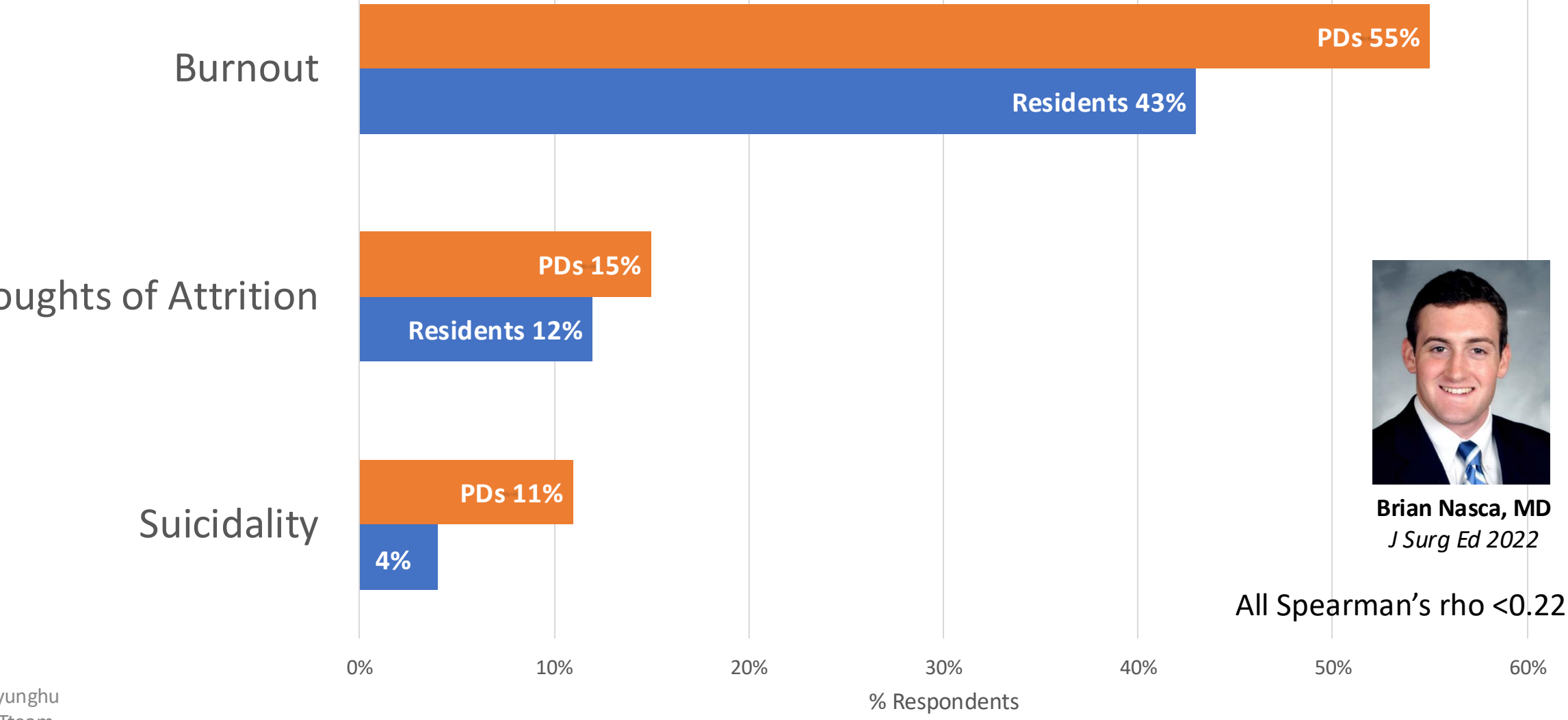
Ellis, Ann Surg 2021

Not Just “Bad Apple” Programs



Hu & Ellis, NEJM 2019

PDs (Slightly) Overestimate Well-Being Issues

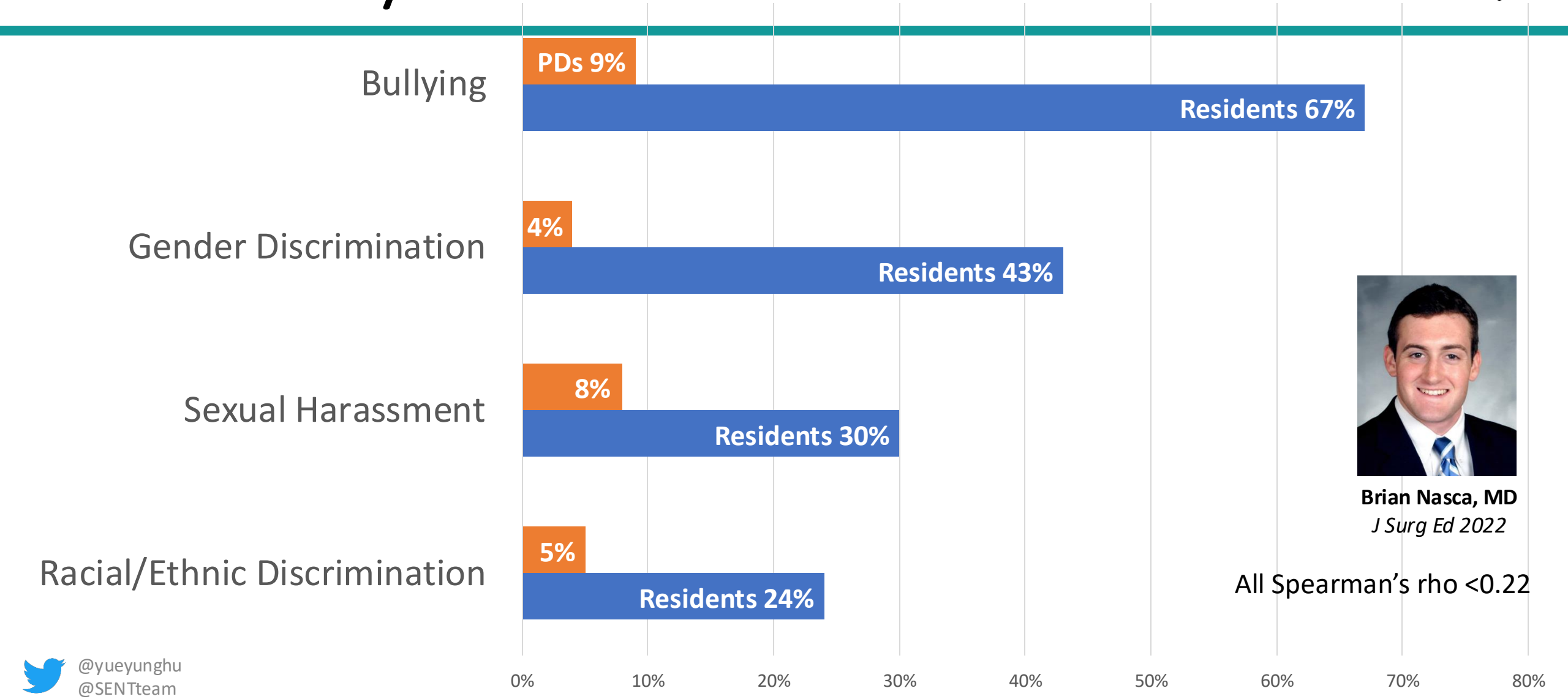


Brian Nasca, MD
J Surg Ed 2022

All Spearman's rho <0.22

@yueyunghu
@SENTteam

PDs Vastly Underestimate Mistreatment



Brian Nasca, MD
J Surg Ed 2022

All Spearman's rho <0.22

@yueyunghu
@SENTteam

Intervention: Data

2019 SECOND TRIAL LEARNING ENVIRONMENT & RESIDENT WELL-BEING REPORT

THE SECOND TRIAL

SECOND Trial Program Number: 1006
Program Size: Large (>27 residents)
Program Type: Academic

This report is based on data from the annual post-ABSITE survey taken by your residents each year. The report is intended to highlight areas where your program is performing well and areas that may merit attention. The "Getting Started" document contains instructions for interpretation of this report. Please email SECOND@northwestern.edu with any questions or suggestions on how to improve or clarify the report.

Workload & Job Demands

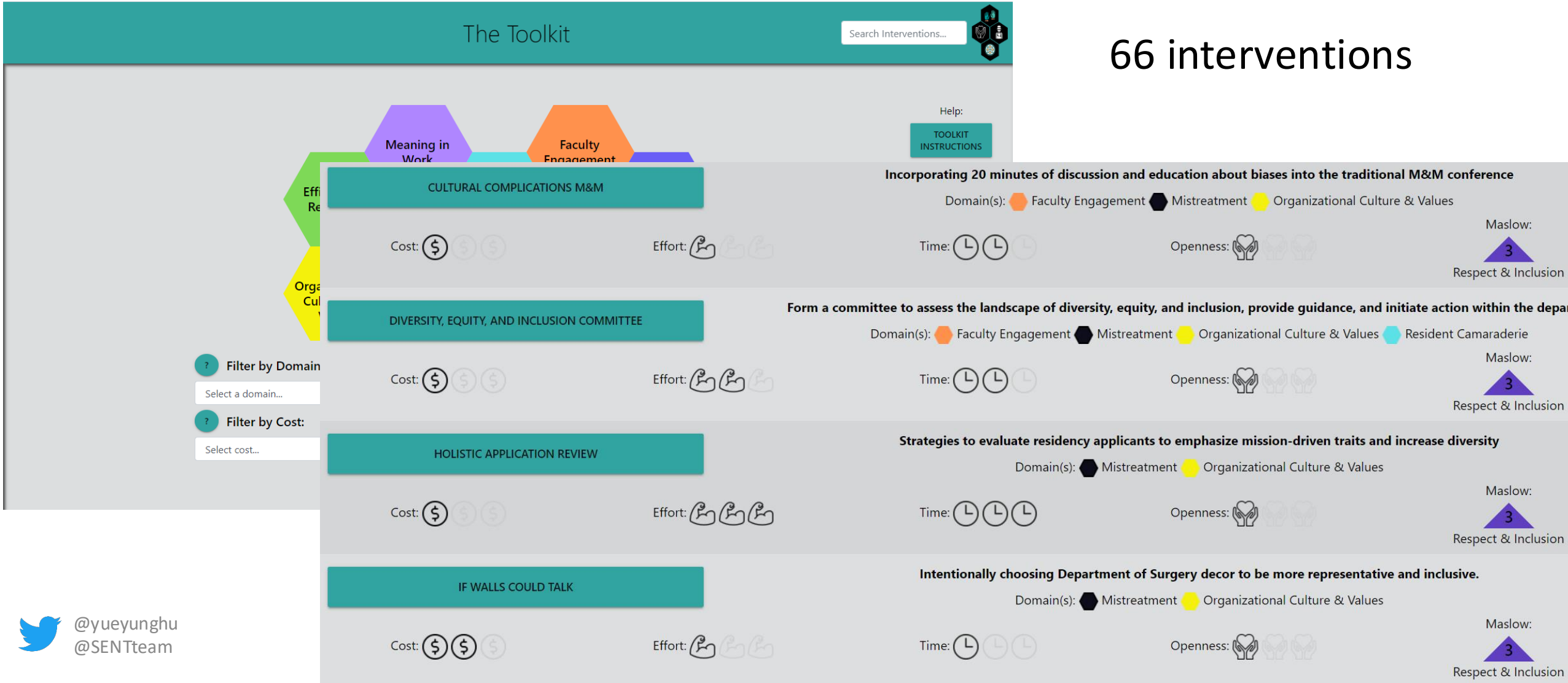
Resident Camara-derie

Faculty Engage-ment

Program

	Your Program's Performance Quartile			Benchmarks: Ranges for Each Quartile for All Programs in the Country				
	Compared to All Programs in the Country	Compared to Large (>27 residents) Sized Programs	Compared to Academic Programs	Q1 Range	Q2 Range	Q3 Range	Q4 Range	Unit of Measurement
Burnout (6-Item Composite)	Q3	Q3	Q3	0.0-29.9	30.0-41.9	42.0-52.9	53.0-86.0	% Reporting at least Weekly Symptoms
Emotional Exhaustion (3-Item Composite)	Q3	Q3	Q3	0.0-27.9	28.0-37.9	38.0-47.9	48.0-79.0	% Reporting at least Weekly Symptoms
Depersonalization (3-Item Composite)	Q3	Q3	Q3	0.0-13.9	14.0-21.9	22.0-29.9	30.0-71.0	% Reporting at least Weekly Symptoms
Personal Accomplishment (3-Item Composite)	Q4: Merits Attention	Q4: Merits Attention	Q4: Merits Attention	96.0-100.0	91.0-95.9	84.0-90.9	53.0-83.9	% Reporting at least Weekly Sentiments
Thoughts of Attrition	Q4: Merits Attention	Q4: Merits Attention	Q4: Merits Attention	0.0-5.3	5.4-10.8	10.9-15.8	15.9-57.9	% Reporting Occurrence
Suicidal Thoughts	Q3	Q3	Q3	0.0-0.0	0.1-3.2	3.3-6.9	7.0-33.3	% Reporting Occurrence
Workload & Job Demands (3-Item Composite)	Q3	Q3	Q3	0.0-7.7	7.8-12.0	12.1-17.5	17.6-44.1	Factor Score on 0-100 Scale
80-hour violations	Q3	Q2	Q3	0.0-21.7	21.8-34.8	34.9-49.2	49.3-88.9	% Reporting Any Months of Violations
1 day off in 7 violations	Q4: Merits Attention	Q4: Merits Attention	Q4: Merits Attention	0.0-0.0	0.1-7.0	7.1-13.0	13.1-56.0	% Reporting ≥ 2 Months of Violations
Call >1 in 3 nights violations	Q3	Q3	Q3	0.0-0.0	0.1-3.9	4.0-7.9	8.0-60.0	% Reporting ≥ 2 Months of Violations
Resident Camaraderie (3-Item Composite)	Q4: Merits Attention	Q4: Merits Attention	Q4: Merits Attention	3.4-3.8	3.2-3.3	3.0-3.2	2.4-3.0	Factor Score on 0-5 Scale
Appreciated by co-residents	Q4: Merits Attention	Q4: Merits Attention	Q4: Merits Attention	4.3-5.0	4.1-4.3	4.0-4.1	3.3-4.0	Avg. Agreement on 1-5 Scale
Residents cooperate	Q3	Q4: Merits Attention	Q4: Merits Attention	4.5-5.0	4.3-4.5	4.1-4.3	3.2-4.1	Avg. Agreement on 1-5 Scale
Co-residents among closest friends	Q3	Q4: Merits Attention	Q4: Merits Attention	4.0-4.8	3.7-4.0	3.5-3.7	2.5-3.5	Avg. Agreement on 1-5 Scale
Faculty Engagement (2-Item Composite)	Q4: Merits Attention	Q4: Merits Attention	Q4: Merits Attention	2.7-3.1	2.5-2.7	2.4-2.5	1.7-2.4	Factor Score on 0-5 Scale
A mentor who genuinely cares	Q4: Merits Attention	Q4: Merits Attention	Q4: Merits Attention	4.1-5.0	3.8-4.1	3.6-3.8	2.9-3.6	Avg. Agreement on 1-5 Scale
Appreciated by attendings	Q4: Merits Attention	Q4: Merits Attention	Q4: Merits Attention	4.1-4.8	3.9-4.1	3.8-3.9	2.3-3.8	Avg. Agreement on 1-5 Scale
Organizational Culture & Values/Flexibility & Control (4-Item Composite)	Q3	Q3	Q3	3.4-4.0	3.2-3.4	3.0-3.2	1.9-3.0	Factor Score on 0-5 Scale
Program takes my wellness seriously	Q3	Q3	Q3	4.2-4.9	3.9-4.1	3.7-3.9	2.1-3.7	Avg. Agreement on 1-5 Scale
Program helps decompress/debrief/cope after adverse events	Q3	Q3	Q3	3.8-4.6	3.5-3.7	3.2-3.5	2.1-3.2	Avg. Agreement on 1-5 Scale
Program emphasizes learning not blame from adverse events	Q4: Merits Attention	Q4: Merits Attention	Q4: Merits Attention	4.1-5.0	3.9-4.1	3.7-3.9	2.6-3.7	Avg. Agreement on 1-5 Scale
Program responsive to resident concerns	Q3	Q3	Q3	3.1-5.0	2.8-3.1	2.5-2.8	2.1-2.5	Avg. Agreement on 1-5 Scale
Burnout is a problem in my program (reverse-coded so higher scores better)	Q3	Q3	Q3	4.3-5.0	4.0-4.2	3.7-4.0	1.9-3.7	Avg. Agreement on 1-5 Scale

Intervention: Wellness Toolkit



66 interventions

@yueyunghu
@SENTteam

Intervention: Wellness Toolkit

Coach: Cary Aarons, MD

Holistic Application Review

BACK TO INTERVENTIONS

Strategies to evaluate residency applicants to emphasize mission-driven traits and increase diversity

Add to My Interventions
NO YES

Cost	Effort	Time	Maslow	Domain
$ $ $			3 Respect & Inclusion	Mistreatment; Organizational Culture & Values

WHAT?

- Understand how recruitment strategies impact your ability to match diverse applicants.
- Develop recruitment strategies to holistically evaluate applicants.

WHY?

The ACGME Common Program Requirements mandates that programs must engage in practices that focus on ongc recruitment and retention of a diverse and inclusive workforce. [1] Based on a 2018 review of ERAS applications, a re general surgery residency programs with a stated interested in diversity found that identification as non-White race, significant independent predictor for decreased likelihood of interview selection (OR = 0.73, 95% CI 0.58-0.89). [2]

Traditionally used metrics to evaluate general surgery applicants, such as USMLE scores, are flawed based on racial/ USMLE performance, and have not been shown to correlate with residency performance.[3,4] Thus, the USMLE has a transition Step 1 to pass/fail by 2022. Similarly, AOA selection processes have been shown to disproportionately fav with some medical schools putting moratoriums on AOA nomination and/or closing their chapters.[5,6] This chang opportunity for residency programs to transition to holistic application review.[7] Letters of recommendation and u interviews likewise are subject to "just like me" bias.[8] Various techniques may be helpful in attracting a diverse app particularly in the absence of traditional USMLE and AOA metrics.[9,10,11]

Organizational Culture and Values

Implementing specific recruitment strategies targeted at holistically evaluating residents ma ability to match applicants with skills and values that align with your department's. Furtherm diverse resident cohort makes a visible statement that diversity is important to your prograr

Mistreatment

By intentionally selecting and matching more diverse applicants, as well as applicants who h inclusion values, you may create a more welcoming environment for minority residents.

i. Letters of reference are non-standardized, can be highly subjective, and are sub of recommendation in the application process, consider potential biases that may be i instance, you may use this gender bias calculator that assesses the number of "female- letters. You may also use this tip sheet for avoiding gender bias in reference writing tha letters of recommendation.

e. Consider how ALL applicants will add to a diverse and inclusive environment – no involvement in DEI initiatives at prior institutions, social determinant of health/health c that is welcoming increases URM applicants' sense of belonging and may facilitate futu

5. Limit the pieces of the application available to reviewers and/or interviewers.

a. Penn blinds application reviewers to applicants' test scores, grades, and race/ethn statement, and letters of recommendation.

6. Incorporate standardized questions into some or all of the interviews.

a. OHSU instilled prompts within their residency application that ask applicants to e diversity of the program if they were accepted.

b. The AAMC has provided best practice guidelines for equitable residency interview Diversity & Inclusion Toolkit). [11] You may access the full guidelines at this link.

AAMC'S BEST PRACTICES FOR CONDUCTING RESIDENCY PROGRAM INTERVIEWS

Table 1. The Effects of Components of Structure on Reliability, Validity, Fairness, and Applicant Reactions

Content	Reliability	Validity	Fairness	Applicant Reactions
Ask questions that are job-related		+	+	+
Ask all applications questions that cover the same topics	+	+	+	
Limit probing questions	+	+	+	–
Use behavioral or situational questions	+	+	+	
Use a longer interview	+	+		–
Have no access to applicant information before or during interview	+		+	-
Have applicants not ask any questions	+			–
Evaluation				
Rate each answer or use multiple rating scales	+	+		
Use defined rating scales	+	+	+	
Take detailed notes	+	+	+	
Use multiple interviewers	+	+	+	–
Use the same interviewers for all applicants	+		–	
Have no discussion between interviews	–		+	
Train interviewers	+	+	+	+
Use formulas to create interview total scores	+	+	+	

Notes: "+" means overall positive effect, "–" means overall negative effect, and blank cells mean insufficient research on the effect of the enhancement. Reliability refers the extent to which the evaluation process is consistent and candidate responses are evaluated consistently. Validity refers to the accuracy of inferences made from interview scores.
Source: Adapted from Campion et al. (1997) and Levashina et al. (2014).

Diversity Engagement Survey (DES)

The DES was developed as a validated, benchmarking tool that allows institutions to assess their engagement and inclusion efforts and develop a strategy for achieving their diversity goals. The authors emphasize the importance of starting with an understanding of the extent to which individuals currently feel included and engaged in order to build institutional capacity for diversity.

Response scale: Respondents indicate their agreement to the statements using a 5-point Likert scale (1 = strongly disagree to 5 = strongly agree)

Survey Items:

1. I trust my institution to be fair to all employees and students.
2. The leadership of my institution is committed to treating people respectfully.
3. I am valued as an individual by my institution.
4. I feel that my work or studies contribute to the mission of the institution.
5. This last year, I have had opportunities at work/school to develop professionally.
6. At work/school, my opinions matter.
7. In this institution, I have opportunities to work successfully in settings with diverse colleagues.
8. Someone at work/school seems to care about me as an individual.
9. There is someone at work/school who encourages my development.
10. I receive recognition and praise for my good work similar to others who this institution.
11. I believe my institution manages diversity effectively.
12. In my institution, I experience respect among individuals and groups wi differences.
13. If I raised a concern about discrimination, I am confident my institution right.
14. I consider at least one of my coworkers or fellow students to be a truste
15. In my institution, I receive support for working with diverse groups and cultural situations.
16. In my institution, I am confident that my accomplishments are compens others who have achieved their goals.
17. I feel connected to the vision, mission and values of this institution.
18. I believe that my institution reflects a culture of civility.
19. I believe that in my institution harassment is not tolerated.
20. In this institution, there are opportunities for me to engage in service ar outreach.
21. I feel that I am an integral part of my department or school.
22. The culture of my institution is accepting of people with different ideas.

Reference: Person SD, Jordan CG, Allison JJ, Ogawa LM, Castillo-Page L, Cc MA, Plummer DL. Measuring diversity and inclusion in academic medicine: Th engagement survey (DES). Academic medicine: journal of the Association of A Colleges. 2015 Dec;90(12):1675.

Available at: https://www.aamc.org/system/files/c/2/498820-measuringdiversityandinclusioninacademicmedicine.pdf

General Surgery Residency Interview Selection Committee
Application Evaluation Form

Applicant Name: _____

Undergraduate School: _____

Medical School: _____

Advanced Degrees: _____

Please rate ALL of the following 1 to 5.

	Score
1. Academic Achievement/Academic Potential	
2. Quality of Research/Intellectual Curiosity	
3. Capacity for Leadership	
4. Teamwork and Altruism	
5. Motivation for Surgery	
6. Strength of Letters of Recommendation	

Scale
1 = Serious concerns
2 = Below average
3 = Average
4 = Above average
5 = Excellent

Reviewer Name: _____

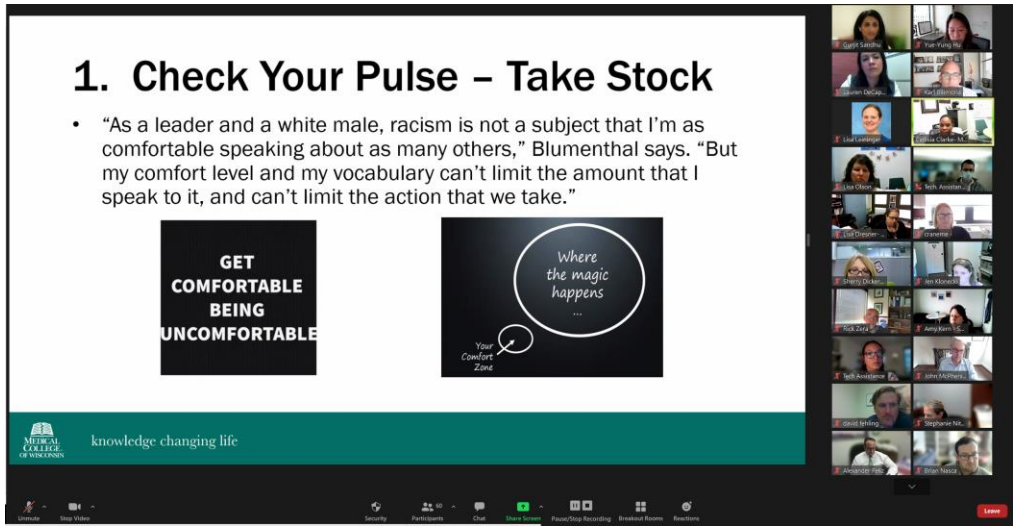
Invite for Interview?

- ☐ Yes
- ☐ No
- ☐ Hold for Re-Review

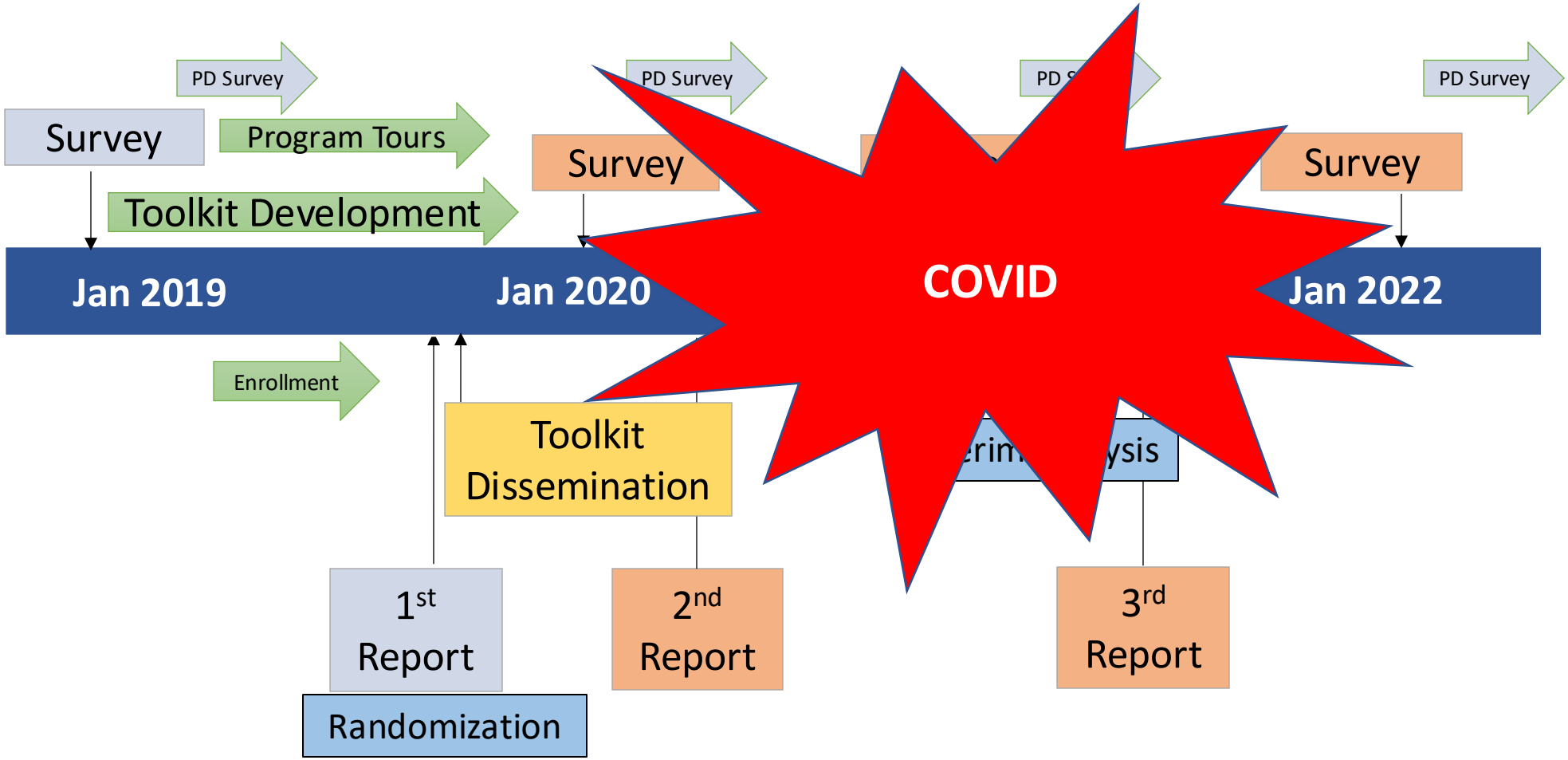
@yueyunghu
@SENTteam

Intervention: Implementation Support

- Webinars
  - 25 interventions
  - 330 attendees
  - 77 institutions
- Working groups
- Newsletters
- Virtual conference
- In person workshops
- 38 1:1 virtual & in person office hours
- Dashboard



SECOND Trial Timeline



@yueyunghu
@SENTteam

Wellness Failure #1

- Residency yoga at 7 pm on Wednesdays


HAVE YOU CONSIDERED TAKING UP YOGA?
THE NEW YORKER

Wellness Failure #1

- Residency yoga at 7 pm on Wednesdays

"Everyone got emails like, 'Why aren't people going to yoga?' which then puts the burden on the resident, like, 'Why aren't you helping your wellness by going to yoga?' There was the blame: 'Do we need a yoga champion so that people go to yoga?'"

– Resident

Lessons Learned About Well-Being

1. It's about meaning, not hours
2. No wellness without inclusion
3. Don't ignore the system
4. Wellness is self-defined
   - Need options
   - Can't be a checkbox

"It's really important for the residents to have a voice in what they're doing because otherwise, they would just perceive it as people telling them to do something else. It can be onerous. They don't have buy-in. They don't have ownership over it. They're not excited about it."

– Attending

@yueyunghu
@SENTteam

Wellness Failure #2

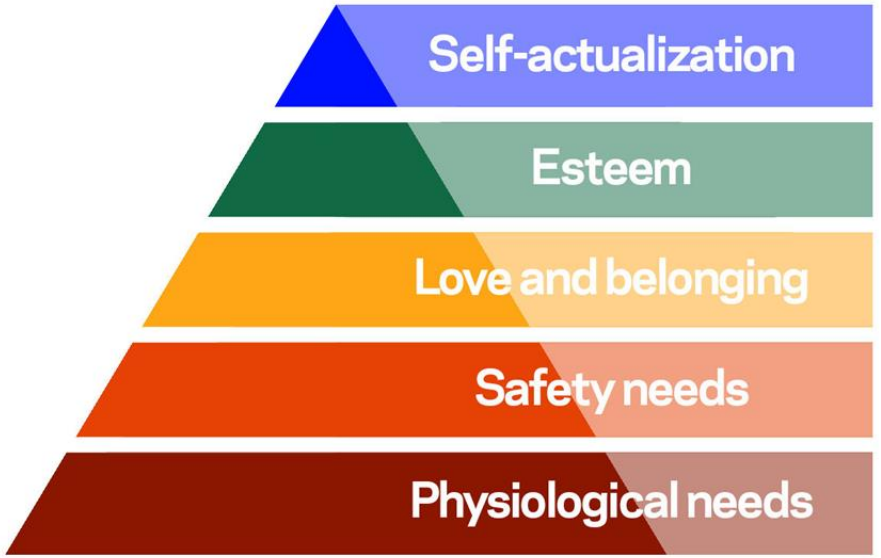
- A lecture series on wellness

"It turns out that because of the <u>basic needs that weren't being met</u>, they didn't really feel like having another 60 minute facilitated discussion about wellness…People wanted lockers, they wanted better call rooms, they wanted meal tickets for when they're on call…Until that was satisfied, we really couldn't have more abstract discussions about things that are peripheral to wellness."

– Program Director

Lessons Learned About Well-Being

1. It's about meaning, not hours
2. No wellness without inclusion
3. Don't ignore the system
4. Wellness is self-defined
5. Meet people where they are



lecture series

lockers

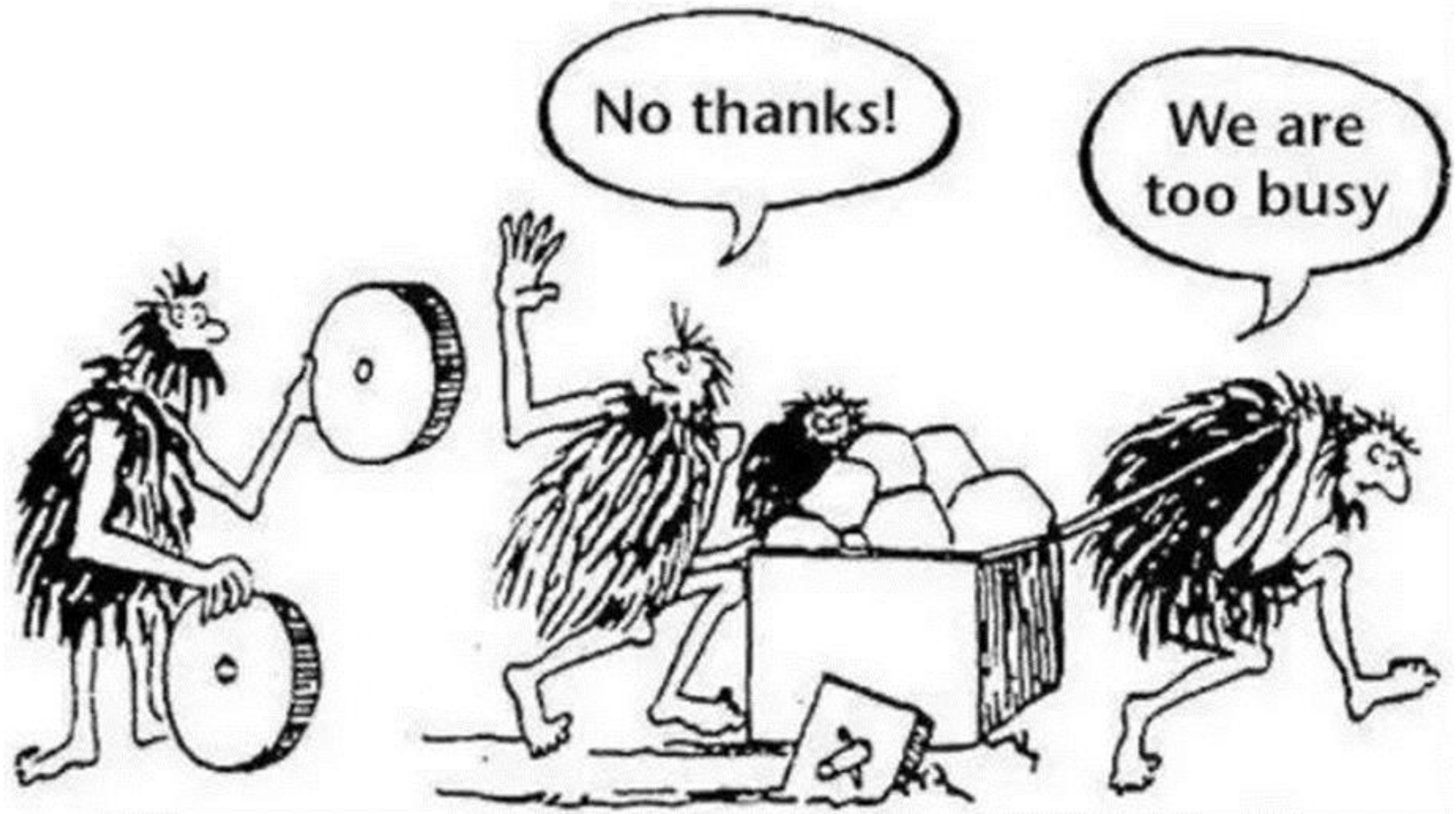
meal tickets

@yueyunghu
@SENTteam

Wellness Success #1

- Birthday cards
- Birthday emails

Lessons Learned About Well-Being



6. It doesn't have to be hard

@yueyunghu
@SENTteam

Wellness Success #2

Leadership

Harvard Business Review

What Bosses Gain by Being Vulnerable

"It's a once a month thing, and it's made a huge difference. Even though it's a small thing…it's…dramatically shifted our structure in the way that we relate to each other." – Resident

"What the residents need is to think that people are investing in their well-being. And that doesn't really cost anything." – Chair

Lessons Learned About Well-Being

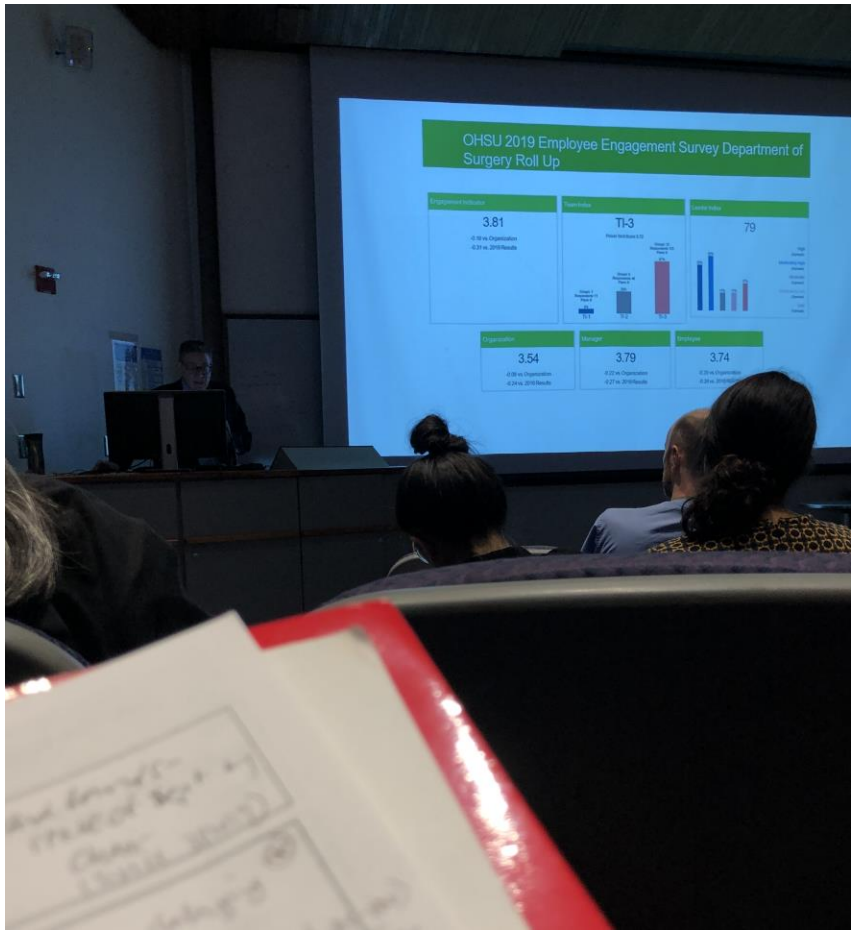
7. Radical transparency builds trust

Data Transparency in Intervention Programs

- 88% of PDs shared report with residents
- 89% of PDs shared report with faculty

Lessons Learned About Well-Being

7. Radical transparency builds trust
   - Acknowledges issues
   - Demonstrates care
8. Prioritize voice & agency
   - Ask what it means
   - Ask what to do
   - Listen (not just to argue/defend)



Program Responsiveness

"My residents are phenomenally talented…Part of the reason I think our [program] is really effective is we've tried to empower them. 'What do we need? Ok, if this isn't working, what would you do? What do you think is better?' – PD

	Program Responsiveness
Burnout	OR = 0.47
Attrition thoughts	OR = 0.32
Suicidality	OR = 0.52

	Program Responsiveness
Faculty mentorship	OR = 2.64
Input into call & vacation schedules	OR = 3.31
Comfort speaking up	OR = 4.20

Org Culture & Values

Rachel Joung, MD
J Surg Ed 2022

@yueyunghu
@SENTteam

Lessons Learned About Well-Being

1. It’s about meaning, not hours
2. No wellness without inclusion
3. Don’t ignore the system
4. Wellness is self-defined
5. Meet people where they are
6. It doesn’t have to be hard
7. Radical transparency builds trust
8. Prioritize voice & agency

@yueyunghu
@SENTteam

THIRD

Trial to Harness Inclusion to build Resilient Departments of surgery

- Inclusion
- Faculty Well-Being

Inclusion = Belonging & Valued Uniqueness

Differentiation
(recognition of unique value without acceptance)

INCLUSION!

Exclusion

Assimilation
(belonging requiring conformity)

Uniqueness

Belonging

@yueyunghu
@SENTteam

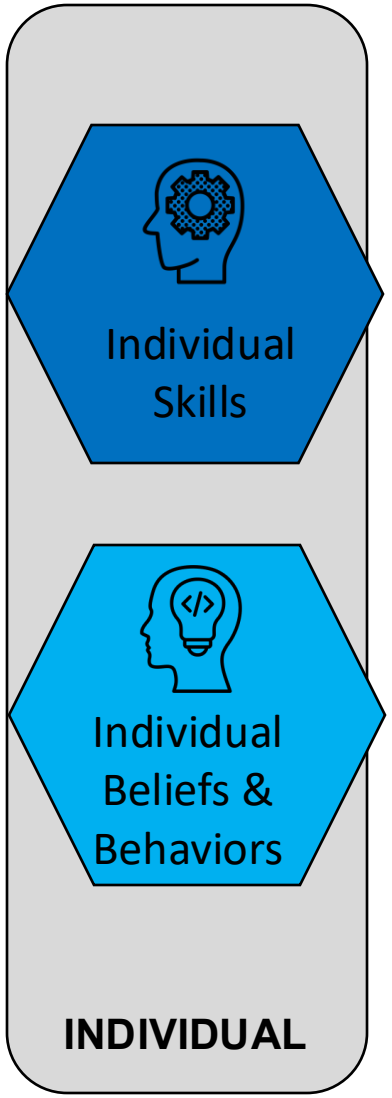
Shore et al, J Management 2011

Lack of Inclusion Drives Lack of Diversity

"When I [interviewed], I thought that they were…intellectually serious…and respected…differences among each other, and weren't very focused on one identity as a program…I wanted a place where people could research what they wanted to research, they could have hobbies that they wanted to have…The people I met here weren't all doing the same thing…People had families or they didn't…They liked physical sports, or they didn't…It just didn't seem a place where you had to be a certain way to fit in."

– Resident

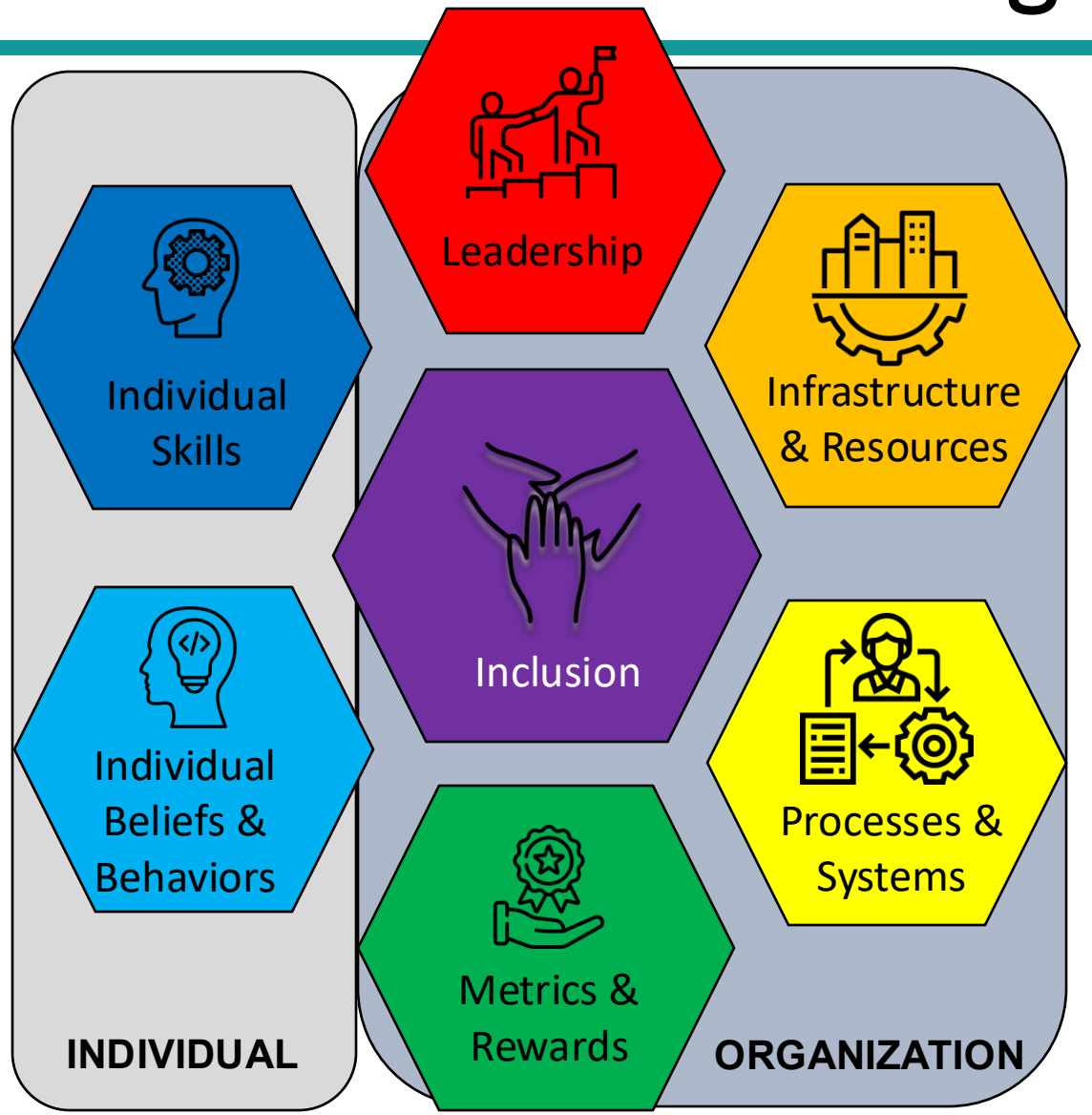
Inclusion Efforts in Medical Education



> [Hospital] mandated… implicit bias training...and the School of Medicine also... and…as a department of surgery...So unfortunately, all this hit people at the same time…Everyone had three different versions of implicit bias training. They did it over and over again. – VC DEI

- Data on implicit bias training is not good
  - No relationship between hours of training and explicit or implicit bias expression in residency *Onyeador et al, Psychol Sci 2020*
  - Implicit biases & associated behaviors highly resistant to change *Lai et al, J Exp Psychol Gen 2016*
  - Training may be actively counterproductive *Forscher et al, J Pers Soc Psych 2019*
    - Normalizes & reinforces biases
    - Reduces perceptions of harm/accountability, support for efforts to combat *Legault et al, Psychol Sci 2011* *Daumeyer et al, J Exp Soc Psych 2019*

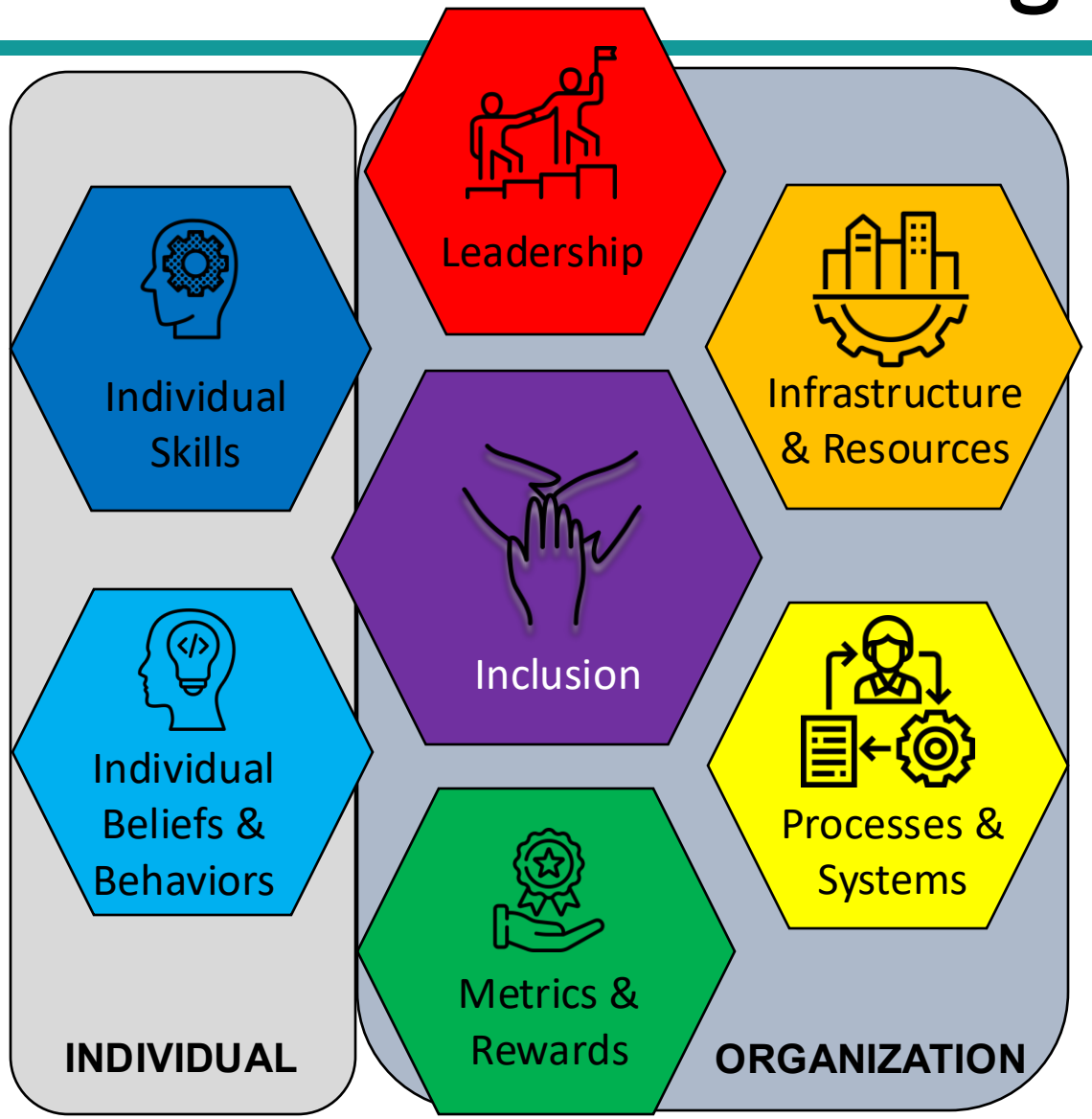
What We're Missing: The Organization



- Organizational culture
  - Shared & fundamental beliefs
  - Normative values
  - Related social practices
- Organizational policies & practices
  - Reflect & reinforce culture
  - Lay critical groundwork for inclusive behavior

Stephens, Res Org Behavior 2021
Maitland & Steele, INdivisible 2020

What We're Missing: The Organization



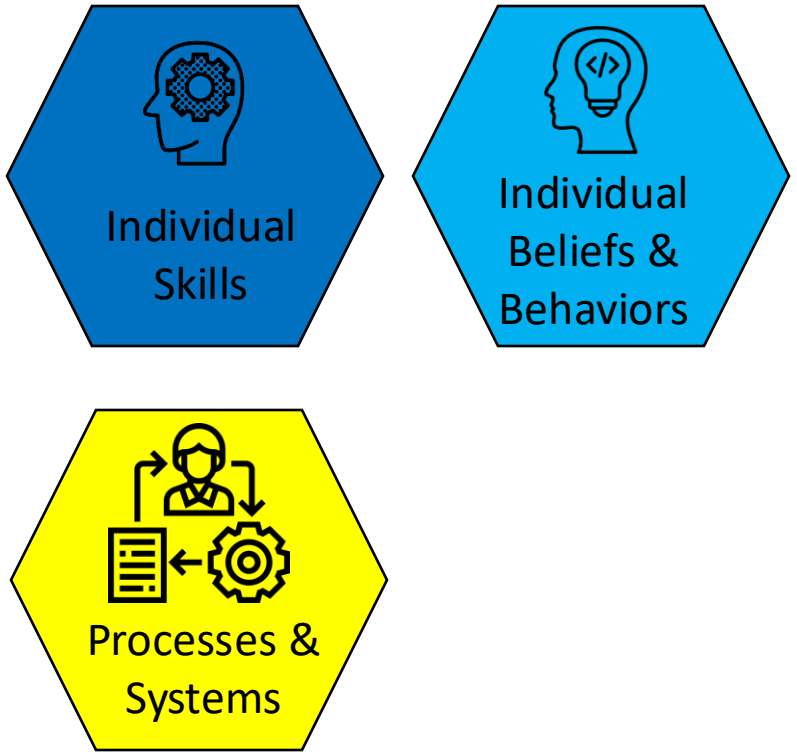
An Example: Pregnancy & Parenthood in Surgical Residency

Ruojia (Debbie) Li, MD
JAMA Surg 2024

Lauren Janczewski, MD

Erika Rangel, MD

Lots of Education & Policy



- Lots of attention

- ABMS/ABS parental leave policy
- Institutional lactation policies

Livingston-Rosanoff, Ann Surg 2019

46.8% of women still delay childbearing due to surgical residency!

Li, JAMA Surg 2024

Need a Better Metric than Presenteeism

I don't feel that issue of, 'You're a bad mom because you're working.' But I definitely feel the reverse of that…You're a bad worker because you're a mom. – Resident

Harvard Business Review

What's Really Holding Women Back?

It's not what most people think. by Robin J. Ely and Irene Padavic

From the Magazine (March–April 2020)

Need Better Childcare Infrastructure

Infrastructure & Resources

You can't really pay for a good daycare on a resident's salary…You're dependent on your partner either having a good enough job that they can pay for those things or not working.

– Faculty

Darci Foote, MD

Ruojia (Debbie) Li, MD

Lauren Janczewski, MD

Erika Rangel, MD

Need Leaders to Normalize Prioritizing Family

40 years ago, no one gave a sh*t if I spent time with my kids…The way I was a good husband is: I was going to be a surgeon.

– PD

Darci Foote, MD

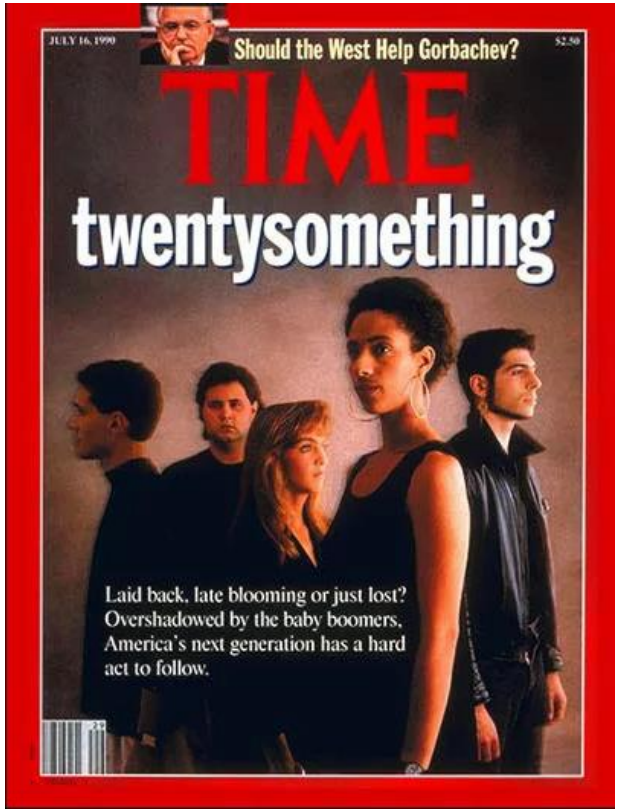
Ruojia (Debbie) Li, MD

Lauren Janczewski, MD

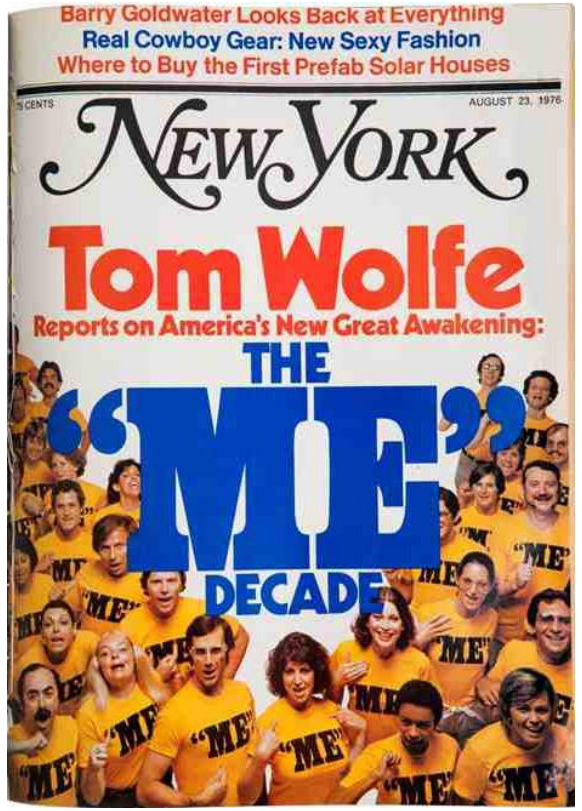
Erika Rangel, MD

Is It Generational?

2013



1990



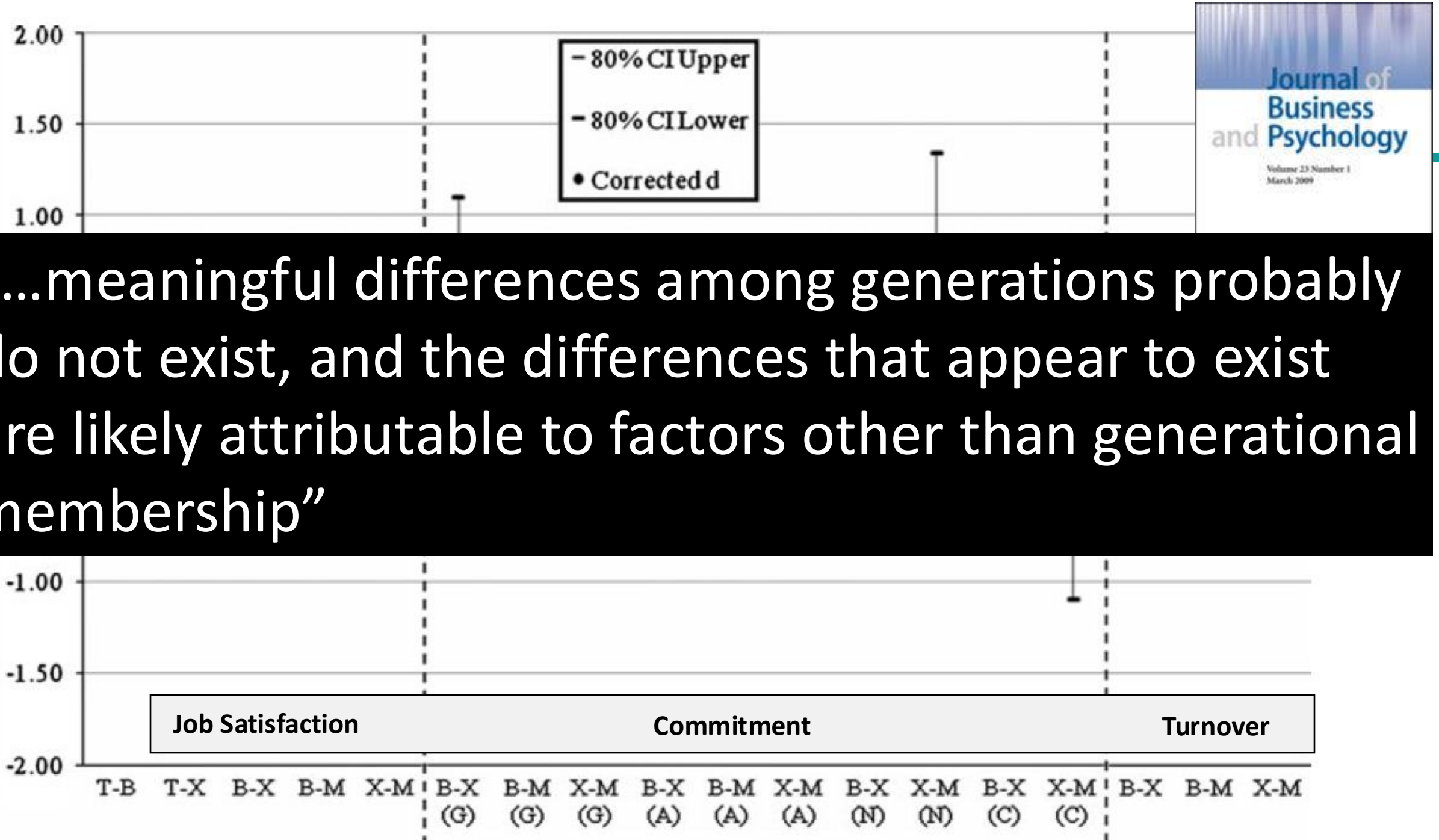
1976

@yueyunghu
@SENTteam

Is It Generational?

“The children now love luxury; they have bad manners, contempt for authority; they show disrespect for elders. They contradict their parents and tyrannize their teachers.”

- Socrates (~400 B.C.)



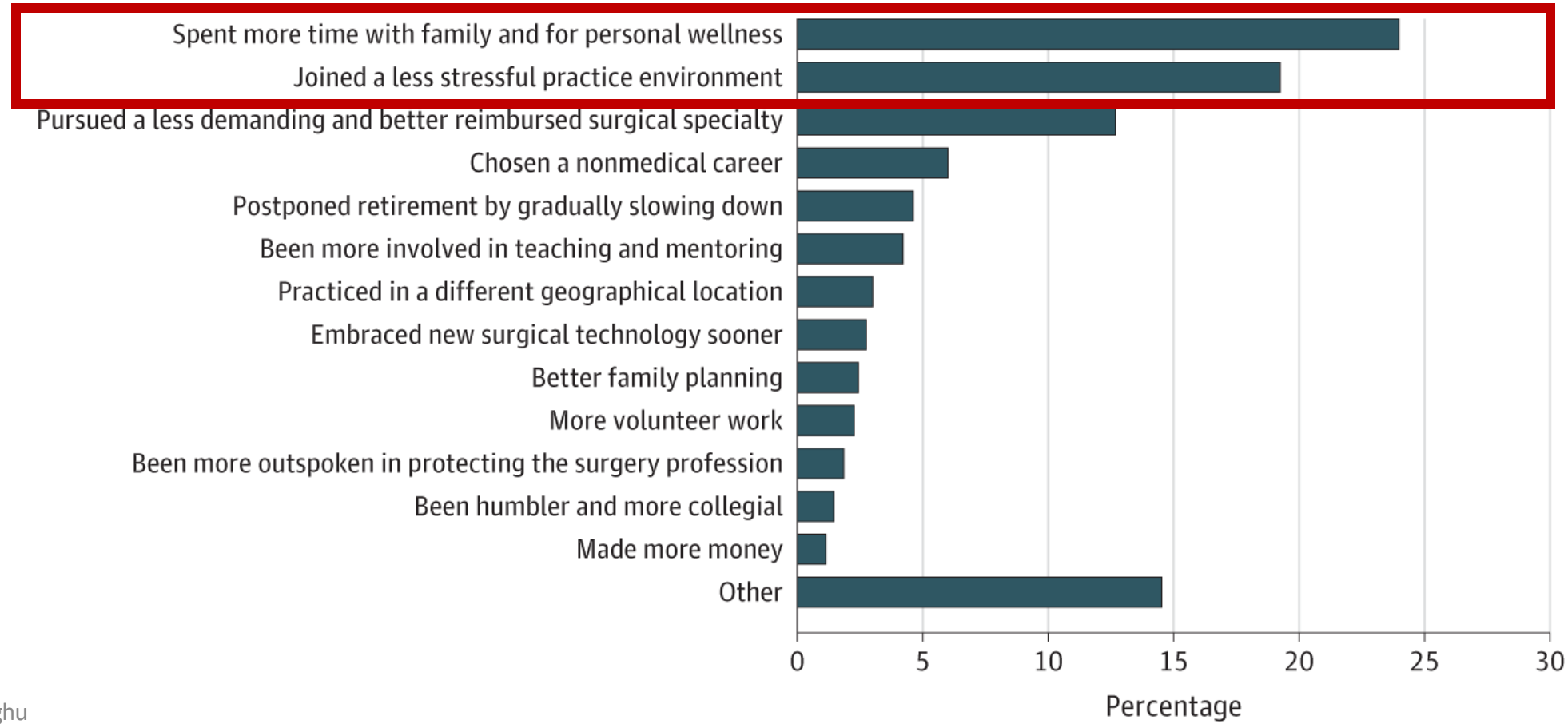
Journal of Business and Psychology

Volume 23 Number 1
March 2009

"…meaningful differences among generations probably do not exist, and the differences that appear to exist are likely attributable to factors other than generational membership"

Retired Surgeons Regret Inattention to Wellness

What would you have done differently?



Stolarski, JAMA Surg 2020

@yueyunghu
@SENTteam

Why should hospitals care about faculty well-being?

The Business Case

JAMA Internal Medicine
December 2017

The Business Case for Investing in Physician Well-being

Tait Shanafelt, MD[1]; Joel Goh, PhD[2,3]; Christine Sinsky, MD[4]

- Attrition is expensive
  - Direct costs of recruitment ~$88k
  - Lost revenue during recruitment, onboarding, and ramping up ~$990k/FTE
  - Cost of patient transitions?
  - Increases risk of turnover of all other members of care team for 12 mo

The Business Case

JAMA Internal Medicine
December 2017

The Business Case for Investing in Physician Well-being

Tait Shanafelt, MD[1]; Joel Goh, PhD[2,3]; Christine Sinsky, MD[4]

- Decreased productivity is expensive
  - 1 point increase in burnout associated with 30-50% increase in likelihood that physician will reduce professional work effort in the next 24 mo
  - Burnout reduces academic productivity by ~15%

The Business Case

- Happy people are more productive (12%)

Oswald, J Labor Econ 2015

"If I have people who are happy, who like being here, they actually work harder…I feel like they would do anything that I asked, even at expense to themselves, because they felt that way." – Chair

The Quality & Safety Case

Burnout and Medical Errors Among American Surgeons

Tait D. Shanafelt, MD, Charles M. Balch, MD,†‡ Gerald Bechamps, MD,†§ Tom Russell, MD,† Lotte Dyrbye, MD,* Daniel Satele, BA,* Paul Collicott, MD,† Paul J. Novotny, MS,* Jeff Sloan, PhD,* and Julie Freischlag, MD†‡*

- 1 point increase in depersonalization associated with 11% increase in likelihood of reporting error
- 1 point increase in emotional exhaustion associated with 5% increase in likelihood of reporting error
- No effect of # call nights/week, practice setting, compensation plan, number of hours worked

The Quality & Safety Case

December 9, 2020

Association of Physician Burnout With Suicidal Ideation and Medical Errors

Nikitha K. Menon, BA[1]; Tait D. Shanafelt, MD[2]; Christine A. Sinsky, MD[3]; et al

September 6, 2006

Association of Perceived Medical Errors With Resident Distress and Empathy

A Prospective Longitudinal Study

Colin P. West, MD, PhD; Mashele M. Huschka, BS; Paul J. Novotny, MS; et al

- Burnout associated with 44-48% greater odds of reporting error
- 1 point increase in DP associated with 10% increase in odds of reporting error in the next 3 months
- 1 point increase in EE associated with 7% increase in odds of reporting error in the next 3 months

@yueyunghu
@SENTteam

6. It Doesn't Have To Be Hard

- Emotions, happiness, and burnout are contagious

Petitta, Stress Health 2017
Fowler, BMJ 2008

- Guidance from org psych

Faculty Wellness

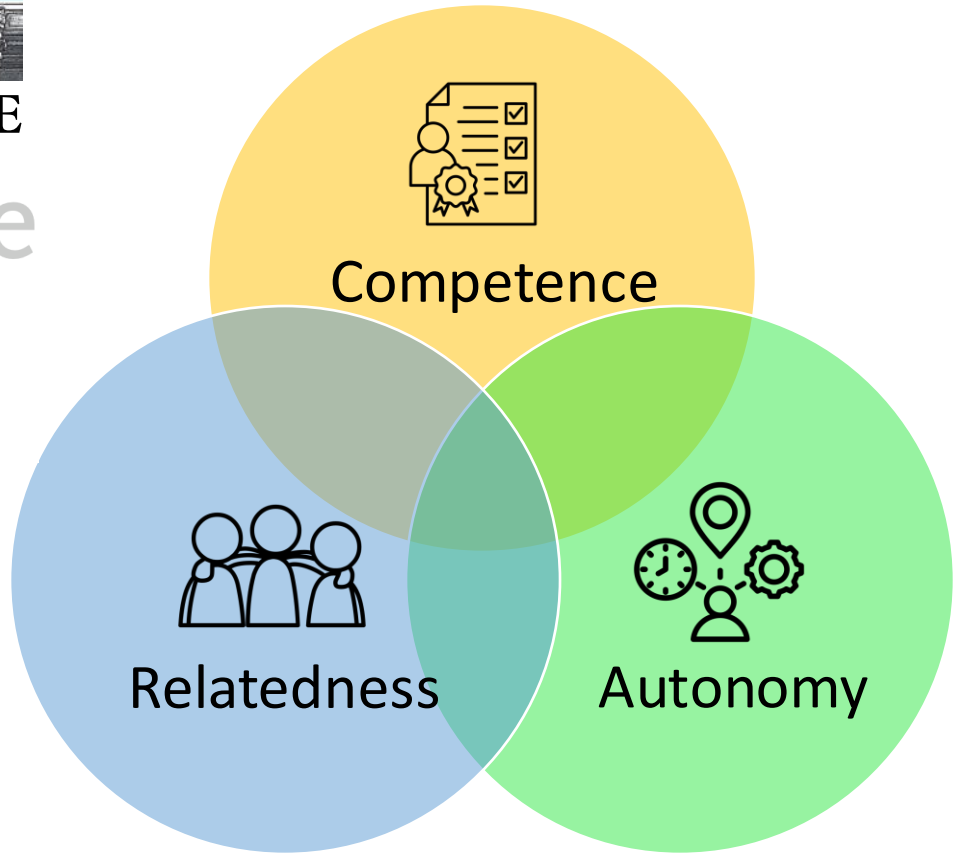
The NEW ENGLAND JOURNAL of MEDICINE

Perspective

JUNE 25, 2020

Physician Burnout, Interrupted

Pamela Hartzband, M.D., and Jerome Groopman, M.D.



@yueyunghu
@SENTteam

Competence

Individual

- Sense of efficacy
- Professional growth

Organizational

- Efficiency
- Resources
- Support – e.g., after complications

3. Don’t Ignore the System

“Hey, Sisyphus, when you’ve got a minute I’d like to discuss this progress report with you.”

- Organizational inefficiency underlies low self-efficacy
- Burnout derives from futility & compensating for gaps in the system

Systems Approach: Increase Efficiency

"Somewhere along the way, the administrators figured out that the whole goal of the whole operation should be to expedite and facilitate surgery. You would never ever want to tell a patient, 'You can't have surgery tomorrow because there's not enough beds'…People aren't going to beat their heads against the wall in that system…There is extraordinarily low turnover here among the surgeons."

– Faculty

Relatedness

Individual

- Collegiality
- Shared mission
- Inclusion

Organizational

- Aligned incentives
- Servant leadership
- Recognition & appreciation

Focus on Individual RVUs Hinders Collegiality

He had a partner, and he would try to help her. She had 4 nannies, her husband was a fellow, and she would be like, 'No, no, no, no. Those are my RVUs; don't touch them.' And that was the behavior, because everybody was just trying to get RVUs. It was just really toxic." –Chair

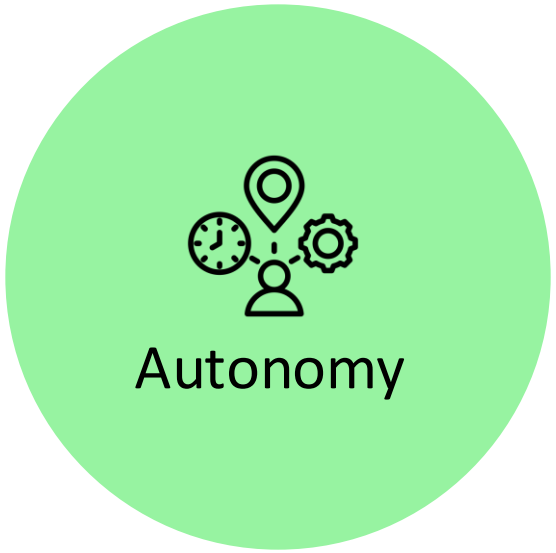
@yueyunghu
@SENTteam

Systems Approach: Incentivize Teamwork

We just redesigned our comp plan... [In the] Division Model…they have a divisional RVU target…I predict that the people… are going to be much happier than the people who have these individual targets…They're not competing…I have another division who…have five different values per work-RVU based on practice. So, it's effectively still a collections-based model, more or less. And that's the group that competes the most, too – the most unhappy."

–Chair

Autonomy



Individual Control

- Work product
- Work scheduling
- Work processes

Organizational

- Respect
- Flexibility
- Responsiveness to feedback

1. It's About Meaning

- Financial incentives do not provide meaning

"I long ago lost my love of this job because it has become about making money for the hospital instead of about patient care." – Faculty

"[The] issue of RVUs where you're given a target, and you're constantly checking...[a] checkbox of metrics where you feel like you're constantly failing in some ways; [it] is really demoralizing. – Chair

@yueyunghu
@SENTteam

1. It's About Meaning

"The finances have changed…People are expected to work all the time to generate the RVUs and the income...But it's very hard to balance that…Burnout comes from feeling like you're just physically unable to keep it up...Doctors, we're driven by guilt and responsibility and ethical obligation… And so when your boss asks you to be on a committee or you are trying to publish a paper...but then the patient is sick and you have to go to the operating [room]...you somehow have to do it all and stay up all night and write the paper..."

– Faculty

Work Meaningfulness

- Job satisfaction
- Career clarity
- Personal fulfillment
- Life satisfaction

- Work engagement
  - Work effort
- Job performance
  - Work efficacy
- Organizational commitment
  - Citizenship behaviors
- Innovation/creativity
- Customer/client satisfaction

Weinstein & Finkel, in press.

Systems Approach: Autonomy

- 8. Prioritize voice & agency
  - Autonomy reflects respect and trust
    - Clinic templates
    - Program building
- 7. Radical transparency builds trust
  - Open discussions

- What is an FTE?
- How to recognize/value work that advances the nonclinical mission?

Intervention: Data Reports

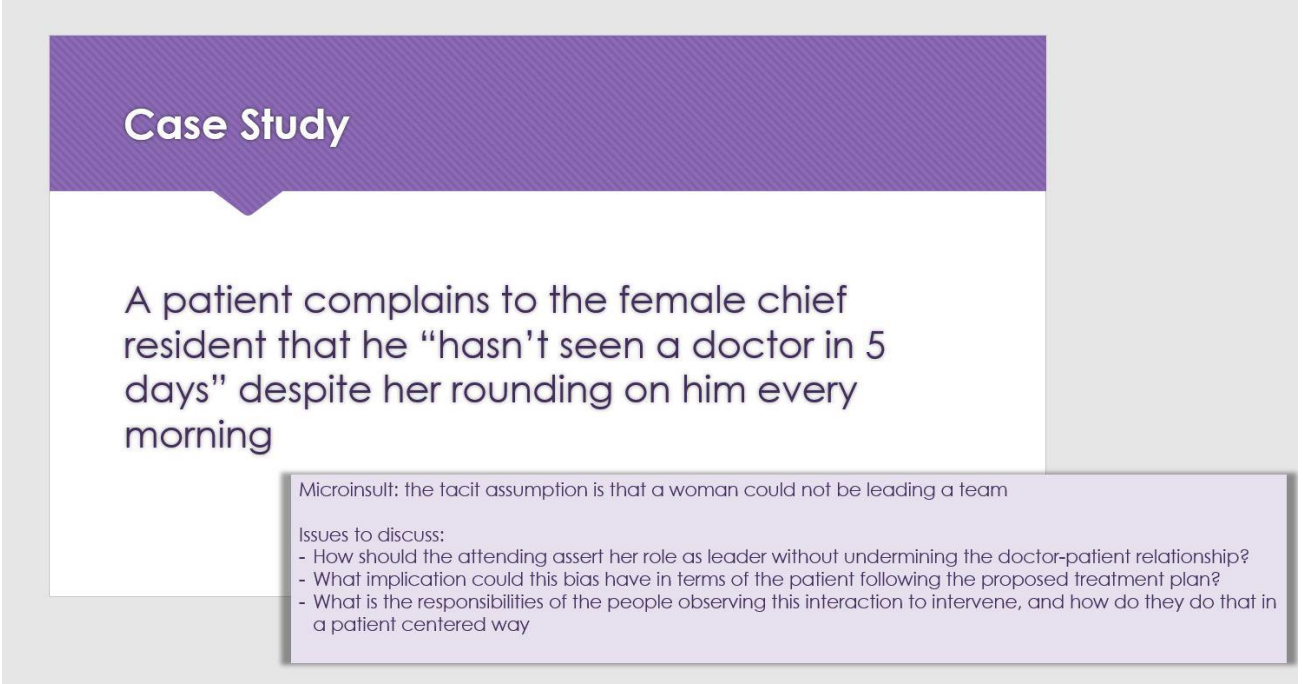
- Resident & faculty
  - ACGME survey
  - ABSITE survey
- Leadership
  - Priorities
  - Inventory of policies & practices
- Centralized review of primary data?
  - NLP of evaluations
  - Faculty demographics & promotion/attrition statistics

Org Psych Interventions: Individual

- Intergroup Contact
- Countering Stereotypes
- Perspective Taking
- Superordinate Identity

Stephens, Res Org Behavior 2021

Cultural Complications M&M



Harris CA, Ann Surg 2021

Org Psych Interventions: Organizational

- Diversifying Opportunity
- Increasing Transparency
- Making Evaluation More Systematic
- Increasing Accountability

Stephens, Res Org Behavior 2021

Forbes

Culture Fit Versus Cultur
Add: Hiring For Growth

Louis Montgomery Jr. Forbes Councils Member

Culture-Fit Hiring Hinges On Implicit Bias

We all have implicit biases. Being able to categorize peo
humans survive. Unfortunately, tho
inst us. And in the case of workplac
ainst the success of our businesses
ine, so when companies hire for cu
ing on their implicit biases both fo

[BIAS INTERRUPTERS] *small steps big change* WORKLIFE LAW

– **Designing the Performance Evaluation Form**

· **Begin with clear and specific performance criteria directly related to job requirements.**
Try: "She writes maintainable code, tests her work thoroughly, offers clear and useful sugges
reviews, and communicates well with clients to gather requirements," instead of: "She's a gre

· **Require evidence from the evaluation period that justifies the rating.**

@yueyunghu
@SENTteam

Implementation Support

- Minimum commitment?
- Learning collaborative & coaching
  - Vice chairs of DEI
  - Department chairs
- Centralized resources
  - National Grand Rounds
  - Community
  - ARMOR

Centralized Resource: Community

- Non-white or Hispanic residents less likely to report a mentor who genuinely cares about them and their career (OR 0.81, 95% CI 0.71-0.91) *Silver, JAMA Surg 2024*
- AAS-SECOND National Mentorship Network
  - 151 residents matched to external mentors, 98% minoritized identity
  - 97% honest advice
  - 64% emotional support
  - 58% new opportunities
- Peer groups


Tarik Yuce, MD, MS


Casey Silver, MD


Callisia Clarke, MD
AAS President-Elect


Imani McElroy, MD

@yueyunghu
@SENTteam

Centralized Resource: ARMOR

- Referrals from PDs, self-referrals
- Independent assessment & recommendations
- Meaningful remediation
- External mentorship & coaching teams
- Liaison with program

William McDade, MD
Chief DEI Officer, ACGME

Callisia Clarke, MD
AAS President-Elect

Bonnie Mason, MD
Director of DEI, ACS

Melissa Hogg, MD

Our Research Fellows


Ryan Ellis, MD, MS


Brock Hewitt, MD


Tarik Yuce, MD, MA


SchMiyah Smith, MS, MD


Rhami Khorfan, MD


Brian Nasca, MD


Andrew Hu, MD


Joseph Sanchez, MD


Ray Ramirez, MD


Lindsey Zhang, MD, MS


Meixi Ma, MD MS


Brian Brajcich, MD


Maya Hunt, MD


Bona Ko, MD, MPH


Casey Silver, MD


Ruojia Debbie Li, MI


Egide Abahuje, MD


Radha Patel, MD Candidate

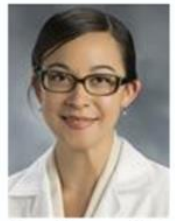

Rachel Joung, MD


Michael Visenio, MD


Kimberly Golisch, MD


Sam Warwar, MD


Jennifer Delgado, MD


Darci Foote, MD


Eric Pillado, MD


Evan Heiderscheit, MD


George Javitch, MD Candidate


Lauren Janczewski, MD


Charesa Smith, MD


Suhail Zeineddin, MD


Asia Swinarska, MD


Chelsea Fischer, MD, MS


Matthew Chia, MD


Cary Jo Schlick, MD, MS


Rhea Verma, MD Candidate

SENT Team

Daniela Amortegui, MS
Project Manager

Joshua Eng, PhD
Statistical Analyst

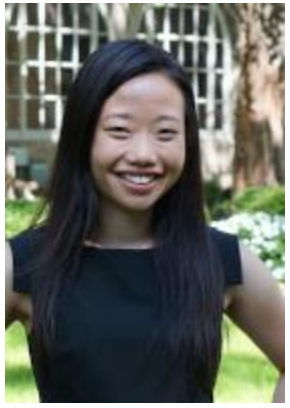
Julie Johnson, PhD
Qualitative Research

Natalia Mackiewicz
Research Assistant

Nathan Monson
Web Developer

Tiannan Zhan, MS
Statistical Analyst

Gaurava Agarwal, MD
Psychiatry



Elaine Cheung, PhD
Psychology

Charity Glass, MD, MPH
Co I

Callisia Clarke, MD
Co I

Amy Holmstrom, MD
Co PI

Karl Bilimoria, MD, MS
Co PI

Thoughts?

yueyunghu@luriechildrens.org

SENT@iu.edu