Visioning Inclusion in an Academic Medical Center

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Abstract: It has been said that microaggressions such as microinsults, microinvalidations, microassaults, and environmental microaggressions are “commonplace” in medicine. Despite their ubiquity, they are preventable at an individual, group, institutional, and societal level. However, without understanding their prevalence and content they are impossible to address. Therefore, to determine the prevalence of microaggressions at an academic medical center we surveyed faculty, staff, and students. Consistent with what has been reported in the literature, the survey revealed a relatively high level of microaggressions across all levels of the academic medical center. Based on the survey findings, we developed specific, targeted actions including dissemination of a monthly calendar designed to heighten awareness and understanding of diversity, annual recognition of a faculty member and staff member for their efforts to further diversity and inclusion, revision of recruitment procedures for all senior administrative and many faculty positions, and the initiation of a diversity strategic action planning process.

Keywords: *Inclusion; diversity; academic medical center; microaggression; diversity strategic action plan; microaffirmation.*

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1. Introduction

Evidence suggests that women and underrepresented minorities in medicine, whether students, staff, or faculty, continue to be confronted by discriminatory practices and microaggressions (Carr et al., 2000; Jagsi et al., 2016; Peterson et al., 2004; Torres et al., 2019). Indeed, at least one author has suggested that microaggressions are “commonplace” in medicine (Overland, 2019). As currently understood, microaggressions are “snubs, slights, and insults directed towards minorities, as well as to women and other historically stigmatized groups, that implicitly communicate or at least engender hostility” (Sue et al., 2007). Microassaults include name calling and blatant refusals to work with someone perceived as different (Torres et al., 2019). Microinsults are rude, demeaning, and/or insensitive communications focused on an individual’s identity. Microinvalidations are communications that negate, invalidate, or dismiss an individual’s thoughts, feelings, experiences, or concerns. Environmental microaggressions occur when microassaults, macroinsults, and microinvalidations are part of the culture, policies, procedures, and climate of a workplace (Sue et al., 2007; Wong et al., 2014). The communicators may have no understanding or awareness of either their negative impact on their recipient (Overland, 2019; Sue et al., 2007) or of their own underlying bias that may have prompted the microaggression (Zumsteg & Lindo, 2019).

As one author noted, “[M]icroaggressions are not about having hurt feelings. Rather, it is about the negative effect that being repeatedly insulted, invalidated, alienated, and dismissed have at both a micro and macro level” (Montenegro, 2016). The deleterious effects of microaggressive behavior can be seen at all levels of medicine. Students may feel devalued and such experiences may adversely affect their learning, academic performance, and personal wellness (Ackerman-Barger et al., 2019). A microaggressive environment may be unable to recruit or retain women and underrepresented minorities (Ackerman-Barger et al., 2015) and may limit their ability to advance or remain in medicine (National Academies of Sciences, Engineering, and Medicine, 2018). Ultimately, the lack of a diverse healthcare workforce contributes to lesser patient care, poorer patient outcomes, poorer physician-patient communication, and increasing health disparities (Alsan et al., 2018; Sederstrom et al., 2018).

Despite the seeming ubiquity of microaggressions, they are preventable (Zumsteg & Lindo, 2019). Interventions can be implemented at the individual, group, institutional, and societal levels (Zumsteg & Lindo, 2019). We describe here our conduct of a diversity needs assessment survey

undertaken at one academic medical center to better understand the experiences of all students, faculty, and staff and discuss the actions taken by the academic medical center following that assessment to address the issues raised and pursue the school's vision and core value of increasing diversity and developing a climate that welcomes and celebrates diversity.

2. Approach

2.1. The Diversity Needs Assessment

Ten individuals holding key positions throughout the university were invited to participate as volunteers on a diversity needs assessment committee to develop the survey instrument or questionnaire, and plan its rollout. Members included administrators, faculty, and medical and graduate school students. The committee reviewed published instruments focused on diversity needs-related issues. Using these as a foundation, the committee developed a draft survey questionnaire, which was pretested in two ways: first, in focus groups with faculty and students and, second, through dissemination to a selected group of faculty and students with a request for comments. The questionnaire was revised based on feedback from these two pretests and then pretested again.

The resulting final diversity needs assessment instrument consisted of 42 questions that asked about individual's demographic characteristics, their relationship to the medical center, the climate of the medical center, and their experiences of verbal, electronic (e-mail text message, social media), or physical harassment due to race, ethnicity, sex, gender identity, sexual orientation, religion, disability, immigration status, or primary language. Respondents were instructed to focus solely on experiences that had occurred on the premises of the medical center within the two years immediately preceding the date on which they completed the survey. Individuals were asked to respond to many of the questions using a 6-point Likert scale that ranged from strongly disagree to strongly agree and were also provided with an opportunity to add comments.

The survey was distributed in 2017 to all faculty, staff, and students of the academic medical center. We studied quality of the survey data by running frequency analyses, contingency table analyses, and graphs. Demographic variables were rigorously examined to better understand their relationship with the survey responses. For example, we classified the responders by creating generations: millennials (50.6%), generation X'ers (33.3%), and baby boomers (16.0%) and assessed the association between generation and climate of the academic medical center, as an example.

Continuous and categorical variables were summarized as median (IQR), and frequency (%), respectively. We performed Chi-square tests to examine the equality of various proportions of microaggressions across the study groups (results are not shown). We evaluated the association between microaggressions and group status (faculty, staff, students, female, and minority) with logistic regression analysis and reported statistically significant odds ratios (OR). All quantitative data analyses were performed using statistical software Stata 15.0.

To examine the qualitative data, each comment was assigned a number. A systematic classification scheme (codebook) was developed, consisting of general categories and subcategories of topics; each of these categories and subcategories was assigned a number. Each comment was assigned as many classification numbers as required to describe accurately its contents. One computer entry was made for each idea in each such entry. We organized the qualitative responses using Atlas.ti to identify themes and subthemes. Although the respondents often provided nuanced comments, this report focuses on only the major themes.

Of the 5918 individuals surveyed, 774 responded (13.1%). Respondents were almost evenly divided between faculty (31.5%), staff (34.8%), and students in the various clinical and basic science programs based at the medical school (33.7%). Slightly more than one-half of the respondents were female (57.2%), almost one-third self-identified as non-white (30.2%), 13.8% self-identified as non-heterosexual, and just over one-half were millennials, ages 21-37 (50.6%).

Although the vast majority (>92%) of respondents reported that they believed that everyone was treated with respect and that the medical center created a climate of respect, a number of respondents reported a significant number of verbal, electronic, and/or physical harassment incidences during the previous two years. (See Tables 1 and 2, below.)

Table 1. Incidence of Verbal, Electronic, and/or Physical Harassment Experiences
Source: Authors' own conception of table, data from survey

	Faculty (n=244)	Staff (n=269)	Students (n=261)	Total (N=774)
Verbal harassment*	162	184	239	585
Electronic harassment	76	90	93	259
Physical harassment	54	88	72	214
Total	292	362	404	1058

* An individual could experience multiple different types of harassment because of sex, race, ethnicity, religion, immigration status, primary language, etc.

Table 2. Number of Unique Individuals Reporting Experiences of Verbal, Electronic, and/or Physical Harassment

Source: Authors' own conception of table, data from survey

	Faculty (n=244)	Staff (n=269)	Students (n=261)	Total (N=774)
Verbal harassment	52 (21.3%)	60 (22.3%)	75 (28.7%)	187 (24.2%)
Electronic harassment	22 (9.0%)	25 (9.3%)	26 (10.0%)	73 (9.4%)
Physical harassment	13 (5.3%)	21 (7.8%)	17 (6.5%)	51 (6.6%)
Total ^a	57 (23.4%)	65 (24.2%)	79 (30.3%)	201 (26%)

^a This is a count of unique respondents who experienced any harassment. Anyone who experienced multiple harassments is counted as 1; those who did not experience any harassment are counted as 0.

Student status (OR= 1.56, $p=0.02$), being female (OR= 1.61, $p=0.01$), and self-identifying as a minority (OR= 1.40, $p=0.07$) were found to be statistically associated with having experienced verbal harassment. Being female was associated with physical harassment as well (OR=1.86, $p=0.05$). None of the groups felt significant electronic harassment or threat because of their race, ethnicity, sex, gender identity, sexual orientation, religion, disability, immigration status or primary language.

Qualitative responses revealed four major themes: (1) microaggressions are committed by individuals at all levels (faculty, staff, and students) and individuals at all levels are the targets of microaggressions; (2) additional and more nuanced programming across all levels of the academic medical center is needed to address bias; (3) there exists systemic bias in favour of white men with respect to recruitment of faculty, salary, and receipt of awards; and (4) “mainstream” people are (a) often made to feel as though they have done something wrong and (b) are often falsely accused of discrimination. A fifth theme was also noted: that there is too much emphasis on diversity. Table 3 below provides examples of quotes that illustrate each of these themes.

Table 3. Sample of Comments Illustrative of Themes from Qualitative Survey Responses

Source: Authors' own conception

Theme	Illustrative Example
Microaggressions are committed by individuals at all levels (faculty, staff, and students) and individuals at all levels are the targets of microaggressions	I can rarely leave my office without being catcalled by a custodian ... This is harassment. The staff should know better. My own experience is to walk down the hall and say good morning and get looked at like you're the plague. [from someone who identified themselves as a person of color]
Additional and more nuanced programming across all levels of the academic medical center is needed to address bias	[This] is a very rough environment and none of you do enough to make sure that it is inclusive of marginalized groups. Diversity is thrown around as a feel good term. You will have diversity talks, but no action, no funding, no training that is sustainable to actually make sure that the culture [of the institution] changes My office may need diversity training, sensitivity classes—and faculty/staff have to come in with an open mind for these classes and not take offense to everything! It is very frustrating that my voice seems to not be heard.
There exists systemic bias in favour of white men with respect to recruitment of faculty, salary, and receipt of awards.	From a pre-clinical professor: "I don't want you to go into neurosurgery. I want you to get married and have babies." I am a heterosexual female and this comment is unacceptable. How come only one basic science chair is female? URM [under-represented minority] chairs? Seems same few white straight men in leadership positions make all the decisions for [the academic medical center]. I do not observe this at all outside [the academic medical center]. Very different culture.
"Mainstream" people are (a) often made to feel as though they have done something wrong and/or (b) are often falsely accused of discrimination.	I believe the school does a good job in looking at under-represented groups, but feel that in doing so, they sometimes make traditionally well-represented groups feel like they have done something wrong. To clarify on the question about harassment, while at [the academic medical center], the one time I have felt overt harassment on basis of gender was

	when I as a white male was falsely verbally accused of gender discrimination (for an action that actually I had not even instigated but was nonetheless blamed for and in the course of that was accused of gender discrimination
There is too much emphasis on diversity.	Too much. It's in our face too much. Every week I get emails about this topic. The differences emphasized should be de-emphasized and this program just is a constant reminder that we should see each other as a race, ethnicity, sex, age ... We shouldn't strive to be diverse. Diversity for the sake of diversity is counter-productive. Sometimes, the lack of diversity is truly the best option to achieve certain goals. I will respect everyone that walks through my door and treat them with kindness, but being forced to accept and be trained in something that goes against my beliefs to me is discrimination in itself even though I am considered a majority.

2.2. Pursuing Our Core Value Through Social Action

The findings from the survey provided a baseline for faculty, staff, and student experiences of microaggressions in the academic medical center within the recent past. Despite the previous efforts of the academic medical center to provide a foundation for all faculty, staff, and students to better understand and welcome diversity, the results of the survey suggested that these efforts had not been adequate. The findings additionally indicated a clear divergence between individuals who reported having experienced microaggressions and a need for greater emphasis on diversity-related issues, and those who felt that they were being viewed as perpetrators due to the emphasis on diversity.

The findings of the diversity needs assessment survey were presented to faculty, staff, and students at several town hall meetings and, additionally, to faculty and staff at department level meetings. In order to address the concerns raised by the survey findings, the academic medical center moved forward with several initiatives: the revision of search procedures for all senior level administrators and all faculty who would receive 50% or more of their salary from the academic medical center; the development of a monthly holiday calendar; the initiation of annual awards to one faculty member and one staff member for their efforts to promote diversity and inclusion within

the academic medical center; and the initiation of the diversity strategic planning process for the second iteration of the school's diversity strategic action plan, which would take effect on January 1, 2020. Figure 1 below provides a timeline of the various diversity-related initiatives that had been implemented before the survey and those that were implemented thereafter.

Search procedures were revised to require that: (1) every search committee include at least one female and one individual who self-identified as an underrepresented minority in medicine; (2) the venues for recruitment be expanded to better target sites that would be of interest to qualified female and underrepresented minority candidates for a specific position; and (3) every phase of the search must include at least one qualified female or underrepresented candidate, e.g., at the initial interview phase, at the on-campus interview phase. Additionally, approval was required at each phase of the process from both the academic medical center's Office for Faculty Development and Diversity and the university-level Office for Inclusion, Diversity, and Equal Opportunity prior to progressing to the next phase of the search.

The holiday calendar was designed to include all national holidays, as well as all religious and many secular holidays for a given month. As an example, the calendar for January 2018 included not only the Feast of the Epiphany, Orthodox Christmas, and Tu B'Shevat, but also Martin Luther King, Jr., Day, World Braille Day, National Hat Day, Winnie the Pooh Day, and National Hug Day, among others.

The annual award to a faculty member and a staff member for their efforts in promoting diversity and inclusion in the academic medical center was instituted in 2017. A nomination required the signatures of a minimum of three persons and an explanation of how the individual exemplified through their actions a commitment to diversity and inclusion. The awards were presented at center-wide catered receptions and were recognized with both a memento and a check.

The diversity strategic planning process was formally initiated in March 2019 with a call for faculty, student, and staff volunteers. The final planning committee consisted of more than 50 individuals from all levels of the academic medical center. The volunteers divided into subcommittees that focused on development, student recruitment, diversity training, overall climate in the academic medical center, faculty recruitment and retention, and medical and graduate education/curriculum. Each subcommittee included faculty, staff, and student representatives. The committee as a whole relied on various sources of data as it moved forward in its deliberations: the results of the diversity needs assessment survey; an analysis

of the academic medical center's strengths, weaknesses, opportunities, and threats (SWOT) as they related to diversity; feedback from an external consultant who had been engaged several years earlier with respect to diversity-related issues; findings from a university-wide climate survey; and focus groups with committee members' various constituent groups.

The committee's draft of the diversity strategic action plan was presented to leadership and to faculty, staff, and students in a series of town hall meetings and meetings with specific interest groups. The final version of the strategic action plan incorporated the majority of the suggestions that were offered. The final diversity strategic action plan, to be effective from January 2020 through December 2024, reiterated the school's vision and core value: "To increase knowledge, understanding, presence, and celebration of diversity at all levels of the School of Medicine." Several specific goals were enumerated:

- To enhance the overall climate to reflect, promote, and welcome diversity
- To enhance the curriculum and associated training opportunities to increase inclusiveness and decrease adverse experiences
- To improve and expand content and format of diversity training for faculty, staff, and students in the context of professionalism
- To enhance the diversity of the academic medical center and diversity-related functions through the development of adequate financial resources

Specific action steps and responsible parties were identified for each of the above goals. As an example, some of the specific goals included improving training of faculty and staff to better manage conflict situations, increasing the number and frequency of diversity-related events and celebrations at the academic medical center, better integrating diversity-related issues into the graduate and medical school curricula, and conducting a systematic evaluation of all policies and procedures to assess the existence of unintended bias.

3. Discussion

This diversity needs assessment survey, to the best of our knowledge, represents one of the first attempts by an academic medical center to determine the prevalence of experiences of microaggressions at faculty, staff, and student levels. It is likely that the findings of that survey reflect bias in view of the relatively low response rate and the likelihood that those who responded were those who were more interested in diversity

and/or had experienced or been accused of committing microaggressions. Nevertheless, the numbers of individuals reporting experiences of harassment, particularly physical aggression, are alarming and are likely an undercount. Although the survey was confidential, some individuals may have declined to participate because they feared that their responses might endanger their position within the academic medical center.

The initiation of the monthly calendar and the diversity awards are examples of microaffirmations that recognize, validate, and reward positive behaviors consistent with the institution's expressed values (Molina et al., 2019). Additionally, the individuals who receive such recognition serve as role models to others, encouraging them to adopt similar behaviors (Helitzer et al., 2017).

The impact of the Diversity Strategic Action Plan 2.0 formulated following the diversity needs assessment survey can only be evaluated over time, ideally by resurveying medical center faculty, students and staff. Our initiation of additional activities and our revision of internal policies and procedures are clear examples of institutional steps that can be taken to further emphasize our core values of diversity and inclusion where there is the commitment to do so. The engagement of individuals at all levels of the academic medical center in these efforts, including faculty, staff, students, and senior leadership, suggests the need for broad-based support if such efforts are to be successful. Leadership support for such initiatives and leadership modelling of appropriate behaviors are particularly critical to the success of efforts intended to enhance diversity and promote inclusion (DiTomaso & Hooijberg, 1996).

Figure 1. Timeline of Diversity-Related Initiatives Pre- and Post- Diversity Needs Assessment Survey

Source: Authors' own conception

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