

An Honest Look in the Mirror – Cultivating a Culture of Equity in Surgery
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James Baldwin, one of the most pivotal literary figures of the 20th century, poignantly wrote in 1962 at the peak of the Civil Rights Movement, “Not everything that is faced can be changed, but nothing can be changed until it is faced.” It’s hard to imagine that almost sixty years later, we find ourselves in the midst of a public health crisis - juxtaposed between a global pandemic, unmasking the long-standing failure of our health system to adequately treat persons of color and widespread social upheaval from police killings of black citizens. The culmination of these timely events reflects a history of racism and discrimination that has permeated US society, but more acutely reveals how pervasive systemic racism still is in 2020. A truth we need to face with no qualifications.

Surgical care in the United States is no exception. The 2002 Institute of Medicine Report “Unequal Treatment” comprehensively exposed the prevalence of racial disparities in the US health care system, highlighting race as an independent predictor of receiving low quality care across a spectrum of diseases.¹ The IOM report ignited prolific research on surgical disparities over the past few decades.² However, almost twenty years after the IOM report, there is no evidence that racial disparities in surgery have been eliminated; in fact our understanding of what drives racial disparities remains sparse. How can we revamp the academic surgery platform to ensure we are not in the same position twenty years from now?

Racism in surgery is not a historical vestige; it is a current reality. Boyd and colleagues recently highlight this essential failure of recognizing and naming the explicit role that racism plays in exacerbating health disparities, “despite the abundance of scholarship on racial inequity, preeminent scholars and the journals that publish them, routinely fail to interrogate racism as a critical driver of racial health inequities.”³ The article further highlights explicit bias in disparity literature that often postulates unmeasured biological factors as a driver of racial differences in health outcomes – despite a lack of robust evidence supporting this hypothesis. Despite the

evidence for racism as a mechanism of health disparity⁴, Boyd and colleagues highlighted how rarely the words “racism”, “institutional racism”, “systemic racism”, and “structural racism” appear in racial disparities articles, let alone are interrogated as a mechanism of disparate outcomes. Additional assertions targeting patient mistrust as a driver of disparities and not a consequence of systematic mistreatment, ignore our culpability in the process and further emphasize the need to restructure our framework for investigating and eliminating racial disparities in surgical care.

To make any real progress towards equity, we must demand more from our scholarship. Research efforts must evolve beyond using administrative data sets to show a disparity gap. The challenge for the next generation of academics studying racial health disparities is to be as vested in eliminating them as we have been in discovering their existence, and in measuring the impact that racism has on surgical outcomes. Funding mechanisms must incentivize studies that interrogate mechanisms of disparities, develop targetable interventions for eliminating disparities, and engage a spectrum of stakeholders to achieve sustainability. Bridging the divide between the communities that experience racial health inequity and the ivory towers that are well resourced to study it will be critical.⁵ Funding here can be paramount, supporting community stakeholder engagement early in the research design and implementation phase will be vital. The Metropolitan Chicago Breast Cancer Task Force (MCBCTF)⁶ formed in 2008 serves as an excellent example of interrogating mechanisms of racial disparity, developing targetable interventions, and engaging a spectrum of stakeholders to reduce racial disparities. The MCBCTF engaged over 100 community/healthcare partners from 74 organizations and convened working groups for nine months to study racial disparities in breast cancer care in Chicago. Driven by data, they explored three guiding hypotheses as explanations for the racial inequity in female breast cancer mortality in Chicago: (1) black women receive fewer mammograms, (2) black women receive mammograms of inferior quality, and (3) black women receive lower quality treatment for breast cancer, once diagnosed. They then embarked on broad-based public health, public policy, and quality improvement focused initiatives ultimately leading to a reduction in breast cancer mortality rates among black women in Chicago.⁶ We must cultivate a research environment that can scale similar efforts. There is a dearth of evidenced-based interventions to eliminate disparities in surgical care. Surgical journals can help drive needed innovation by rapid dissemination of high quality pilot studies and protocols at the earliest phases of research to spur collaboration and inspire further investigation.

A critical examination of our grant review committees and our editorial boards is fundamental to creating an academic surgery culture, which fosters and prioritizes disparity research. The role of grant funding and journals in launching and sustaining research careers, serving as the gateway for dissemination of scientific knowledge, and the validation of academic achievement cannot be understated. Homogenous grant review committees must be replaced by those that encompass broad representation across age, gender, race, and research expertise. A study investigating the association between NIH R01 applicants’ self-identified race and the

probability of receiving funding, found that after controlling for an applicants educational background, country of origin, training, previous research awards, publication record, and employer characteristics black applicants remain 10 percentage points less likely than whites to be awarded NIH research funding.⁷ This disparity is likely due not only to bias against researchers, but also because they tend to be situated outside of well-resourced academic “powerhouses,” and to study areas that are not highly regarded among existing reviewers.⁸ Career development awards from surgical societies also catapult academic success. Reviewers and recipients from these avenues must start to reflect the diverse interests and constituents, which comprise the current complexion and heterogeneity of academic surgery. Socially and professionally diverse grant reviewers can counter racial bias, promote innovation, and ensure that a wide spectrum of science is supported. Growing evidence suggests that greater diversity in senior leadership positions and boards enhances the performance of organizations.⁹ Similarly surgical editorial boards need to do more to ensure that different perspectives are regularly elicited and integrated into their governance, as well as their peer review process. Editorial boards need to make concerted efforts to expand peer review networks beyond their typical academic circles, to identify experts across race, gender, geography, institution, career stage, and research background. Efforts must be put in place to track and audit diversity among editors, editorial boards, reviewers, and those invited for commentary. At a minimum participants in the peer review process should represent women and under-represented minorities proportionate to how they currently exist in surgery; ideally the composition of participants should reflect our aspirations as an inclusive subspecialty that is representative of the communities we serve.

To close as we began with words from James Baldwin, “Any real change implies the breakup of the world as one has always known it, the loss of all that gave one an identity, the end of safety”. The academic surgery environment must vastly transform and address structural inequity in order to achieve real progress towards eliminating racial disparities in surgical care. To summarize our suggestions above, here are a few take-aways:

- Face the scope of the problem – It’s 2020 and we have not made sweeping progress towards eliminating racial disparities in surgical care.
- Explicitly interrogate racism as a mechanism of racial disparity.
- Disparity research that unveils mechanisms and target interventions for elimination of racial disparities must be prioritized and incentivized by funding agencies and surgical societies.
- Community stakeholders must be engaged early and be an integral part of the design to eliminate racial disparities in surgery.
- Grant review committees, both at the federal and surgical society level, must broaden representation to ensure diverse research agendas are supported.

- Surgical editorial boards must reflect the diversity we aspire to represent as an inclusive subspecialty, especially in leadership roles, and iterative processes should be implemented to evaluate our progress.

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