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Let Us Not Be Silent

Surgical Perspective

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On May 25, 2020, George Floyd died after Minneapolis police officer Derek Chauvin knelt on the back of his neck for eight minutes and forty-six seconds. This event occurred just weeks after Breonna Taylor, a young and talented emergency medical technician, was shot and killed in her sleep by police during a "no-knock warrant." The circumstances of their deaths followed a disturbing narrative that plays out ad nauseum in Black communities in America – one where Black lives are disposable and the right to justice is bargained as a luxury in a broken system.[1] The days that followed Floyd's death were marked by widespread outrage. The media became saturated with coverage of the controversy surrounding Floyd's death, protests broke out across the United States, and his death was condemned by leaders at every level. Many Americans took to the Internet to express their feelings and join the national conversation. Searches for "police brutality," "justice," and the victim's names skyrocketed, and social media outlets such as Twitter and Facebook became avenues for individuals to voice their feelings.

For the surgeons, residents, and medical students who took to social media to voice their horror at Floyd's death, many were politely ignored amidst COVID-19 updates and the "business as usual" announcements of grant awards, promotions, and publications. Disturbingly, some were even met with direct opposition, as if speaking out on matters of justice and equality were somehow unprofessional. The role of healthcare providers as advocates during these crises continues to be challenged on the basis of political correctness and public sensitivities. This is eerily similar to the viral #ThisIsOurLane movement that began in 2018, in which the National Rifle Association implored physicians to "mind their own business when it comes to gun violence."[2] Similarly, when the #WhiteCoats4BlackLives movement brought 3,000 medical students to a national white coat die-in in 2014 in the wake of the deaths of Michael Brown and Eric Gardner, many medical schools actively discouraged their students from participating.[3]

Residents are in the peculiar position where they are often directly affected by larger social issues, but may be discouraged from speaking up. This was painfully evident during the height of the COVID-19 crisis, in which providers even faced dismissal for speaking out about personal protective equipment (PPE) shortages. Yet events like Floyd's death demonstrate that residents are often intimately connected to events, policies, and debates that take place beyond hospital walls.

First, the social issues tied up in Floyd's death such as systematic marginalization and inequity are actively experienced by underrepresented minority residents, especially Black surgery residents in America. There is vast underrepresentation of minorities in surgical training programs in the United States.[4] Minority surgical residents are more likely to report not feeling like they fit in with their program or feeling like they cannot count on their peers.[5] Most minority surgical residents report experiencing racial discrimination from staff and patients.[6] Minority surgical residents are at the highest risk of quitting residency before completion.[7] They are also at increased risk of being bullied at work, including being shouted at, persistently criticized, excluded, or victim to offensive remarks or jokes.[8] This risk is not confined only to the hospital but is part of their lived experience outside work. For Black residents, the reality of violence, mistreatment, and discrimination fueled by systemic racism is part of their daily lives.[1] So it should be no surprise that the killing of Black men and women by the police should inspire a vocal response from trainees who live this reality. In a training paradigm where emotional energy is in

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short supply, resident safety and well-being is directly impacted by events that occur on a larger national scale.

The well-being of surgical trainees has become an area of significant interest in the last two decades and a large amount of effort has been dedicated to understanding the factors that influence residents' welfare. The vast majority of these studies have examined work-related factors such as duty hours and negative treatment on the job.[9] Some of the largest survey studies of surgical residents have shown that mistreatment and bullying are frequently reported and associated with burnout and suicidal thoughts.[8] Much less attention has been devoted to how forces outside the workplace affect resident wellness or how these experiences may have profoundly different effects on residents of different races and ethnicities. In a training system that has historically functioned with a color-blind mentality, residents of color are assumed to have equivalent workplace experiences to their Caucasian counterparts when the reality is that our profession provides minimal protection against abuse both inside and outside the hospital. Even less consideration is given to trainee interests that ought to be nurtured but are instead undermined. Interests beyond working hard and achieving traditional benchmarks of academic excellence are often presented as dead ends in the path to becoming a surgeon, especially in a system where little value is placed on community engagement, social justice, advocacy, and activism at the faculty level.

Residents need and deserve the freedom to express their feelings about events such as George Floyd's death. Not only are trainees passionate about these issues, but those whose privilege has spared them from the most atrocious injustices have a duty to act as allies for our Black colleagues. There are discreet, actionable, and impactful steps that can be taken to combat – and hopefully dismantle – the inequity that affects surgical residents:

1. Create a reporting system for all members of surgical departments to report racial abuse, mistreatment, and discrimination from fellow employees.
2. Build an algorithm available to all trainees and faculty to assist in dealing with racist patients and families based on patient acuity.[10]
3. Develop equity committees to systematically prioritize workforce diversity and value equity related work.[11]
4. Recognize and reward engagement in social activism in the same way as publication and grant accrual.
5. Establish strategic pipeline programs to identify, recruit, and assist minority applicants into a career in surgery.

These strategies, while vital to promoting a more equitable training environment, fall short of recognizing the daily, lived experience of minority surgical residents. Therefore, surgical leaders must also intentionally seek out and amplify the voices of minority trainees. For example, these themes can be incorporated into the resident curriculum. In the same way that trainee time is protected for didactic learning or case review, dedicating time to discussing issues of systemic racism – with intentional inclusion of minority residents – would not only strengthen programs by helping them identify opportunities for improvement, but would promote allyship among trainees of different backgrounds.

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One particularly impactful example of this is the concept of a regular "cultural complications" conference, where instead of discussing deaths and complications, residents and staff discuss cases such a patient who refuses to see a Black doctor or a coworker who is concerned a "more qualified" candidate was passed over in favor of a more "diverse candidate."[12] Intentionally protecting time to highlight these issues is crucial in achieving an atmosphere of inclusion. In short, reporting mistreatment and establishing equity committees can certainly steer a program in the right direction, but creating space for the voices of minority trainees and providing all trainees with the tools to recognize systemic inequities can change a program's culture.

Minority trainees should be further supported in addressing these issues through vocal activism, publication, and even social media, where many surgical residency programs have a strong presence.[13] They should be uniformly supported to engage in social justice activities, from the support of pipeline programs benefiting underrepresented students, to engagement in action-oriented health disparities research. At the same time, there needs to be universal organizational buy-in into the mission of anti-racism. The work of equity and justice cannot only fall solely on those most affected by discrimination and racism. These are activities which Departments can support, encourage, and fund. Despite the lack of a formal support system to respond to social injustices as part of their training, residents have an incredible privilege in that they are precisely in a position to be the leaders and voices of change. What's more, the current generation of surgical trainees is particularly adept in their recognition and response to these complex issues. The swell of their voices reflects the moral passion they feel, a passion reflected eloquently in the following words:

> *The work of a physician as healer cannot stop at the door of an office, the threshold of an operating room, or the front gate of a hospital. The rescue of a society and the restoration of a political ethos that remembers to heal have become the physician's jobs, too. Professional silence in the face of social injustice is wrong.*[14]

Yes, these events are outrageous. They are appalling. But they are not new. Violence against the Black community has been tolerated, forgiven, and forgotten for hundreds of years. The current events are rooted in an ongoing national crisis of racial inequity. To the resident who has been in the trauma bay and seen what violence does to a body, who has had a patient look at them and say, "I can't breathe," they are all but overwhelming. We speak out because we are compelled to give a voice to the feelings that overwhelm us. And in our voice is our sense of duty to treat those who have suffered violence. In our voice is our concern for the wellbeing of ourselves and our colleagues who live these tragedies and face the countless barriers of discrimination as part of a day's work. In our voice is our demand for justice and our desire to change the world in which these tragedies occur. We refuse to be silent because we refuse to be complicit. And we encourage those who hear us to welcome our message and join in our refusal to be silent, so that our collective voice will not be drowned out in this midst of this storm.

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References

1. Edwards F, Lee H, Esposito M. Risk of being killed by police use of force in the United States by age, race-ethnicity, and sex. *Proc Natl Acad Sci U S A.* 2019;116(34):16793-16798.
2. Ranney ML, Betz ME, Dark C. #ThisIsOurLane - Firearm Safety as Health Care's Highway. *N Engl J Med.* 2019;380(5):405-407.
3. Bassett MT. #BlackLivesMatter--a challenge to the medical and public health communities. *N Engl J Med.* 2015;372(12):1085-1087.
4. Butler PD, Longaker MT, Britt LD. Major deficit in the number of underrepresented minority academic surgeons persists. *Ann Surg.* 2008;248(5):704-711.
5. Wong RL, Sullivan MC, Yeo HL, Roman SA, Bell RH, Jr., Sosa JA. Race and surgical residency: results from a national survey of 4339 US general surgery residents. *Ann Surg.* 2013;257(4):782-787.
6. Yuce TK, Turner PL, Glass C, et al. National Evaluation of Racial/Ethnic Discrimination in US Surgical Residency Programs. *JAMA Surg.* 2020.
7. Yeo HL, Abelson JS, Mao J, et al. Who Makes It to the End?: A Novel Predictive Model for Identifying Surgical Residents at Risk for Attrition. *Ann Surg.* 2017;266(3):499-507.
8. Zhang LM, Ellis RJ, Ma M, et al. Prevalence, Types, and Sources of Bullying Reported by US General Surgery Residents in 2019. *JAMA.* 2020;323(20):2093-2095.
9. Hu YY, Ellis RJ, Hewitt DB, et al. Discrimination, Abuse, Harassment, and Burnout in Surgical Residency Training. *N Engl J Med.* 2019;381(18):1741-1752.
10. Paul-Emile K, Smith AK, Lo B, Fernandez A. Dealing with Racist Patients. *N Engl J Med.* 2016;374(8):708-711.
11. Bonner SN, Wakam GK, Kwayke G, Scott JW. Covid-19 and Racial Disparities: Moving Towards Surgical Equity. *Ann Surg.* 2020.
12. Harris CA, Dimick JB, Dossett LA. Cultural Complications: A Novel Strategy to Build a More Inclusive Culture. *Ann Surg.* 2020.
13. Hill SS, Dore FJ, Em ST, et al. Twitter Use Among Departments of Surgery With General Surgery Residency Programs. *J Surg Educ.* 2020.
14. Berwick DM. Moral Choices for Today's Physician. *JAMA.* 2017;318(21):2081-2082.