Microaggressions, Bias, and Equity in the Workplace: Why Does It Matter, and What Can Oncologists Do?

Ana I. Velazquez, MD, MSc[1]; Timothy D. Gilligan, MD, MS[2]; Lauren L. Kiel,[3]; Julie Graff, MD[4,5]; and Narjust Duma,MD[3]

Downloaded from ascopubs.org by 98.42.87.148 on July 30, 2024 from 098.042.087.148
Copyright © 2024 American Society of Clinical Oncology. All rights reserved.

overview

Despite efforts to embrace diversity, women and members of racial, ethnic, and gender minority groups continue to experience bias, inequities, microaggressions, and unwelcoming atmospheres in the workplace. Specifically, women in oncology have lower promotion rates and less financial support and mentorship, and they are less likely to hold leadership positions. These experiences are exceedingly likely at the intersection of identities, leading to decreased satisfaction, increased burnout, and a higher probability of leaving the workforce. Microaggressions have also been associated with depression, suicidal thoughts, and other health and safety issues. Greater workplace diversity and equity are associated with improved financial performance; greater productivity, satisfaction, and retention; improved health care delivery; and higher-quality research. In this article, we provide tools and steps to promote equity in the oncology workplace and achieve cultural change. We propose the use of tailored approaches and tools, such as active listening, for individuals to become microaggression upstanders; we also propose the implementation of education, evaluation, and transparent policies to promote a culture of equity and diversity in the oncology workplace.

Over the last few years, events in our social environment and context—like the COVID-19 pandemic, public acts of overt racism, and the crisis of police brutality—have highlighted longstanding inequities in health care.[1,2] These inequities are seen directly in patient care, as health care disparities and structural barriers to care, and in the workplace environment, affecting the health care workforce. Despite increasing representation of women in medical education and health care, and despite increasing attention to diversity, equity, and inclusion efforts that promote the recruitment and inclusion of racial minority groups in medicine, individuals in these groups continue to experience inequities and bias in formal and informal workplace settings.[3–5] Women, gender-minority groups, and individuals who belong to nonracial majority groups (e.g., those groups underrepresented in medicine and Asian individuals) continue to face barriers when advancing through academic and nonacademic medicine that majority individuals (e.g., men and non-Hispanic White individuals) do not.[6–8]

With the changes in clinical volume, limited access to supportive resources, and transition to remote learning and work (i.e., telehealth) that resulted and learning that resulted from the COVID-19 pandemic, inequities among the health care workforce are likely to widen.[9,10] These new challenges are compounded by underlying stressors from busy clinical practice; research funding challenges; productivity and documentation requirements; administrative burden; inequities in workload, salary, and opportunity; and other factors that contribute to increasing dissatisfaction and burnout rates among the health care and oncology workforces.[11] The U.S. Bureau of Labor Statistics estimates that the health care sector has lost nearly half a million workers during the COVID-19 pandemic since February 2020.[12,13] Surveys estimate that 18% of health care workers quit and 12% were laid off.[14] The long-term effects of these changes on the oncology workforce and workplace environment are unknown. In this article, we highlight the importance of equity in the workplace, and we provide tools to achieve equity in our oncology environment.

EQUALITY OR EQUITY: WHAT IS THE GOAL?

The terms equality and equity are often mistaken and used interchangeably. Although they are related, equality and equity are distinct terms with different implications (Fig. 1). The Equality and Human Rights Commission defines equality as the distribution of the same resources and opportunities to every individual across a population.[15,16] In the workplace, equality means providing all employees with the same rules, privileges, and benefits. By not tailoring to specific individual needs, workplace equality can result in unfairness in the workplace environment.

Author affiliations and support information (if applicable) appear at the end of this article.

Accepted on April 13, 2022, and published at ascopubs.org on June 1, 2022: DOI https://doi.org/10.1200/EDBK_350691

Downloaded from ascopubs.org by 98.42.87.148 on July 30, 2024 from 098.042.087.148
Copyright © 2024 American Society of Clinical Oncology. All rights reserved.

PRACTICAL APPLICATIONS

- Equity refers to the absence of avoidable or remediable differences among groups of people; equity requires a customized distribution of resources and opportunities to ensure no subsets of the group are at a disadvantage in achieving their maximum potential in the workplace.
- Gender, racial, and ethnic inequities prevail in the health care workforce, limiting the income, retention, and promotion of women and members of underrepresented groups in medicine to leadership positions in oncology.
- Diversity and equity in the workplace improve health care delivery and patient care; research quality and innovation; individual satisfaction, performance, and productivity; and institutional growth and financial performance.
- Women and members of underrepresented groups in medicine are commonly the recipients of microaggressions and discrimination from colleagues and patients; to reduce microaggressions in oncology, we must educate health care workers on the negative effects of microaggressions, recruit allies, and create policies for institutional accountability.
- To achieve cultural change, cancer centers and health care systems must invest in resources and staff to perform internal measures of institutional culture and equity; ensure diversity, equity, and inclusion are centered in all activities; provide bias training for all staff; create and implement safe reporting mechanisms; and adopt transparent policies and procedures.

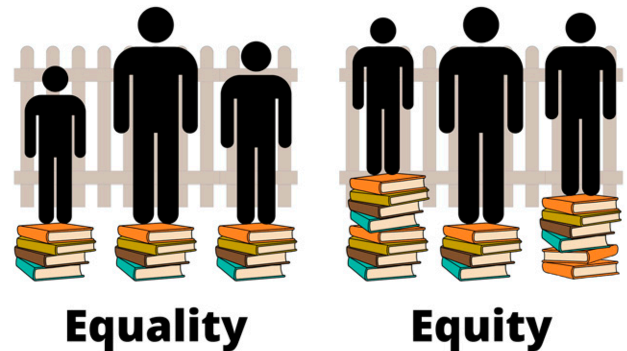

FIGURE 1. Understanding Equality Versus Equity

Equity, on the other hand, is defined by the World Health Organization as the "the absence of unfair, avoidable or remediable differences among groups of people, whether those groups are defined socially, economically, demographically, or geographically or by other dimensions of inequality (e.g., sex, gender, ethnicity, disability, or sexual orientation)."[17] Therefore, equity requires that the distribution of resources and opportunities is customized across a group or population to ensure no subsets of the group are at a disadvantage in achieving their maximum potential.[15] Equity in the workplace environment strives to identify the specific requirements of the employee, including particular needs that can be related to the intersection of personal identities such as race, ethnicity, age, gender identity, sexual orientation, disabilities, and religion. Therefore, institutions, oncology practices, and societies should set equity and justice (fixing the systems in a way that leads to long-term, sustainable, equitable systems for future generations)[16] in their workplace as primary goals. Understanding the differences between equity and equality is critical; in Table 1, we outline examples of equity and equality in the oncology workplace.

IS THERE EQUITY IN THE ONCOLOGY WORKPLACE?

Multidisciplinary care is the cornerstone to providing care for patients with cancer. The oncology workforce encompasses diverse clinicians, providers, and staff from various subspecialties, practice settings, and cultural backgrounds.[18,19] Despite the diversity of providers who encompass our workforce, inequities persist in the representation of women and racial and ethnic minority groups in health care and oncology.[20,21] As of 2021, only 35.2% of practicing oncologists identified as female; 4.7% self-identified as Hispanic or Latinx, 3.0% as Black or African American, and 0.1% as American Indian or Alaska Native.[22] Similar trends prevail among radiation oncologists; only 3.0% of practicing physicians in this oncology specialty identify as Black, 4.0% as Hispanic or Latinx, and 25.5% as women.[21] These inequities prevail across the spectrum of our workforce and are similarly reflected in leadership roles and advancement opportunities.[23,24]

Understanding the landscape of inequities encountered by providers and staff in the health care and oncology workplace is imperative to promoting equity. Women in oncology and academic medicine are promoted at slower and lower rates, are paid lower salaries, and receive less research funding.[25–33] Despite having levels of engagement and leadership aspiration similar to those of men, women are less likely to hold leadership positions or to be members of editorial boards or senior

TABLE 1. Examples of Equality Versus Equity in the Workplace Environment

Example	Equality	Equity
Needs of Breastfeeding Providers	All health care providers have standardized clinic schedules, with 30-minute patient visits during work hours; new nursing mothers must find time between patient visits, cut visits short, or risk delaying their schedule to breastfeed or pump	Clinic schedules are adapted to individual needs; protected nursing time is blocked between patient visits and built into the provider's schedule; nursing time is accounted equal to patient care toward productivity goals
Employee Workspace Needs	All employees have equal resources and office space at the workplace; all staff should perform work-related tasks from the workplace	As their roles and tasks allow, employees may (partially or fully) work remotely to accommodate specific needs
Provider Promotion and Advancement	Advancement and/or promotion for all providers is based on clinical productivity metrics; a provider who leads the quality and safety monitoring efforts of the practice is not promoted when their clinical productivity is inferior to that of their peers	Advancement and/or promotion metrics account for the diversity of roles and tasks within the practice (e.g., clinical productivity, research, leadership or management roles; teaching; community outreach; quality; and safety); these metrics are reevaluated periodically
Negative Patient Experiences	A provider receives derogatory and/or racist comments from a patient and/or caregiver; leadership responds that practice policies state patients cannot switch providers within the same practice and specialty, and asks all providers to handle disagreements or encounters with patients by themselves	Leadership listens and provides support to the provider, establishes patterns and prevalence with data from the practice, reviews and revises current policies to prevent future events, and addresses the event with the patient and/or caregiver

Downloaded from ascopubs.org by 98.42.87.148 on July 30, 2024 from 098.042.087.148
Copyright © 2024 American Society of Clinical Oncology. All rights reserved.

authors of clinical trials.[34–42] Women and minority individuals report less mentorship and sponsorship, both of which are important to career advancement and promotion.[43–45] In addition, women are more likely to report sexual harassment from both colleagues and patients and to have increased rates of burnout; both of these metrics are directly related to workplace satisfaction.[46–49] Victims of sexual harassment are more likely to report decreased mental health, workplace safety, and work satisfaction and are more likely to have intentions to change their current employment.[46,50] Added to these, providers from racial and ethnic minority groups are more likely to experience microaggressions and discrimination from patients, colleagues, and supervisors.[51–54] These experiences are commonly compounded at the intersection of identities (e.g., gender, race, and ethnicity), leading to increased distress and burden among individuals with multiple minoritized or stigmatized identities. For example, men, irrespective of race or ethnicity, are less likely than women to report stress resulting from subtle discrimination than are women of color (including Asian women), who are uniquely affected by discrimination.[55] Academic institutions have failed to create and sustain environments where women and racial and ethnic minority individuals feel fully accepted and supported to succeed, leading to decreased satisfaction with the academic workplace and a higher probability of leaving academics early in their careers compared with male and White colleagues.[29,34,55,56]

VALUE OF EQUITY IN THE ONCOLOGY WORKPLACE

Workplace equity is critical for health care systems, oncology practices, and cancer centers to provide high-quality care and for oncology professionals to find satisfaction and joy within their work environments. The lack of gender, racial, and ethnic diversity within the oncology workforce has considerable implications for health care delivery and research. Diversity in the workplace increases the range of perspectives, lived experiences, and expertise available to inform innovative questions and solve problems and challenges.[57,58] Research shows that engaging a more diverse team of investigators translates into higher quality and more impactful research.[59,60] A diverse workforce also improves health care delivery by helping to bridge cultural gaps and improve access, quality, and patient safety.[61–65] Data from science, technology, engineering, and mathematics fields have shown that a diverse workforce can also improve work performance and engagement, reduce conflict in the workplace, and promote innovation and growth.[61,66–68] An excellent example of the benefits of equity in the health care workplace and workforce are the business-resource groups of Robert Wood Johnson University Hospital.[69] The business-resource groups are employee-affinity groups (i.e., groups of individuals with shared identity characteristics) that provide employee support, foster career development, and contribute cultural sensitivity to the workplace environment. Since their inception, these business-resource groups have evolved into a

Downloaded from ascopubs.org by 98.42.87.148 on July 30, 2024 from 098.042.087.148
Copyright © 2024 American Society of Clinical Oncology. All rights reserved.

sought-after organizational resource that develops and leads innovative projects on organizational financial performance and employee and patient engagement.[69]

Greater diversity also promotes a more equitable work environment and lowers employee turnover.[70–74] Workplace environment and climate have been associated with employee satisfaction, productivity, retention, and burnout.[47,75–77] Studies evaluating employee perceptions of the workplace environment identified that women and racial and ethnic minority individuals are more likely to report and experience microaggressions, discrimination, sexism, and unwelcoming workplace environments than their non-Hispanic White or male counterparts.[4,50,54,78,79] Similarly, compared with men, women more frequently report negative experiences in the workplace as a result of gender and/or race, and a higher frequency of negative experiences was associated with an 83% increase in the odds of burnout.[80] Burnout itself is associated with increased costs resulting from malpractice claims, reduction in clinical hours, and increased physician turnover.[81–85] Amid the current physician burnout and health care workforce exodus crisis,[12] concerted efforts to achieve equity in the workplace are necessary; these efforts are imperative to creating welcoming workplace environments that increase health care workers' satisfaction and trust, and that decrease stress and turnover.

In addition to the aforesaid benefits of equity in the workplace (summarized in Fig. 2), greater workplace equity and diversity have been associated with improved financial performance in both business and academia.[86,87] Organizations with women in leadership roles perform better financially.[87–90] From a health care systems perspective, lack of diversity in leadership can result in policies that do not adequately address the needs of diverse populations; this results in loss of potential revenue and perpetuates health care disparities.[91] Equity and diversity in leadership provide multiple other potential benefits including reducing implicit bias; allowing for diversity of thought and perspectives in institutional-level decisions; increasing value alignment between physicians and leaders; and improving professionalism, humanism, and cultural competency.[92–95] Importantly, leaders who promote and support diversity and equity can sponsor faculty and staff underrepresented in medicine who are frequently overlooked and underrepresented in leadership positions.[96]

Benefits of Equity in the Workplace

Research
- Improved quality
- Increased impact
- Creative and innovative questions
- Innovative solutions
- Complex problem solving

Patient Care
- Higher quality of care
- Improved healthcare delivery
- Increased access
- Improved patient safety
- Cultural competency
- Community responsiveness

Individuals
- Improved job satisfaction and joy
- Increased work performance
- Increased productivity
- Decreased burnout
- Increased trustworthiness
- Professionalism
- Humanism

Teams
- Reduced conflict
- Diversity of perspectives
- Broad range of lived experiences
- Diversity of available expertise
- Enhanced engagement
- Decreased turnover

Environment / Institution
- Promote innovation & growth
- Reduced implicit bias
- Improved financial performance
- Value alignment with leadership

FIGURE 2. Benefits of Promoting Equity in the Workplace

MICROAGGRESSIONS AND MARGINALIZATION IN MEDICINE AND ONCOLOGY

The following are only some of the examples of the multiple ways in which bias and microaggressions affect our oncology workforce on a day-to-day basis.

"In 2021, I submitted my packet for promotion to full professor. If successful, I would be the first female to advance from assistant professor to full professor in my division. I had published 54 papers, received $10 million in funding, but most importantly, I had developed a national Veterans Affairs clinical trials consortium for men with prostate cancer (2019 to present). The progress in this venture demanded collaboration, communication, and program building. My mentor of 16 years completed the 2020-2021 Annual Proficiency for my promotion packet. I had given myself 4s for all but Program Management, and my mentor gave me 3s in Program Management, Communication, Collaboration, and Program Vision and Development. Notably, the form states that a 3 is where most faculty fit. When I received his responses, I signed the form and immediately sent it off to

the promotion and tenure committee because the form was overdue, and I did not want to miss my opportunity for promotion. Furthermore, I did not want to exacerbate my mental health issues or take any time away from my kids, whom I single-parent. This microinvalidation ultimately led me to leave his program." —Julie Graff, MD

"'Your husband must be scared you'll go all angry Latina on him'; these were the words a man in a leadership role told me, laughing, as I disagreed with him over a subject. This incident occurred in a small group setting with only a handful of other women present and him as the only man, and he was our supervisor. I was shocked, angry, and paralyzed; I sat in silence. The other women looked at me with expressions of disbelief. Afterward, we all debriefed and discussed how inappropriate the comment was, yet none of us felt empowered to call it out. His comment made me question how I communicate and portray myself, my identity, and my future. How can I be a physician leader if I'm perceived as 'angry Latina'? That interaction made me filter my words, be quiet, be hypervigilant of how I express my emotions. It brought up the stereotype threat." —Ana I. Velazquez, MD, MSc

"'You are so exotic' were the words coming from a colleague's mouth after meeting me for the first time. The words got into my head and immediately made me feel like I did not belong because I was different from the rest, different from the majority group in medicine. Luckily, this was not my first time facing a microaggression. These have been part of my daily life as a physician-scientist. I am reminded often that there are not many Latinas in medicine and oncology and that I do not look or sound like the majority group. In the instance described above, I was able to stop the microaggression by asking, 'What do you mean by that?', a phrase that helps me stop or break a microaggression and helps the aggressor understand the negative connotations of their comments or actions." —Narjust Florez Duma, MD

To facilitate creating welcoming workplace environments centered on equity, we will review in the upcoming sections what microaggressions are and the tools to combat them and promote cultural change.

What Are Microaggressions?

These are brief verbal, behavioral, and environmental indignities that convey hostile or derogatory slights based on racial, gender, sexual orientation, religion, skin color, or education, occurring independently of intent. These indignities insult a target person or group that already experiences marginalization. Compared with full-out aggressions, microaggressions usually do not involve physical confrontations and are conducted during everyday living.[97,98]

Microinvalidations, a subcategory of microaggressions, involve communications that exclude, negate, or nullify the psychological thoughts, feelings, or experiential realities of individuals who experience microaggressions. These are commonly seen in hierarchic workplaces like those within the health care system.[98]

Microaggressions stem from implicit bias and occur at an interpersonal level. Implicit bias refers to unconscious stereotypes, assumptions, and beliefs about an individual's identity. In medicine, microaggressions and implicit bias may be encountered throughout medical training and clinical practice in interactions with colleagues, superiors, patients, and families.[98] Examples of microaggressions in medicine include demeaning comments, nonverbal disrespect, generalizations of social identity, assumption of nonphysician status, role- or credential-questioning behavior, explicit epithets, rejection of care, questioning or inquiries of ethnic or racial origin, and sexual harassment.[3,97]

Microaggressions can lower productivity and problem-solving abilities in all settings in medicine.[3] Although microaggressions may be unconscious and unintentional by the offender, the negative ramifications are notable. Microaggressions have been associated with depression, a sense of isolation, increased burnout, sleep disturbances, and suicidal thoughts.[99] Repetitive microaggressions are harmful to the health and safety of medical students, residents, physicians, other providers, and patients who are women or belong to other groups underrepresented in medicine.[100] They frequently devalue and question an individual's contributions, qualifications, and credentials based on identity. These behaviors cultivate unwelcome and hostile work and learning environments that are stressful and polarizing for the recipient.[3,101]

How Can We Reduce Microaggressions in Oncology?

To minimize the harmful effects of microaggressions, intervention strategies must be implemented that reduce the likelihood of the occurrence of microaggressions and challenge the stereotypes that undergird implicit bias. Three components are essential for reducing or eliminating microaggressions in oncology:

1. Educate oncology providers, staff members, patients, and family members about the negative repercussions of microaggressions and the value of cultural humility when interacting with all team members.
2. Recruit allies who will serve as upstanders when team members or patients are facing microaggressions.
3. Implement institutional accountability for creating an inclusive work environment and taking action when team members or patients are discriminated against.

We will expand further on the role of the upstander. Data show that microaggressions negatively affect all team members, not just the person facing the microaggression. Other team members can feel marginalized or excluded, even if the comment or action was not directed toward them. The concept of an upstander derives from the need to have active allies in

Downloaded from ascopubs.org by 98.42.87.148 on July 30, 2024 from 098.042.087.148
Copyright © 2024 American Society of Clinical Oncology. All rights reserved.

medicine. An ally—typically from a privileged social group—is someone who supports and advocates for marginalized individuals. An active ally understands the challenges faced by minority groups, actively provides a safe environment, and acts when an minority individual is discriminated against or excluded. The upstander is an active ally who addresses microaggressions directed toward a team member, colleague, patient, or family member to break the cycle associated with these negative comments or actions. Table 2 summarizes effective tools to become a microaggression upstander.

How To Effectively Intervene and Become an Upstander

1. Actively listen. Active allies understand that microaggressions can happen in any setting, so active listening is key for identifying microaggressions. Responding to a microaggression can be complicated, because it is not always apparent to a bystander whether harm occurred or was intended; listening to the comment and to the response by the individual facing the microaggression will help us understand whether harm occurred and whether an intervention is needed.
2. Tailor your approach to the situation. Microaggressions can take several forms, ranging from explicit and intentional microassaults (e.g., racist jokes) to more subtle microinsults and microinvalidations, which tend to be unintentional. Situational factors, such as the type of microaggression and the relationship between the bystander, target, and perpetrator, can help determine what approach will be most effective.[98]
3. Learn phrases that could be used in any situation. One strategy to disarm a microaggression includes voicing disapproval with phrases like, "Not okay," "That comment is not appropriate," or, "I do not agree with what you just said." Another approach is to call attention to subtle or invisible microaggressions behind the perpetrator's comment. That could take the form of a statement such as, "Not all Asian Americans are good at math," or a question such as, "Do you have evidence to back that up?" or, "Is this person's race, religion, or identity relevant to this conversation?"[98]
4. Speak for yourself. Whichever response you choose should reflect your perspective and feelings about the microaggression. Please do not presume that other people are offended, hurt, or debilitated by the microaggression or state that you are speaking on their behalf. Speaking on behalf of others without their approval can be seen as a microaggression. Instead, speak in first-person language and refer to your own emotions or perceptions.
5. Target the behavior, not the person. Regardless of the circumstances, bystanders should avoid calling a perpetrator racist or otherwise attacking their character,

TABLE 2. Tools for Becoming a Microaggression Upstander

Action	Example Response
Actively listen	Observe and listen to interactions with all team members; this will help you understand when and how microaggressions appear and how to act after the harmful comment or action
Tailor your approach to the situation	Microaggressions can appear at any time during rounds and interactions with family members; understanding that each situation is different will allow the upstanders to tailor their actions
Learn phrases that could be used in any situation	"What do you mean by that?" "Can you help me understand your comment?" "I do not feel comfortable with comments like that"
Speak for yourself	Please do not speak on behalf of the victim or perpetrator; using phrases in first-person language will assure others it is your opinion, and you are not making assumptions about someone else's feeling or perceptions Phrases like these can be used: "What you said made me feel uncomfortable" "I find that action harmful and exclusionary"
Target the behavior, not the person	Avoid describing the person; address the behavior that can be improved Phrases like these can be used: "That statement was hurtful, and I felt that it reflected some racial bias" "Your actions excluded certain members of the team; let us discuss how that can be improved"
Consider circling back	Certain situations are not ideal for addressing microaggressions because they can disrupt team dynamics or negatively affect patient interactions Phrases like these can be used: "Let us circle back after rounds" "I would like to discuss a comment you made earlier today"
Seek outside support	Informing leadership about pervasive behavior is necessary for institutional accountability and incident documentation

Downloaded from ascopubs.org by 98.42.87.148 on July 30, 2024 from 098.042.087.148
Copyright © 2024 American Society of Clinical Oncology. All rights reserved.

which tends to trigger defensiveness and diminish the rapport that leads to growth and understanding. Target the harmful comment or action.

6. Consider circling back. An immediate and public response to a microaggression is an effective way to model appropriate behavior for other bystanders, but such a direct approach is not always possible; if you anticipate that an in-the-moment response could lead to defensiveness or hostility, circle back with the individual for a follow-up discussion.
7. Seek outside support. As discussed, institutional accountability is essential for creating an inclusive workplace environment; in some instances, it is necessary to involve outside support—supervisors, inclusion officers, or human resources—particularly in cases of repetitive behavior from the aggressor.

Downloaded from ascopubs.org by 98.42.87.148 on July 30, 2024 from 098.042.087.148
Copyright © 2024 American Society of Clinical Oncology. All rights reserved.

WHY SHOULD WE PROMOTE CULTURAL CHANGE IN ONCOLOGY?

Bias, inequities, and exclusion would not exist at the levels they do if our culture did not tolerate and propagate them.[102–105] If we hope for a better future, we must change the culture. But what is culture? In this context, key elements include norms with regard to how we interact with one another, what behavior is acceptable or unacceptable, how resources are allocated, what is valued with regard to outcomes and metrics, which voices are elevated or privileged, and who is represented in leadership positions.[97] In the workplace specifically, culture refers to shared values, attitudes, and assumptions among individuals. Workplace culture is shaped by individuals, leadership, management, and organizational values.[106] A positive workplace culture that is inclusive of all identities improves teamwork and job satisfaction; decreases stress; increases collaboration, productivity, and efficiency; and enhances retention.[106]

HOW DO WE CREATE CULTURAL CHANGE IN ONCOLOGY?

An easy place to start is identifying who is included and who is excluded. When we form groups or teams, when we choose people to fill positions, and when we look for leaders, which identities are represented and which are absent? One of the first steps toward cultural change is starting to notice who is and who is not present.[24] Our longstanding culture celebrated the “wall of portraits” of White male leaders.[105] A changed culture asks, “Where are the women and underrepresented minority groups?” In oncology, this applies to which medical students and residents we mentor and sponsor, who is accepted into fellowship programs, who is hired as faculty, whose career development and advancement are supported, who is invited to speak or collaborate, and whose leadership potential is recognized.

A second key issue is how we treat one another. As described, microaggressions and other forms of biased behavior are painfully common in health care and result in measurable harm.[107–109] Our longstanding culture tolerated this and offered little, if any, training for recognizing or responding to such behaviors. A changed culture empathizes with those affected by microaggressions and other forms of bias and strives to develop initiatives and programs to reduce the frequency of such behaviors and to prepare individuals to recognize them and respond when they occur. A changed culture stops invalidating the experience of those subjected to bias and starts listening to them and supporting them. A different but related issue is whether, when rules or policies are violated, similar behaviors have similar consequences irrespective of gender, race, and other individual characteristics.

A culture broadcasts its values when it distributes its resources. When we invest more heavily in developing new treatments than in ensuring that the treatments we have are implemented equitably, we make a statement about our values, given the well-documented disparities in cancer diagnosis, treatment, and outcomes.[110] Discrepancies in pay, funding for research, and administrative and clinical support for oncologists have been normative in medicine.[25,111–114] An equity-centered culture does not accept different pay or support for individuals with different identities.

The values of a culture are also broadcast by what and how it chooses to measure and by which outcomes are prioritized. A community that is genuinely committed to developing a just culture will ask about every decision: “How will this affect diversity, equity, and inclusion?” It will measure progress in diversity, equity, and inclusion and demand accountability generally and during performance reviews. Just as we ask leaders to be accountable for revenue and budgets, we can also hold them accountable for the level of diversity in their departments or teams and for whether they are fostering a just, equitable, and inclusive culture. There are also more informal metrics that matter: in a group or team, do we pay attention to who does most of the talking and who is quiet? Do we invite everyone’s voice, and do we create systems and structures that facilitate everyone’s participation? Do we give individuals credit for their ideas and contributions irrespective of their identities? Noticing and measuring disparities is a key early step. Practical steps for cultural change include the following:

1. Learn about and measure your current culture. A central premise of quality improvement is that you cannot change what you do not measure. Surveys of members of your organization can help determine the baseline from which you are starting and can be used to measure change over time. A variety of surveys have been developed for this.[115,116] Additional strategies should be pursued to create opportunities to listen to and learn about the experiences of individuals of color, women, those with disabilities, and those with other

identities that put them at risk for bias. People whose identities give them privilege often fail to understand how different their experience is from those with marginalized identities.

2. Make diversity, equity, and inclusion standing agenda items. Regularly addressing racism, sexism, and other forms of bias is a crucial step in acknowledging and responding to the experience of those subject to such bias. Research shows that bias remains present in the practice of medicine; acknowledging the reality that we do not, in fact, treat everyone the same regardless of their race, ethnicity, gender, or other identity not only validates the experience of those affected by bias, but also prepares us to build a better and more just future.[110,117–122]
3. Make education about bias a required part of faculty development and continuing education. Given the heavy impact of discrimination on both patients and individuals working within the health care system, it is incumbent upon all of us to educate ourselves about the ways in which bias plays out and about strategies to mitigate and overcome it. There are abundant data showing that most of us carry implicit bias and that this can influence how we behave and treat others.[123–125] Learning about our own biases is essential if we are to manage them. There is also a role for skills practice. Racism, sexism, and other forms of discrimination are emotionally fraught topics, and many people find them difficult to discuss. We may find ourselves hijacked by anger, sadness, defensiveness, or other strong reactions. We may witness incidents of bias and have no idea what to say or how to respond constructively. All of this can be learned if we make it a priority.
4. Notice and respond to bias. To change our culture, we must recognize and respond to microaggressions, bias, and other forms of discrimination in the workplace. Organizations often fail to notice bias until it is pointed out by others. Paying attention, and learning to perceive bias when it occurs, prepares us for the work of creating a more just culture. We should consistently ask ourselves who is being included and excluded, who is being considered or not considered for opportunities, and what assumptions we are making about others that may reveal our own implicit (or explicit) biases. When we have systems, processes, or procedures that result in low levels of diversity and inclusion, we should question whether our structures are perpetuating bias and therefore require revision.
5. Standardize and create transparent policies and procedures to make it easier to determine when we are treating individuals differently based on their identities.

CONCLUSION

Workplace equity is fundamental to creating welcoming environments in which all individual identities are celebrated and accepted, delivering high-quality cancer care, and developing innovative and high-quality research ideas. Equity in the workplace can increase employee satisfaction, decrease burnout, and decrease physician turnover. However, the lack of racial and ethnic diversity and the persistence of gender, racial, and ethnic inequities, biases, and microaggressions within the oncology workforce and its leadership are systemic issues that require concerted efforts to promote longstanding cultural and systemic change. To achieve cultural change, cancer centers and health care systems must invest in resources and staff to perform internal measures of institutional culture and equity; ensure diversity, equity, and inclusion are centered in all activities; provide bias training for all staff; create and implement safe reporting mechanisms; and adopt transparent policies and procedures.

AFFILIATIONS

[1]Helen Diller Family Comprehensive Cancer Center, University of California San Francisco, San Francisco, CA
[2]Cleveland Clinic Taussig Cancer Institute, Cleveland, OH
[3]Dana-Farber Cancer Institute, Boston, MA
[4]Veterans Affairs Portland Health Care System, Portland, OR
[5]Knight Cancer Institute, Oregon Health & Science University, Portland, OR

CORRESPONDING AUTHOR

Ana I. Velazquez, MD, MSc, 505 Parnassus Ave., Room M1286, Mailbox 1270, San Francisco, CA 94143-1270; email: ana.velazquezmanana@ucsf.edu.

AUTHORS' DISCLOSURES OF POTENTIAL CONFLICTS OF INTEREST AND DATA AVAILABILITY STATEMENT

Disclosures provided by the authors and data availability statement (if applicable) are available with this article at DOI https://doi.org/10.1200/EDBK_350691.

REFERENCES

1. Stolberg SG. 'Pandemic within a pandemic': coronavirus and police brutality roil Black communities. https://www.nytimes.com/2020/06/07/us/politics/blacks-coronavirus-police-brutality.html. Accessed March 24, 2022.
2. Bion XS. Racism fuels double crisis: police violence and COVID-19 disparities. https://www.chcf.org/blog/racism-fuels-double-crisis-police-violence-covid-19-disparities/. June 8, 2020. Accessed March 24, 2022.
3. Molina MF, Landry AI, Chary AN, et al. Addressing the elephant in the room: microaggressions in medicine. Ann Emerg Med. 2020;76:387-391.
4. Hong L, Rubinsak L, Benoit M, et al. Workplace bullying, harassment and microaggressions: the results of a Women of Gynecologic Oncology (WGO) survey. Gynecol Oncol. 2021;162:1s (suppl; abstr).

Downloaded from ascopubs.org by 98.42.87.148 on July 30, 2024 from 098.042.087.148
Copyright © 2024 American Society of Clinical Oncology. All rights reserved.

5. Ulloa JG, Talamantes E, Moreno G. Microaggressions during medical training. JAMA. 2016;316:1113-1114.

6. Nunez-Smith M, Ciarleglio MM, Sandoval-Schaefer T, et al. Institutional variation in the promotion of racial/ethnic minority faculty at US medical schools. Am J Public Health. 2012;102:852-858.

7. Fang D, Moy E, Colburn L, et al. Racial and ethnic disparities in faculty promotion in academic medicine. JAMA. 2000;284:1085-1092.

8. Campbell KM, Rodríguez JE, Brownstein NC, et al. Status of tenure among Black and Latino faculty in academic medicine. J Racial Ethn Health Disparities. 2017;4:134-139.

9. Woitowich NC, Jain S, Arora VM, et al. COVID-19 threatens progress toward gender equity within academic medicine. Acad Med. 2020;96:813-816.

10. Narayana S, Roy B, Merriam S, et al; Society of General Internal Medicine's Women and Medicine Commission. Minding the gap: organizational strategies to promote gender equity in academic medicine during the COVID-19 pandemic. J Gen Intern Med. 2020;35:3681-3684.

11. Hlubocky FJ, Back AL, Shanafelt TD, et al. Occupational and personal consequences of the COVID-19 pandemic on US oncologist burnout and well-being: a study from the ASCO Clinician Well-Being Task Force. JCO Oncol Pract. 2021;17:e427-e438.

12. Yong E. Why health-care workers are quitting in droves. https://www.theatlantic.com/health/archive/2021/11/the-mass-exodus-of-americas-health-care-workers/620713/. November 16, 2021. Accessed March 13, 2022.

13. U.S. Bureau of Labor Statistics. Employment situation news release: November 2021. https://www.bls.gov/news.release/archives/empsit_12032021.htm. Updated December 6, 2021. Accessed March 24, 2022.

14. Galvin G. Nearly 1 in 5 health care workers have quit their jobs during the pandemic. https://morningconsult.com/2021/10/04/health-care-workers-series-part-2-workforce/. October 4, 2021. Accessed March 24, 2022.

15. Kurapati S. Health equality vs. health equity. https://www.amwa-doc.org/health-equality-vs-health-equity/. March 9, 2020. Accessed March 18, 2022.

16. Equity vs. equality: what's the difference? https://onlinepublichealth.gwu.edu/resources/equity-vs-equality/. November 5, 2020. Accessed March 18, 2022.

17. World Health Organization. Health equity. https://www.who.int/health-topics/health-equity. Accessed March 24, 2022.

18. Winkfield KM, Flowers CR, Patel JD, et al. American Society of Clinical Oncology strategic plan for increasing racial and ethnic diversity in the oncology workforce. J Clin Oncol. 2017;35:2576-2579.

19. Lightfoote JB, Fielding JR, Deville C, et al. Improving diversity, inclusion, and representation in radiology and radiation oncology part 1: why these matter. J Am Coll Radiol. 2014;11:673-680.

20. Velazquez Manana AI, Leibrandt R, Duma N. Trainee and workforce diversity in hematology and oncology: ten years later what has changed? J Clin Oncol. 2020;38:15s(suppl; abstr 11000).

21. Chapman CH, Hwang W-T, Deville C. Diversity based on race, ethnicity, and sex, of the US radiation oncology physician workforce. Int J Radiat Oncol Biol Phys. 2013;85:912-918.

22. 2021 snapshot: state of the oncology workforce in America. JCO Oncol Pract. 2021;17:249.

23. Morgan A, Shah K, Tran K, et al. Racial, ethnic, and gender representation in leadership positions at National Cancer Institute-designated cancer centers. JAMA Netw Open. 2021;4:e2112807.

24. Ong MBH, Goldberg K. First-ever TCL-AACI study of the leadership pipeline points to urgent need for more diversity at elite cancer centers. https://cancerletter.com/the-cancer-letter/20201009_1/. October 9, 2020. Accessed March 13, 2022.

25. Dandar VM, Lautenberger DM. Exploring Faculty Salary Equity at U.S. Medical Schools by Gender and Race/Ethnicity. Washington, DC: Association of American Medical Colleges; 2021.

26. Wang T, Douglas PS, Reza N. Gender gaps in salary and representation in academic internal medicine specialties in the US. JAMA Intern Med. 2021;181:1255-1257.

27. Chaiyachati KH, Liao JM, Weissman GE, et al. Gender differences in retention and promotion among generalists who graduated from research-intensive fellowships. J Grad Med Educ. 2019;11:535-542.

28. Xierali IM, Nivet MA, Syed ZA, et al. Recent trends in faculty promotion in U.S. medical schools: implications for recruitment, retention, and diversity and inclusion. Acad Med. 2021;96:1441-1448.

29. Merfeld EC, Blitzer GC, Kuczmarska-Haas A, et al. Women oncologists' perceptions and factors associated with decisions to pursue academic vs nonacademic careers in oncology. JAMA Netw Open. 2021;4:e2141344.

30. Siddiqui RS, Chaudhary SG, Shahzad M, et al. Gender disparities in the National Institutes of Health funding for hematologic malignancies and cellular therapies. Leuk Lymphoma. Epub 2022 Feb 10.

31. Holliday EB, Jagsi R, Wilson LD, et al. Gender differences in publication productivity, academic position, career duration, and funding among U.S. academic radiation oncology faculty. Acad Med. 2014;89:767-773.

32. Jagsi R, Griffith KA, Stewart A, et al. Gender differences in the salaries of physician researchers. JAMA. 2012;307:2410-2417.

33. Jena AB, Olenski AR, Blumenthal DM. Sex differences in physician salary in US public medical schools. JAMA Intern Med. 2016;176:1294-1304.

34. Pololi LH, Civian JT, Brennan RT, et al. Experiencing the culture of academic medicine: gender matters, a national study. J Gen Intern Med. 2013;28:201-207.

35. Pololi L, Cooper LA, Carr P. Race, disadvantage and faculty experiences in academic medicine. J Gen Intern Med. 2010;25:1363-1369.

36. Silver JK. Gender equity on journal editorial boards. Lancet. 2019;393:2037-2038.

Downloaded from ascopubs.org by 98.42.87.148 on July 30, 2024 from 098.042.087.148
Copyright © 2024 American Society of Clinical Oncology. All rights reserved.

37. Patel SR, Riano I, Geiger G, et al. Where are the women and underrepresented minorities in medicine? Race/ethnicity and gender representation in oncology journals & editorial boards. J Clin Oncol. 2021;39:15s(suppl; abstr 11007).

38. Muquith M, Pham T, Espinoza M, et al. Representation of investigators by gender among authors of phase 3 oncology trials worldwide. JAMA Netw Open. 2022;5:e220031.

39. Ludmir EB, Mainwaring W, Miller AB, et al. Women's representation among lead investigators of clinical trials in oncology. JAMA Oncol. 2019;5:1501-1502.

40. Sun GH, Moloci NM, Schmidt K, et al. Representation of women as authors of collaborative cancer clinical trials. JAMA Intern Med. 2014;174:806-808.

41. Riaz IB, Siddiqi R, Zahid U, et al. Gender differences in faculty rank and leadership positions among hematologists and oncologists in the United States. JCO Oncol Pract. 2020;16:e507-e516.

42. Chowdhary M, Chowdhary A, Royce TJ, et al. Women's representation in leadership positions in academic medical oncology, radiation oncology, and surgical oncology programs. JAMA Netw Open. 2020;3:e200708.

43. Masselink LE, Erikson CE, Connell NT, et al. Associations between hematology/oncology fellows' training and mentorship experiences and hematology-only career plans. Blood Adv. 2019;3:3278-3286.

44. Farkas AH, Bonifacino E, Turner R, et al. Mentorship of women in academic medicine: a systematic review. J Gen Intern Med. 2019;34:1322-1329.

45. Bonifacino E, Ufomata EO, Farkas AH, et al. Mentorship of underrepresented physicians and trainees in academic medicine: a systematic review. J Gen Intern Med. 2021;36:1023-1034.

46. Subbiah IM, Markham MJ, Graff SL, et al: Incidence, nature, and consequences of oncologists' experiences with sexual harassment. J Clin Oncol. 2022;40:1186-1195.

47. McPeek-Hinz E, Boazak M, Sexton JB, et al. Clinician burnout associated with sex, clinician type, work culture, and use of electronic health records. JAMA Netw Open. 2021;4:e215686.

48. Shanafelt TD, Gradishar WJ, Kosty M, et al. Burnout and career satisfaction among US oncologists. J Clin Oncol. 2014;32:678-686.

49. Granek L, Krzyzanowska MK, Nakash O, et al. Gender differences in the effect of grief reactions and burnout on emotional distress among clinical oncologists. Cancer. 2016;122:3705-3714.

50. Jagsi R, Griffith KA, Jones R, et al. Sexual harassment and discrimination experiences of academic medical faculty. JAMA. 2016;315:2120-2121.

51. Filut A, Alvarez M, Carnes M. Discrimination toward physicians of color: a systematic review. J Natl Med Assoc. 2020;112:117-140.

52. Peterson NB, Friedman RH, Ash AS, et al. Faculty self-reported experience with racial and ethnic discrimination in academic medicine. J Gen Intern Med. 2004;19:259-265.

53. Carr PL, Palepu A, Szalacha L, et al. 'Flying below the radar': a qualitative study of minority experience and management of discrimination in academic medicine. Med Educ. 2007;41:601-609.

54. Nunez-Smith M, Pilgrim N, Wynia M, et al. Race/ethnicity and workplace discrimination: results of a national survey of physicians. J Gen Intern Med. 2009;24:1198-1204.

55. National Research Council. Seeking Solutions: Maximizing American Talent by Advancing Women of Color in Academia—Summary of a Conference. Washington, DC: National Academies Press; 2013.

56. Trower CA, Chait RP. Faculty diversity: too little for too long. https://www.harvardmagazine.com/2002/03/faculty-diversity.html. March-April 2022. Accessed March 24, 2022.

57. National Academy of Sciences, National Academy of Engineering, Institute of Medicine. Expanding Underrepresented Minority Participation: America's Science and Technology Talent at the Crossroads. Washington, DC: National Academies Press; 2011.

58. Hunt V, Prince S, Dixon-Fyle S, et al. Delivering Through Diversity. New York, NY: McKinsey & Company; 2018.

59. Campbell LG, Mehtani S, Dozier ME, et al. Gender-heterogeneous working groups produce higher quality science. PLoS One. 2013;8:e79147.

60. Freeman RB, Huang W. Collaborating with people like me: Ethnic co-authorship within the US. https://www.nber.org/papers/w19905. February 2014. Revised August 2014. Accessed March 24, 2022.

61. Cohen JJ, Gabriel BA, Terrell C. The case for diversity in the health care workforce. Health Aff (Millwood). 2002;21:90-102.

62. Rotenstein LS, Reede JY, Jena AB. Addressing workforce diversity: a quality-improvement framework. N Engl J Med. 2021;384:1083-1086.

63. Swider SM. Outcome effectiveness of community health workers: an integrative literature review. Public Health Nurs. 2002;19:11-20.

64. Jackson CS, Gracia JN. Addressing health and health-care disparities: the role of a diverse workforce and the social determinants of health. Public Health Rep. 2014;129(suppl 2):57-61.

65. Brach C, Fraser I. Can cultural competency reduce racial and ethnic health disparities? A review and conceptual model. Med Care Res Rev. 2000;57(suppl 1):181-217.

66. Denson N, Chang MJ. Racial diversity matters: the impact of diversity-related student engagement and institutional context. Am Educ Res J. 2009;46:322-353.

67. Nielsen S, Huse M. The contribution of women on boards of directors: going beyond the surface. Corp Gov Int Rev. 2010;18:136-148.

68. Federal Glass Ceiling Commission. Good for business: making full use of the nation's human capital. https://ecommons.cornell.edu/bitstream/handle/1813/79348/GlassCeilingFactFindingEnvironmentalScan.pdf?sequence=1&isAllowed=y. March 1995. Accessed March 24, 2022.

69. Robert Wood Johnson University Hospital, RWJBarnabas Health. Business resource groups. https://www.rwjbh.org/rwj-university-hospital-new-brunswick/about/diversity-inclusion/business-resource-groups/. Accessed March 13, 2022.

Downloaded from ascopubs.org by 98.42.87.148 on July 30, 2024 from 098.042.087.148
Copyright © 2024 American Society of Clinical Oncology. All rights reserved.

70. Flabbi L, Macis M, Moro A, et al. Do female executives make a difference? The impact of female leadership on gender gaps and firm performance. https://www.nber.org/papers/w22877. December 2016. Accessed February 28, 2022.

71. Pichler S, Blazovich JL, Cook KA, et al. Do LGBT-supportive corporate policies enhance firm performance? Hum Resour Manage. 2018;57:263-278.

72. Terjesen S, Singh V. Female presence on corporate boards: a multi-country study of environmental context. J Bus Ethics. 2008;83:55-63.

73. Kaplan DM, Wiley JW, Maertz CP Jr. The role of calculative attachment in the relationship between diversity climate and retention. Hum Resour Manage. 2011;50:271-287.

74. McKay PF, Avery DR, Tonidandel S, et al. Racial differences in employee retention: are diversity climate perceptions the key? Person Psychol. 2007;60:35-62.

75. Rao S, Ferris TG, Hidrue MK, et al. Physician burnout, engagement and career satisfaction in a large academic medical practice. Clin Med Res. 2020;18:3-10.

76. August L, Waltman J. Culture, climate, and contribution: career satisfaction among female faculty. Res High Educ. 2004;45:177-192.

77. Carr JC, Pearson AW, Vest MJ, et al. Prior occupational experience, anticipatory socialization, and employee retention. J Manage. 2006;32:343-359.

78. Biggs J, Hawley PH, Biernat M. The academic conference as a chilly climate for women: effects of gender representation on experiences of sexism, coping responses, and career intentions. Sex Roles. 2018;78:394-408.

79. Zambrana RE, Harvey Wingfield A, Lapeyrouse LM, et al. Blatant, subtle, and insidious: URM faculty perceptions of discriminatory practices in predominantly White institutions. Sociol Inq. 2017;87:207-232.

80. Audi C, Poplau S, Freese R, et al. Negative experiences due to gender and/or race: a component of burnout in women providers within a safety-net hospital. J Gen Intern Med. 2021;36:840-842.

81. Sinsky CA, Shanafelt TD, Dyrbye LN, et al. Health care expenditures attributable to primary care physician overall and burnout-related turnover: a cross-sectional analysis. Mayo Clin Proc. 2022;97:693-702.

82. Han S, Shanafelt TD, Sinsky CA, et al. Estimating the attributable cost of physician burnout in the United States. Ann Intern Med. 2019;170:784-790.

83. Hall LH, Johnson J, Watt I, et al. Healthcare staff wellbeing, burnout, and patient safety: a systematic review. PLoS One. 2016;11:e0159015.

84. Wright AA, Katz IT. Beyond burnout: redesigning care to restore meaning and sanity for physicians. N Engl J Med. 2018;378:309-311.

85. Moss M, Good VS, Gozal D, et al. An official Critical Care Societies collaborative statement: burnout syndrome in critical care health care professionals—a call for action. Am J Crit Care. 2016;25:368-376.

86. Cook A, Glass C. Does diversity damage corporate value? Measuring stock price reactions to a diversity award. Ethn Racial Stud. 2011;34:2173-2191.

87. Wagner HM. The bottom line: corporate performance and women's representation on boards 2004-2008 (report). https://www.catalyst.org/research/the-bottom-line-corporate-performance-and-womens-representation-on-boards-2004-2008/. March 1, 2011. Accessed March 24, 2022.

88. Athey LA, Kimball PA. How women and men executives perceive healthcare workplaces. J Healthc Manag. 2020;65:307-317.

89. Turban S, Wu D, Zhang L. Research: when gender diversity makes firms more productive. https://hbr.org/2019/02/research-when-gender-diversity-makes-firms-more-productive. February 11, 2019. Accessed March 24, 2022.

90. Women employees boost the bottom line for tech firms. https://www.morganstanley.com/ideas/gender-diversity-tech-companies. May 3, 2017. Accessed February 28, 2022.

91. Espinosa LL, McGuire K, Jackson LM (eds). Minority Serving Institutions: America's Underutilized Resource for Strengthening the STEM Workforce. Washington, DC: National Academies Press; 2019

92. American Association of Medical Colleges. Striving toward excellence: faculty diversity in medical education. https://www.yumpu.com/en/document/read/22797053/striving-toward-excellence-faculty-diversity-in-medical-education. 2009. Accessed March 13, 2022.

93. Kelly-Blake K, Garrison NA, Fletcher FE, et al. Rationales for expanding minority physician representation in the workforce: a scoping review. Med Educ. 2018;52:925-935.

94. Ghaddar S, Ronnau J, Saladin SP, et al. Innovative approaches to promote a culturally competent, diverse health care workforce in an institution serving Hispanic students. Acad Med. 2013;88:1870-1876.

95. Shanafelt TD, Wang H, Leonard M, et al. Assessment of the association of leadership behaviors of supervising physicians with personal-organizational values alignment among staff physicians. JAMA Netw Open. 2021;4:e2035622.

96. Guevara JP, Wright M, Fishman NW, et al. The Harold Amos Medical Faculty Development Program: evaluation of a national program to promote faculty diversity and health equity. Health Equity. 2018;2:7-14.

97. Duma N, Maingi S, Tap WD, et al. Establishing a mutually respectful environment in the workplace: a toolbox for performance excellence. Am Soc Clin Oncol Educ Book. 2019;39:e219-e226.

98. Sue DW, Capodilupo CM, Torino GC, et al. Racial microaggressions in everyday life: implications for clinical practice. Am Psychol. 2007;62:271-286.

99. Overland MK, Zumsteg JM, Lindo EG, et al. Microaggressions in clinical training and practice. PM R. 2019;11:1004-1012.

100. Feaster B, McKinley-Grant L, McMichael AJ. Microaggressions in medicine. Cutis. 2021;107:235-237.

101. Torres L, Driscoll MW, Burrow AL. Racial microaggressions and psychological functioning among highly achieving African-Americans: a mixed-methods approach. J Soc Clin Psychol. 2010;29:1074-1099.

102. Sudol NT, Guaderrama NM, Honsberger P, et al. Prevalence and nature of sexist and racial/ethnic microaggressions against surgeons and anesthesiologists. JAMA Surg. 2021;156:e210265.

Downloaded from ascopubs.org by 98.42.87.148 on July 30, 2024 from 098.042.087.148
Copyright © 2024 American Society of Clinical Oncology. All rights reserved.

103. Murrar S, Johnson PA, Lee Y-G, et al. Research conducted in women was deemed more impactful but less publishable than the same research conducted in men. J Womens Health (Larchmt). 2021;30:1259-1267.

104. Duma N, Durani U, Woods CB, et al. Evaluating unconscious bias: speaker introductions at an international oncology conference. J Clin Oncol. 2019;37:3538-3545.

105. Kowalczyk L. In an about-face, hospital will disperse portraits of past White male luminaries, put the focus on diversity. https://www.bostonglobe.com/metro/2018/06/13/about-face-hospital-will-disperse-portraits-past-white-male-luminaries-put-focus-diversity/0pICgbpsw7QoHFFJQQEZOJ/story.html. June 13, 2018. Accessed March 13, 2022.

106. Agarwal DP. How to create a positive workplace culture. https://www.forbes.com/sites/pragyaagarwaleurope/2018/08/29/how-to-create-a-positive-work-place-culture/. August 29, 2018. Accessed March 14, 2022.

107. Hollingsworth DW, Cole AB, O'Keefe VM, et al. Experiencing racial microaggressions influences suicide ideation through perceived burdensomeness in African Americans. J Couns Psychol. 2017;64:104-111.

108. Kim PY, Kendall DL, Cheon H-S. Racial microaggressions, cultural mistrust, and mental health outcomes among Asian American college students. Am J Orthopsychiatry. 2017;87:663-670.

109. O'Keefe VM, Wingate LR, Cole AB, et al. Seemingly harmless racial communications are not so harmless: racial microaggressions lead to suicidal ideation by way of depression symptoms. Suicide Life Threat Behav. 2015;45:567-576.

110. Tong M, Hill L, Artiga S. Racial disparities in cancer outcomes, screening, and treatment. https://www.kff.org/racial-equity-and-health-policy/issue-brief/racial-disparities-in-cancer-outcomes-screening-and-treatment. February 3, 2022. Accessed March 13, 2022.

111. Catenaccio E, Rochlin JM, Simon HK. Addressing gender-based disparities in earning potential in academic medicine. JAMA Netw Open. 2022;5:e220067.

112. Ly DP, Seabury SA, Jena AB. Differences in incomes of physicians in the United States by race and sex: observational study. BMJ. 2016;353:i2923.

113. Silva NA, Cerasiello SY, Herendeen JS, et al. Gender differences in NIH grant funding in neurological surgery. J Clin Neurosci. 2020;80:43-49.

114. Nocco SE, Larson AR. Promotion of women physicians in academic medicine. J Womens Health (Larchmt). 2021;30:864-871.

115. Person SD, Jordan CG, Allison JJ, et al. Measuring diversity and inclusion in academic medicine: the diversity engagement survey. Acad Med. 2015;90:1675-1683.

116. Women's College Hospital Black Community Consultation. https://www.surveymonkey.com/r/KQJNN9J. Accessed March 24, 2022.

117. van Ryn M, Burke J. The effect of patient race and socio-economic status on physicians' perceptions of patients. Soc Sci Med. 2000;50:813-828.

118. Sabin JA, Greenwald AG. The influence of implicit bias on treatment recommendations for 4 common pediatric conditions: pain, urinary tract infection, attention deficit hyperactivity disorder, and asthma. Am J Public Health. 2012;102:988-995.

119. Eberly LA, Richterman A, Beckett AG, et al. Identification of racial inequities in access to specialized inpatient heart failure care at an academic medical center. Circ Heart Fail. 2019;12:e006214.

120. Lau ES, Hayes SN, Volgman AS, et al; American College of Cardiology Cardiovascular Disease in Women Section. Does patient-physician gender concordance influence patient perceptions or outcomes? J Am Coll Cardiol. 2021;77:1135-1138.

121. Ross DA, Boatright D, Nunez-Smith M, et al. Differences in words used to describe racial and gender groups in medical student performance evaluations. PLoS One. 2017;12:e0181659.

122. Nelson AR. Unequal treatment: report of the Institute of Medicine on racial and ethnic disparities in healthcare. Ann Thorac Surg. 2003;76:S1377-S1381.

123. FitzGerald C, Hurst S. Implicit bias in healthcare professionals: a systematic review. BMC Med Ethics. 2017;18:19.

124. Hall WJ, Chapman MV, Lee KM, et al. Implicit racial/ethnic bias among health care professionals and its influence on health care outcomes: a systematic review. Am J Public Health. 2015;105:e60-e76.

125. Maina IW, Belton TD, Ginzberg S, et al. A decade of studying implicit racial/ethnic bias in healthcare providers using the implicit association test. Soc Sci Med. 2018;199:219-229.

Downloaded from ascopubs.org by 98.42.87.148 on July 30, 2024 from 098.042.087.148
Copyright © 2024 American Society of Clinical Oncology. All rights reserved.