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RACISM, EQUITY AND DISPARITIES IN TRAUMA (S ROGERS AND T ZAKRISON, SECTION EDITOR)

Department of Surgery Leadership Towards Diversity, Equity, and Inclusion

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Abstract
The best teams—whether focused on clinical care, research, or education—are those that build an inclusive culture, foster diversity, and relentlessly pursue equity. Our patients, trainees, and colleagues deserve inclusive environments to be cared for, to learn, and to work. An academic surgical department spans the tripartite missions and thus is the responsible organizational unit through which cultural progress in surgery may be pursued. Surgical department chairs, because of the position they occupy, play a central role in leading change. Success towards the goals of diversity, equity, and inclusion depends on an engaged and committed department chair. Due in no small part to the historical and ongoing systemic biases—racism, sexism, ableism, heteronormativity, White supremacy—that permeate our profession and all aspects of society, most surgical chairs are White males who have benefited from these systemic biases to varying extents over the course of their careers in order to arrive at the crucial leadership positions they occupy. As three cis White male surgical chairs, we believe that it is essential that we are aware of the various forms of privilege that contributed to our own professional successes. This perspective has deepened our sense of responsibility as leaders to continue to educate ourselves and work to use our privilege to help reform the systems that continue to create differential advantages for some and not others. Our goal in this article is not to center the stories of cis White males. Sharing our individual stories is less important and may provide the impression of being performative. Thus, we believe the best use of this forum is to share our experience and specific approaches as we have attempted to learn along with our own organizations. We hope these experiences will help enlist and inspire others, especially those from majority groups who occupy similar leadership positions to become more effective allies and champions for inclusion. The burden and responsibility for eliminating sexism, racism, and other forms of bias in our field cannot rest with those who have been historically excluded or discriminated against; neither can it be delegated. The goals of this article are to (1) define some basic concepts, which are also covered in more detail elsewhere in this supplement; (2) share perspectives on the minority tax, and our experiences learning while leading in the domain; and (3) provide specific examples about what we are doing in our departments.

Introduction

The best teams—whether focused on clinical care, research, or education—are those that build an inclusive culture, foster diversity, and relentlessly pursue equity. Our patients, trainees, and colleagues deserve inclusive environments to be cared for, to learn, and to work. An academic surgical department spans the tripartite missions and thus is the responsible organizational unit through which cultural progress in surgery may be pursued. Surgical department chairs, because of the position they occupy, play a central role in leading change. Success towards the goals of diversity, equity, and inclusion depends on an engaged and committed department chair.

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The Role of the Surgical Chair

Despite the progress that has been made in the recruitment of women, and, to a lesser extent, underrepresented-in-medicine students into surgical careers, recent evidence highlights ongoing gender and racial/ethnic disparities in surgical departments with respect to pay, promotion, leadership roles, and other measures suggesting that deeper systemic barriers and biases persist within our environment [1–4].

Less has been written about heteronormative biases or ableism in surgery, but these are also important and closely related concerns in the context of diversity, equity, and inclusion. Thus, addressing the equity and inclusion gap is not simply a matter of improving recruitment and hiring practices. Intentional strategies are required to create and diversify pathways to entry to the field, to provide effective mentorship and sponsorship, and to support career development opportunities that lead to promotion and advancement. The commitment to equal treatment and intentional involvement of all members of the organization must be reflected in formal and informal modes of departmental communication, including the way people and their accomplishments within the work environment are recognized and celebrated. Equity and inclusion also extend to all aspects of clinical care and research, including a dedication to equitable health care access, the integration of social determinants of health, and the elimination of biases in the delivery of care. Departmental efforts may also lead to more robust community engagement, advocacy, and activism on critical issues. It is important to embed the principles of equity and inclusion into all aspects of the everyday work and operations of the department.

Surgical chairs must be visibly willing as leaders to be vulnerable in recognizing and confronting our personal blind spots, individual biases, and shortcomings. It is imperative that we are comfortable with failure and foster a culture of learning from our mistakes. We must be open to continual learning, to active and passive listening, and to educating ourselves about history and about current lived experiences of the marginalized if we are to be effective leaders in eliminating barriers to equity and inclusion within our department. Moreover, we must appreciate the pervasive nature of everyday bias and discrimination faced by individuals in their lives both inside and outside of our departments and medical centers and the impact this may have on emotional well-being, resilience, career development, and job performance. Because a diverse and culturally humble workforce is integral to surgical excellence, it is the responsibility of the chair to ensure as equitable an environment as possible in which all (students, trainees, staff, faculty, and other providers) can optimally work, provide clinical care, conduct research, and train.

In this work at improving culture, the authors acknowledge that our departments are works in progress—we are at the starting point, not at the finish line. Thanks to the engagement of our faculty, residents, and students, we believe that significant progress can be made within a department by intentionally focusing on building an inclusive culture. Some examples are discussed below, drawn from the experiences of our departments. However, it is also a frustrating reality that, whatever personal priority we may place on diversity, equity, and inclusion, so much of what needs to be addressed lies outside of the direct control of a single chair. Our ability to be successful within the departmental context requires alignment with other leaders in departments and units across our medical schools and hospitals, which have their own complexly matrixed organizational structures. Department chairs are bound to follow existing institutional policies and procedures, some of which may in fact contribute to persistent problems of inequity and exclusion. Thus, department chairs can be seen as part of the problem. However, because of our positions of power and respect within our institutions,

we can also exert considerable influence on other senior leaders within our health systems to drive change, and thus department chairs can (and must) also be part of the solution.

Chairs are responsible for setting the departmental agenda, managing expectations, and ensuring sustained progress towards goals. Bold departmental initiatives in equity and inclusion can be undermined by institutional inertia and a loss of a collective sense of urgency amidst the many issues that compete for attention including the day-in, day-out management of clinical practices, research, and education programs. The pace of change towards equity and inclusion will inevitably feel too fast for some and too slow for others. There will inevitably be setbacks and disappointments that may be felt as "two steps forward, one step back." Failure of leaders to respond appropriately to situations that do not live up to expected standards (or, worse, to patterns of harassment or repeated discriminatory behavior) will feel to some more like two or three steps back despite forward progress made in other areas.

Understanding Barriers and Committing to Personal Improvement

Implicit Bias

Starting from a very young age, we absorb a variety of notions about race, class, gender, ability, ethnicity, and sexuality and develop stereotypical assumptions that we may not even recognize. Though not conscious, these biases still affect how we interact with colleagues, and for those of us in healthcare, how we interact with patients. Unconscious bias can be a useful mechanism that helps us quickly filter information and make decision shortcuts that are useful in daily interactions, such as differentiating friends from strangers. However, these biases are frequently shaped by the need for the familiar, and from an evolutionary point of view, we have adapted to favor things that are like us and have an aversion to things that are different.

The challenge of implicit bias is that it often directly contradicts the beliefs and values that people claim to hold. Those who claim to not be prejudiced or racist are defending their sincere belief in how they intend to act with others. In the surgical workplace, it is increasingly clear that there is a substantial impact of unconscious bias in the hiring and promotion of staff, trainees, and faculty, as well as an impact on the care we provide for patients. This affects multiple groups including women, racial/ethnic minorities, individuals who do not speak English as their primary language, LGBTQ + colleagues, and even those with common physical differences. Healthcare organizations and surgical departments have a responsibility to mitigate the impact of unconscious bias in organizational decision-making. While some emerging training programs may impact the behavior of healthcare providers and have been shown to mitigate some of the adverse impacts of implicit bias, the vast majority of evidence indicates that implicit bias training itself has very little impact. Leaders need to be committed to continue to engage in innovation in developing impactful training programs.

Cultural Humility

A common trait of White men who are well educated and who have ascended to major leadership positions, such as surgery department chair, is a strong self-sense of confidence, competence, and authority across a broad range of topics well beyond surgery. This trait is frequently accompanied by a compulsion to opine, whether on sports, politics, human relations, and even the lived experience of others, albeit without the self-awareness of the narrowness of the White male perspective. This tendency is so well known among women that it developed the pejorative neologism "mansplaining" to describe a situation where a man explains something to a woman in a condescending, overconfident, oversimplified manner, often with the irony that the explainee knows more than the explainer in the first place [5].

Recognition of the increasing cultural, racial, and ethnic diversity of our clinical and workplace environments has introduced the need for "cultural competence" in order to better understand other's beliefs and life experiences, and to mitigate against unintentional and intentional processes of racism, sexism, ablesim, classism, homophobia, and transphobia. However, the term "competence" implies an endpoint or mastery that is not realistically achieved when we do not share each other's lived experiences. While the intent is laudatory, it is better described as a commitment and active engagement in lifelong learning rather than a discrete endpoint of achieved competence. A better and more accurate term would be "cultural humility," a process that requires humility as individuals continually engage in self-reflection and self-critique as lifelong learners [6]. White individuals, and particularly those in positions of authority like department chairs, have a benefit and obligation of doing the hard work of better understanding the lives and experiences of those who do not share our background. It is not the responsibility of women, minority, or other underrepresented colleagues to teach White men; instead, men can read and be intentional, open-minded, and curious as they work to better understand the lived experiences of others with a sense of respect and humility.

Leading While Learning

For White male department chairs, this process is a unique challenge of "leading while learning." In a position of

leadership and authority, we find ourselves faced with the expectation of expertise and competence, while also facing the scrutiny of being in a highly visible position with a diverse and critical constituency. It is easy for us to make mistakes due to the myopia of generation, race, and privilege. The historical hierarchy and power structure within surgery have often been a barrier to recognizing and correcting errors. Relating to patient care, we have learned from the airline industry a practice of flattening hierarchy and empowering a culture of speaking up. The same principle can be helpful to surgeon leaders who acknowledge their own cultural humility, admit the possibility (no, even the likelihood) of committing mistakes in words or actions, and openly ask others to speak up to correct us. For example, in the operating rooms, we have gone to great lengths to adopt checklists, and surgical timeouts, for actively encouraging speaking up for clinical safety. Similar approaches, and a similar culture of psychological safety, are needed for improving our culture and environment.

For White males, particularly those in senior leadership positions, discussions about racism or diversity, equity, and inclusion are often felt to be fraught with landmines or missteps that may embarrass us, demonstrate our ignorance, or unintentionally disenfranchise individuals who are not in a majority group. Fear leads many to avoid these issues, despite recognizing their importance. Critical discussions may get delegated to others within the department, for example, a vice chair of diversity or underrepresented faculty. While all of these people are important partners and collaborators in the work of DEI, they do not replace the responsibility and accountability of the department chair, who still today is most likely to be a White male. This requires both courage and humility on the part of White male leaders: the courage to not shy away from challenging issues or awkward conversations, and humility in acknowledging our own lack of expertise, our own benefits of privilege, and our own biases and blind spots that may interfere with our understanding or effectiveness of the DEI work we are trying to accomplish.

Our leadership positions have us accustomed to being in control and in charge; this is our comfort zone; this is what we are good at doing. What is critically different for those of us in the majority who want to make a difference in DEI is a willingness to be comfortable with being uncomfortable. The institutional issues and individual issues that we need to confront are often those that we have become very comfortable with and, in fact, likely benefited from in our own career path. We need to be willing to listen to and accept criticisms and challenges to the norms of our institutions that seem routine to us, but on closer look support structural racism that undermines the environment and opportunities for advancement for those in historically excluded groups.

As senior academic leaders, we have often grown accustomed to doing most of the talking and being turned to for advice and problem-solving. One aspect of improving the departmental culture in DEI is to listen more and talk less. If we acknowledge our lack of expertise, yet also lean in with curiosity and sincere engagement, we are better positioned to grow in our own understanding as well as to gain trust and credibility with those we serve in our departments.

Gender and Minority Tax

As we work to lead efforts in anti-racism and diversity, equity, and inclusion in our departments, it is only normal that we would tap into the authenticity, expertise, and lived experiences of women and minority faculty, residents, and students. While well intended, this can also provide a new set of challenges for these members of our departments. First, there may be an unstated but strong sense of obligation to be engaged in departmental diversity activities [7]. Given the small numbers within surgery departments, faculty may feel pressured to step into roles of "representatives" [8]. For some, there may be a strong interest and desire to participate and to lead such programs, but for others, diversity equity and inclusion (DEI) may not be their primary interest, yet they may feel uncomfortable to acknowledge this and turn down such a role [7, 8]. One thing that we can do as department chairs is to recognize this potential conflict and not assume an interest or desire of one of our faculty to have a major role in the department [9]. This is a place where a quiet, one-on-one conversation between the chair and faculty member can explore the level of interest and allow the chair to explicitly acknowledge their support for faculty who do not wish to have a major role in this area.

A second issue for women and URM faculty is the so-called gender tax or minority tax. DEI efforts, which disproportionately impact historically excluded faculty, represent additional work on top of an already-full portfolio of clinical, teaching, and academic pursuits that impact remuneration, career satisfaction, reputation, and promotion. In most cases, DEI work is voluntary with no additional compensation or effort allocation. It may extend beyond DEI and search committee time to less readily quantifiable activities including informal mentoring, recruiting, counseling, and even participation in marketing and public relations activity to highlight the institution's efforts in DEI [7–9]. The additional work of DEI is meant to be accomplished in between operations or clinics, in addition to grant writing and submitting papers, and outside of the time that we are teaching students or residents. It is an added burden of time and effort that competes with the traditional metrics of professional success in surgery: work RVUs, teaching evaluations, and academic productivity. Historically, the work of DEI has

not had a place within a professional *curriculum vitae* or institutional promotion criteria.

While it is currently not possible to completely correct the gender or minority tax given the lower numbers of women and URM faculty, residents, and students in our departments, there are effective strategies that can mitigate the unintended consequences our faculty may face in taking on these roles. The first, and most obvious, is to pay for the work like we would pay for other important leadership roles. Yet one of us, recently attempting to do just that, was rebuffed at the senior level of the institution, requiring a complicated workaround to assure compensation for those faculty leading important DEI work. A second strategy is to create an expectation and norm of a Diversity, Equity, and Inclusion section within faculty *curriculum vitae* (CV) that can demonstrate the importance and value of this work, and create an expectation and place for DEI documentation. Finally, one can revise departmental promotion criteria, creating intentional commitment to DEI and further demonstrating value of this work. Department promotion criteria can define metrics of DEI involvement that become part of departmental and institutional promotion criteria.

Department Strategies for Promoting Diversity Equity and Inclusion

Recruitment Committee

Building a diverse department requires special attention to recruitment procedures and policies. Our departments often rely on peer networks and word of mouth for hiring new faculty. However, this often results in "hiring your buddies, or hiring your buddies' buddy", which does not lead to always hiring the best candidate or allowing consideration of diverse candidates. These networks tend to maintain the status quo, favoring "connected" individuals as not everyone has equal access to these opportunities.

Careful attention should be paid to designing procedures for equitable recruitment. A standing recruitment committee, with intentional diversity from across the department (e.g., clinical specialties, ranks, gender, race, ethnicity), is one strategy for ensuring broad input and monitoring adherence to best practices. The recruitment committee should be trained in implicit bias in hiring, use standardized, behavior-based questions, and use outreach from members to a broad range of networks to cultivate a diverse applicant pool. We have intentionally advertised and used networks through the Association of Women Surgeons, Society of Black Academic Surgeons, and Latino Surgical Society as an example. Institutional membership and participation in these organizations offers an opportunity for faculty, residents, and students to attend and create critical relationships and build networks and confidence. It also helps demonstrate the commitment of a department to supporting their underrepresented faculty and expanding the department and chair's network, facilitating a broader profile of candidates considered for recruitment. Personal membership and engagement by the Chair in the activities of these important professional societies is encouraged, irrespective of their identity status.

It is important for the recruitment committee to have backing from the department leadership. Specifically, when division leadership and the recruitment committee have different perspectives on the candidates, potential conflicts need to be navigated carefully. Both sides should have input and the chair should make a decision that reflects the integrity of the process and the values of inclusion. Early results (2 years) from implementing a standing recruitment committee, and the processes outlined above, demonstrated an increase in the hiring of faculty that were women and underrepresented in medicine [10, 11].

Like many departments, we are working to extend these efforts in equitable recruitment to our residency programs. We are moving to holistic review processes and, in our own departments, have seen a dramatic increase in the representation of URM and other historically excluded individuals in our interview process and in our intern classes. Our observed experience is consistent with emerging published evidence [12].

Team-Based Mentorship

Even with equitable hiring practices, department chairs need to ensure equal advancement of faculty. Equal access to mentorship and sponsorship is crucial for clinical, academic, and professional development. The same exclusive networks that contribute to inequitable hiring can lead to a lack of access to mentorship and sponsorship. Indeed, evidence indicates that disparities in promotion for women and those underrepresented in medicine are from a lack of mentorship and/or sponsorship.

The most widely used strategy for ensuring equitable access to mentorship and sponsorship is the intentional use of team-based mentorship, sometimes called "launch teams" [13]. With launch teams, each new faculty hire is assigned a clinical and academic mentor who convenes a team of 5–6 individuals who meet quarterly (for 3 years) to advise the new faculty member in all aspects of their career, including building a clinical practice, developing their scientific program, becoming an educator, and integrating work and personal life effectively.

Each launch team is assigned a chair, who might be the individual's division chief, or academic mentor, someone who is highly invested in the individual. The chair of the launch committee is responsible for ensuring the meetings are valuable, by bringing forth the expertise of each member, and keeping the team focused on important areas.

One strategy for ensuring a uniform process is to provide a workbook with agendas, built with flexibility, for each of the 12 meetings over 3 years [14].

However, launch teams only promote equitable access to mentorship and sponsorship if they are effective. Like any initiative, the quality of the launch teams will be variable, and dependent on the experience and engagement of the chair and members of the team. Thus, a robust evaluation infrastructure is necessary to inform the department leadership when a launch team is not working and needs adjustment or to be re-energized. Conversely, some new faculty may launch quickly, and in those cases, you may want to disband the launch team earlier, opting for 1:1 ad hoc mentoring meetings.

Mid-career surgeons often need a different type of mentorship and sponsorship. Once surgeons have launched their clinical practice, established a scholarly niche, and become comfortable as educators, they may often start thinking about leadership roles. For this stage, "boost teams" can be used to bring together a new type of team-based mentorship [15]. Preparing for leadership roles involves tacit rules of engagement that are not necessarily distributed in equitable ways. The boost team process is designed to bring a team of mentors and sponsors to help make this process accessible and transparent to any interested faculty.

The process includes phenotyping (i.e., what leadership opportunity are you looking for), trajectory mapping (i.e., what smaller roles or projects do I need to take on to grow the appropriate competencies to do well in that leadership role?), and explicit sponsorship (i.e., what can the mentors and sponsors on the boost team do to help attain those smaller roles, project leadership opportunities, or the ultimate leadership role?).

Boost teams may involve 5–6 individuals, some who hold the role the individual aspires to someday and others who can help build skills or create intermediate opportunities. These committees usually meet quarterly over the course of a year to conduct the phenotyping, trajectory mapping, and targeted sponsorship. At the end of the year, the individual should have clarity about their goals, a plan for achieving the competencies necessary for their ultimate goals, and a new network to access as they work towards their goals.

These initiatives around team-based mentorship are also being expanded to our residency programs. One of our departments offers launch teams for those residents preparing and entering academic development time. Intentional, structured mentorship can have the same advantage in addressing disparities by providing equal access to development.

Chair Sponsorship

One of the greatest privileges and joys of being a department chair is the opportunity to support and promote faculty, residents, and staff. We are in a unique position of influence that has an enormous impact when we nominate or recommend someone for a hospital position, a panel at a national meeting, or a committee in one of our professional societies. These are the small steps in career growth where we have the satisfaction of helping advance the academic and professional careers of those who work in our departments. It is likely that we are mentors for several faculty and residents, supporting them with career advice and the security of a confidant about career choices. However, we also have the ability to sponsor and not just mentor those individuals on our teams. This involves actively identifying roles in the hospital, speaking opportunities at our national meetings, committee positions, and other academic or professional opportunities. This is a chance to be deliberate about identifying faculty, trainees, or staff who may benefit from one of these opportunities and actively promoting them. It is one of the most effective ways that we can support the career advancement of our departmental colleagues. Some of us have developed an intentional process of nominating a Department of Surgery member for every institutional award that is offered and are also developing a formal network for identifying local and national opportunities and matching appropriate faculty for nomination. As chairs, this provides us with the added opportunity to identify women and other underrepresented groups in these positions, and sponsor their names for consideration.

Allyship in Addressing Microaggressions

White men of older generations who have grown to be leaders may have matured within a culture that encouraged stoicism along with quiet tolerance of perceived insults, slights, stereotyping, and bad behavior. These negative experiences can exacerbate and compound the sense of historical exclusion and non-belonging of women and individuals from underrepresented groups with a serious cumulative impact on wellness. Often referred to as "microaggressions," many of those that we have seen people suffer through could rightly be determined "macroaggressions." These microaggressions can be both verbal and nonverbal behaviors that may be subtle and insidious but nevertheless communicate negative, hostile, or derogatory messages that marginalize female or underrepresented colleagues. We have all seen them, and most likely we have let them pass. However, these microaggressions take a cumulative toll on women and other underrepresented members of our departments who often face them daily. The frequent slights, whether intended or unintended, are demoralizing and undermine the quality of the workplace culture and environment for our non-majority faculty. This cumulative toll has been referred to as "death by a thousand cuts."

The approach that many have adopted for decades has been to stay quiet, "suck it up," and to avoid confrontation. However, cis White men, and particularly those in leadership positions, must play an outsized role not just in calling out and correcting this behavior when it occurs, but also creating a culture of reporting and empowering people to speak up. We admit it is uncomfortable and hard work to speak up in the moment as an ally for our colleagues. Nonetheless, such allyship is critical for White men in surgery and for White male leaders in particular [5]. Each of us has experienced situations when we have not spoken up and have felt guilty and awkward afterwards for not knowing what to say and for not speaking out. But with practice, we can improve in being more attentive and aware, as well as more deliberate in calling out inappropriate behavior or comments when they occur. Some of us have developed specific programs in teaching techniques that help to identify microaggressions and teaching verbal responses and strategies for speaking up, even in the face of an imbalance of power hierarchy.

Leadership Term Limits

The goal of many of the programs above is to ensure equal access to mentorship and sponsorship. However, the ultimate goal of equal access to leadership roles will not be met unless opportunities exist. For example, prior to becoming a chair, emerging leaders need access to intermediate roles (e.g., Division Chief or Vice Chair roles) to build the competencies necessary to take on larger leadership roles. There are two ways to ensure these opportunities are more available. First, putting term limits in place. For example, one of our departments has 5-year terms for Division Chief roles and 3-year term limits for Vice Chair roles. These terms are potentially renewable, with the Chief roles more likely to renew once, and Vice Chair roles rarely renewing. Second, the number of leadership roles can be increased by adding new positions (e.g., adding vice chair, associate chair, and director roles) or breaking up existing roles (e.g., separating clinical director roles from division chief roles, e.g., Bariatric Program Director and Chief of Minimally Invasive and Bariatric Surgery). The combination of creating new roles and adding term limits creates many opportunities for faculty to enter into these roles, ensuring the diversity of department leadership does not lag behind the diversity of the department as a whole.

What about department chairs? Chairs are typically appointed for 5-year renewable terms (3-year terms at one of our institutions). It has been long-debated term limits whether chair effectiveness declines after a decade. Whether White male chairs (irrespective of their effectiveness) should voluntarily step away from their roles after a period of time to increase opportunities for others is controversial but increasingly openly discussed.

Systems to Ensure Equal Pay

Department leadership should pay close attention to equity in pay and have a system for performing equity analyses on an annual basis. One of our departments mandates such an equity analysis as part of each Division Chief's budget packet annually. Another performs an annual review internally and goes through a vigorous review in the School of Medicine every 3 years. This includes a comparison of each faculty to appropriate benchmarks and explicit comparison of those at each rank and according to time at that rank.

Programs to Improve Environment and Culture

Surgical culture needs a reboot. Historically, surgery has been one of the most hierarchical and exclusive specialties. Incivility was (and often still is) tolerated or even seen as part of the culture. Surgical chairs lead the transition of our collective culture from hierarchical and exclusive, to psychologically safe, and inclusive.

What does it mean to be more inclusive? It means creating an environment where everyone can succeed. It means respecting differences and understanding that diversity makes us stronger. It means collectively embracing the idea that excellence flows from allowing each individual to come to work whole.

Often a surgical department will appoint a Vice/Associate Chair to lead culture change initiatives. In many cases, this individual might be one of the only minorities underrepresented in medicine in the department. Of course, this raises concerns with the "minority tax." These individuals may not be appropriately resourced with staff; or may not receive adequate support from the chair. However, we believe this is too much work for one person. In fact, this is the work of everyone. One strategy is to put this work on a much larger group—and a broadly representative group from the entire department.

A steering or leadership committee of this sort (which one of our departments calls a "Culture Crew") can include 15–30 individuals who collectively work on a portfolio of projects all aimed at improving workplace environment and culture. It is encouraged that such a steering committee not only include faculty but also interested trainee and staff leaders. Below is an example of some projects that a leadership committee can oversee.

Mission

One sub-group can begin by working on a department mission statement and objectives for the Culture Crew. Here is an example of an early draft of a department of surgery

Culture Crew mission statement: "The success of the Department of Surgery rests on a culture in which individuals are supported to advance and thrive. Our goal is to intentionally promote and protect an environment which cultivates and supports academic and clinical excellence, discovery, and innovation; one that celebrates individual differences, honors our shared values of inclusion, collaboration, and wellness, and fosters a sense of pride and excellence in our daily work." Mission statements are often overlooked, yet they can speak volumes to those who look at the department website or are considering a faculty or residency position. Another one of our departments has explicitly identified diversity in its mission statement, and has it prominently displayed in the opening departmental webpage and hallway monitor outside of departmental offices.

Implicit Bias and Bystander/Ally Training

One sub-group should work on a portfolio of strategies to ensure that Culture Crew members and department faculty respond appropriately to events in a way that will move our culture in the right direction. There are numerous local resources at most institutions that can be leveraged to conduct such training. Evidence clearly indicates that one-time implicit bias training does not yield long-term change. However, we believe that creating numerous ongoing opportunities to learn (e.g., grand rounds) and share perspectives (e.g., town halls) and having a large group of faculty trained as bystanders will help move the culture in the right direction. We have included specific Grand Rounds dedicated to women in surgery, and separately dedicated to diversity, equity, and inclusion. Not only does this afford the opportunity to bring in outstanding outside faculty to network with and inspire, but also creates a deliberate venue to present department data, e.g., diversity survey and research on gender disparity in resident evaluations. Finally, attention to women and underrepresented visiting professors for other special events further magnifies this positive influence and role modeling of successful surgeons to our faculty and trainees.

One important aspect is how a department or institution responds to negative events, such as claims of bias or harassment. This can be challenging due to confidentiality of the due process, but chairs should be courageous to be as transparent as possible, seeking guidance and sharing outcomes and learning from mistakes with vulnerability and humility. Recently, one of our departments asked for, and received, a new health system policy regarding bias and harassment from patients and families, similar to that adopted recently by Mayo Clinic [16]. This has made us better equipped with the policy, training, and authority to respond to biased actions by patients and their families in a way that supports our faculty, residents, and staff, and moves us towards a safer and more inclusive culture.

#WallsDoTalk

Another sub-group can work to ensure that the pictures on our walls represent the current and future workforce in surgery, while also explicitly discussing how we want to honor our past. Many departments of surgery have been taking down older portraits and artwork that show exclusively White male leaders and modernizing with more inclusive artwork; others have kept historical portraits but supplemented them with current residents and faculty to represent the future.

One of our departments had the good fortune of a talented nurse artist who started to create portraits of residents who demonstrated the diversity that exists now and that we aspire to for the future [17]. We specifically wanted to maintain the photographic history of the department, even though it was dominantly White and male. But we brought our more current, and more diverse photos to the most prominent area of our hallways and benefited from purchasing and adding the art that causes people to stop and appreciate diversity in the incredible paintings. One of our departments has recently begun reimagining its walls as a place to tell stories of historical exclusion and of successful community activism and advocacy to address structural violence.

Cultural Complications

Another sub-group can work to implement the cultural complications curriculum. This strategy aims to influence a department's culture by creating a space to openly discuss "cultural complications" the same way we discuss clinical complications. We are all familiar with the value of using the Morbidity and Mortality (M&M) conference to create space for learning from failure and role modeling honest discussions about what we might have done differently surrounding clinical care (18).

The cultural complications curriculum toolkit is available for download and can be customized locally (https://www.culturalcomplications.com). This curriculum covers 12 core themes in Diversity, Equity, and Inclusion. Each module introduces the audience to key terminology, provides scientific evidence for the concept, and offers sample cases to spur discussion.

One of our departments has added to every case presentation at M&M a routine question as to whether implicit bias or inequitable access plays a role in the development of the patient's complication.

Anti-Racism Training

Other groups can tackle the issue of anti-racism training and support. There are many ways to approach this. One of

our institutions is requiring a 6-h, 3-day course dedicated to anti-racism. But similar to implicit bias training, an episode of training is insufficient to maintain attention and to continue to move the culture to one of inclusion. We have added book clubs and anti-racism groups within our faculty and staff to keep individuals engaged, and to build an environment where conversations about racism and other forms of discrimination can occur more easily and with a foundation of trust and understanding. A "lending library" to exchange books of interest has also been established in one of our departments.

Reporting and Feedback

All culture falls apart the first time there are major issues and those impacted feel unheard. Formal mechanisms for reporting and addressing such issues are imperative. Departmental leadership, and DEI leaders, should be trained and routinely briefed regarding data from all existing reporting systems (e.g., medical student and resident evaluations, Second Trial data). One of our departments is piloting an additional department-level reporting and action system for those incidents that might not be picked up by other reporting systems, and one of our health systems has developed a "Bias Reporting Tool." The primary goal of the system is to improve our culture by providing feedback and education. Another department has designated ombudspersons ("omsbuddies") that include a designated staff member in addition to several trainees and faculty.

Programmatic Support of These Strategies

There are many examples of department's combining many of these strategies into a centrally supported program aimed at promoting faculty development, improving inclusivity, and promoting best practices. One example of such a systematic approach is the "Michigan Promise." This approach employed by the department at the University of Michigan combines several of the strategies above, including a recruitment committee, launch teams for all new faculty, a Culture Crew, a leadership development program, and several community outreach/pipeline programs, among others. The program is supported by department-level program managers and administrative support. There are several vice chairs, faculty leads, and other faculty, involved in organizing and evaluating each component to ensure the goals are being met, and the programs continuously improved.

Conclusions

It is clear that the best teams—whether focused on clinical care, research, or education—are those that build an inclusive culture that fosters diversity and relentlessly pursues equity. Our patients, trainees, and colleagues deserve inclusive environments to be cared for, to learn, and to work. Surgical culture has a long tradition of hierarchy and exclusion. As current surgical chairs, the authors of this chapter acknowledge that we have benefited from a historical system that reflected structural and institutional racism. There have been relatively small recent gains in the diversity of surgical leadership, with very few women and individuals from other historically excluded groups assuming these roles. Change will therefore require those of us who have benefited from the system to reform it. Bringing about this culture change to foster inclusive environments requires intentional efforts: structurally through a collection of programs and culturally through behavior. One of the key insights regarding our shared goal of building inclusive cultures, highlighted earlier, is that we must continually enhance cultural humility. Positive culture change is a journey without a destination. We can never declare victory over building an inclusive culture, only try to continually improve. We will always fall short and we will always have areas to improve.

Acknowledgements that unconscious bias is a normal human trait helps us be intentional about mitigating the negative effects of bias in our individual and institutional decision-making. Implicit bias in individual interactions can be addressed when encountered if we become aware of it and take actions to redirect our responses. Unconscious bias is a lot like the unseen part of an iceberg, profound but hidden from view, and influences how we as individuals and our institutions respond to people different than ourselves. Recognizing that we all carry these implicit biases is the most important step in overcoming the unintended consequences of how they affect our daily interactions. Self-awareness, slowing down, and using strategies to be deliberate in how we work with and associate with people different than ourselves can allow us to manage, yet not conquer, implicit bias. Our implicit biases are more like a chronic condition, that with ongoing attention can be successfully managed to make a workplace and a healthcare environment that is more welcoming and inclusive.

Declarations

Competing Interests The authors declare no competing interests.

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