ANESTHESIOLOGY 2022: The Faces of Anesthesiology Panel Discussion
Thank you to all of those who attended this session to learn more about the current state of diversity, equity, and inclusion (DEI) in anesthesiology. We were excited to see how many students participated in the discussion, but due to time constraints, we were unable to answer some of the questions during the session. Fortunately, our wonderful panelists took the time to share their responses below.

Student Questions & Panelist Responses

Can you talk a little bit more about going through medical school, residency, and your career as a gay individual? What challenges did you face? What challenges do you still face?

Dr. Reece-Nguyen: I honestly believe the best way to bring your LGBTQ+ identity into your career is to live and work as your true, authentic self. There is so much power in patient encounters when you are authentically yourself. Representation in medicine is crucial and patient safety/satisfaction is absolutely improved when providers are truly themselves, especially when caring for our LGBTQ+ patients. BUT it can sometimes be difficult to feel safe living so authentically, especially when the power dynamic of the medical training hierarchy might be at play.

I chose to remain closeted in my med school application, which was a difficult decision, but was what I thought I had to do in order to succeed and be accepted. Once at med school, I was one of the first out LGBTQ students, made worse by living in a conservative state at the time. I helped create the first med school Gay-Straight Alliance and worked diligently to find some LGBTQ mentors around the city. We definitely faced pushback and homophobia during this time, but I was determined to make my school better than when I found it. I got married and adopted a baby during med school, so I vowed to live authentically from then on which included my residency applications. It is liberating to represent your true self in the application/interview cycle, but it is not without risks. Risks of rejection and discriminatory comments during interviews could possibly impact your future career. Every LGBTQ+ applicant has to face the hard decision of whether to remain closeted and apply to less LGBTQ-friendly programs in an attempt to improve their chances to match or whether they want to be out in their application recognizing that it might limit their interview/match options. I always caution my mentees to make this decision early so you can approach the first steps of your application, personal statement, and program list knowing which version of you will be represented. It is a hard decision and honestly not fair that we even have to consider whether or not we will be physically and psychologically safe at ~50% of the anesthesiology programs in this country.

As a resident/fellow/attending, I have been unapologetically me and I rarely face pushback or discrimination. For me personally, being authentic at work brings me joy and I see the positive
impact it has on my patients and colleagues. I didn’t have a gay anesthesiologist to mentor me when I was a pre-med or even early in med school, so I am determined to change that for your generation! Find mentors early and use their support to continue being as authentic as you can. It takes time to feel confident to be so out and vulnerable all the time (very much so during training), but the rewards and benefits to yourself and patients will be powerful.

One current challenge we face is not having any official/recognized representation at the ASA national level. We are working on changing this and will hopefully have a LGBTQIA(nesthesia) committee soon to focus on networking, mentorship, and connecting our community across the country. If you’re on Twitter, please reach out to me (@reece_nguyen) and follow our new LGBTQ+ Anesthesiology group (@LGBTQIA(nesth)). If you are struggling with these difficult decisions or just need more support in finding ways to be authentic in your career, please do not hesitate to reach out to me whenever: travisreecenguyen@stanford.edu

As someone who is not diverse in the typical sense, how do you best recommend we can be a better ally?

Dr. Reece-Nguyen: This is a great question! Allyship comes in many forms and exists within diverse populations as well. Non-minority allies are vital to a healthy work environment and can be true champions for diversity initiatives. I personally appreciate allies that remain open-minded and truly learn about the barriers, discrimination, and microaggressions minority populations experience. It can be a powerful thing when an ally becomes an Upstander and speaks up when microaggressions or other discriminatory things occur. Allies are also often in positions of relative power, so making sure those allies sponsor and elevate minority colleagues as often as possible, ensuring they also have a seat at the table!

Dr. Nichols: Thanks for this question. I would argue that, because we have multiple aspects to our identity, we are all diverse in some sense. That being said, there are some groups that have been historically excluded and marginalized more than others. One of the most impactful things to do would be to act as an upstander. This means that, if you are witness to an injustice, or a situation that has harmed someone, I would consider asking clarifying questions about the situation. M. DallaPiazza, et al (2018) adapted a framework, called INTERRUPT, that was originally published by G. Kenney from College of the Holy Cross.

It is listed here:

The INTERRUPT framework is as follows:

- I—Inquire: Leverage curiosity. “I'm curious, what makes you think/say that?
- N—Nonthreatening: Convey the message with respect. Separate the person from the action or behavior. “Some may consider that statement to be offensive.” Communicate preferences rather than demands. “It would be helpful to me if….,”
● T—Take responsibility: If you need to reconsider a statement/action, acknowledge and apologize. Address microaggressions, and revisit them if they were initially unaddressed.
● E—Empower: Ask questions that will make a difference. “What could you/we do differently?”
● R—Reframe: “Have you ever thought about it like this?”
● R—Redirect: helpful when individuals are put on the spot to speak for their identity group. “Let's shift the conversation....”
● U—Use impact questions: “What would happen if you considered the impact on ... ?”
● P—Paraphrase: making what is invisible (unconscious bias) visible. “It sounds like you think....”
● T—Teach by using “I” phrases: Speak from your own experience. “I felt x when y happened, and it impacted me because....”


How does the promotion of DEI in anesthesiology also extend to the biases against DO students?

Dr. Nichols: I appreciate this question. Honestly, I was not aware of this bias until I heard from some students from DO schools that they felt they experienced this. It didn’t dawn on me that a candidate who was qualified might be considered less so. That being said, I believe that it is similar to other biases. When there are people from groups that are considered “dominant” who witness minority groups or marginalized being ‘othered’, it would be helpful for them to speak up and ask for clarification. The framework, INTERRUPT, that I mentioned above could be helpful.

Please tell us about a time when you were treated poorly for being your authentic self and how did you respond?

Dr. Reece-Nguyen: I faced homophobic discrimination from patients a few times during medical school. I wore my wedding ring after getting married and many patients would ask about my ‘wife.’ Each time this occurred, I was faced with the decision to correct the patient and out myself, or just respond with genderless pronouns in order to not break my clinical rapport with the patient. This internal struggle is hard enough and not great for your mental health, but occasionally when I did correct the patient and said I actually have a husband, the patient would be abruptly homophobic, saying things like: ‘that’s so unnatural. Gross. I don’t want you to be my doctor. I don’t want a gay doctor doing my exam.” The first few times this happened I left the room (perhaps shedding a tear or two) and went to find them a different provider. Eventually through my journey of authenticity and with the help of several mentors, I
was able to remain in the room, explain that the patient does not get to make that choice and if they’d prefer a different doctor, then they were welcome to leave and schedule a different appointment. This was possible through the support of med school leadership and my incredible mentors. I did choose to leave that conservative state after med school to train in a much more LGBTQ-friendly area which drastically reduced the level of discrimination and allowed me to flourish as my authentic self during the remainder of my training!

I heard from PDs that the applicant pool is 7:3 male to female, which translates to the resident gender ratio we saw in the earlier presentation. What do you think is the cause and what are you doing, if anything, to improve the heavily skewed ratio?

Dr. Nichols: I am pretty visible in my medical school, and I work around a lot of student learners. I am also a professional recruiter of anesthesiology as a career choice. In other words, I use touchpoints that I have with medical students of different identity groups to highlight that I’m an anesthesiologist, and I model the kind of life and career you can have. To the best of my abilities, I try to get interested students exposure to anesthesiology - either through shadowing or research. Further, I have served as a mentor to numerous medical students who were interested in anesthesiology as a career.

As far as the reasons for this ratio, I’m unclear. As with anything else related to anesthesiology as a career choice, it may come down to a lack of exposure, which is why I am happy to help as much as I am able if people are interested.

How would an URIM or DEI medical student feel comfortable if the leadership of residency class is not diverse?

Dr. Reece-Nguyen: I think it truly depends on the environment of diversity and psychological safety the leadership team has created. Leaders themselves don’t have to be diverse, but they do have to be strong allies for DEI work to be taken seriously at a program. Make sure you look at the diversity of their resident classes and have opportunities to speak to those residents off the record. See how/if they feel supported and learn about ways the program strives to support UriMs.

Dr. Nichols: I love Dr. Reece-Nguyen’s answer here. I would add: an environment where inclusivity is a priority is very helpful. In other words, it’s not enough for me to just bring in people who are of “diverse” backgrounds, we need to aim to create a space where people’s backgrounds are appreciated and celebrated so that those individuals can thrive! That is the work of inclusion, and it can sometimes get overlooked.

Medical schools aim to recruit compassionate, empathetic, kind students and then simultaneously expect the resilience, grit, and patience to handle all the rigors of training
with stride. How do you as physicians best support medical students? What can we learn to do as future residents and attendings?

**Dr. Reece-Nguyen:** When I work with med students in the OR, I make sure they know they’re a valuable member of the team and are empowered to speak up. I ask if they want to learn anesthesiology or life/career lessons or both! Outside of the OR, small kindnesses go a LONG way in breaking down the training hierarchy and establishing a safe environment to learn. This means meals when on-call, coffee during morning breaks or on rounds, etc. I am always cognizant of their demanding schedules as well; incorporating any days they may need to leave early for life stuff or just sending them home early on specific days to make sure they have time to study/eat/sleep/play. Even though these are small acts, it sets a tone that their attending genuinely cares about their education, their future, and their wellbeing!

How do you navigate advocating for more diverse, more inclusive residency programs with faculty who may be more hesitant or conservative? In other words, how do you promote change around people who like the status quo?

**Dr. Reece-Nguyen:** The ‘status quo folks’ exist everywhere, and this is something you will face throughout your career. One successful approach I have taken is using the available data that shows the importance of increased diversity and representation within anesthesiology and medicine in general. Patient safety, decreased mortality, patient satisfaction, and patient trust ALL improve with increased diversity so it is hard to argue against this data when we are perioperative patient advocates.

As a side note: it is vital to identify these ‘status quo folks’ and see how involved they are with admission/recruitment/resident support. It might be prudent to push departments to require implicit bias training and periodic analysis of the application reviewers scoring trends.

Sometimes I feel like I'm not valued, not sought after or even at a disadvantage because I'm an "overrepresented" minority although I consider myself an ally, considerate of people from all backgrounds and have lots in common experiences with other minorities as an immigrant and person of color. Thoughts?

**Dr. Reece-Nguyen:** Even if you’re not considered a URiM applicant in certain instances, you still represent valuable diversity in anesthesiology and have power in your unique lived experience, which will have a positive impact on your patients. Your lived experience as an immigrant and person of color directly impacts how you approach anesthesiology and each of your patient encounters. And remember allies are also important in promoting and support other minority communities within our field!

As a medical student, and resident, it often feels like we do not have power because we are under the evaluation of our higher ups (i.e. program directors and attendings). How do we
make a significant impact to address issues such as lack of DEI, without compromising our growth as we build professionally/career-wise?

**Dr. Reece-Nguyen:** This is a great question and can have a myriad of different responses. I think finding URiM mentors or DEI allies within your department would be invaluable in helping you address lack of diversity and other disparities with a team approach instead of just you as a trainee. Program selection is an important aspect of this question too because there are many programs around the country that have robust DEI groups and would be thrilled if a trainee wants to get involved. If you are not at a program like that and you feel there will be pushback to pursuing DEI work, you could try to disguise your DEI work as a QI project in order to gather data and make positive changes at your hospital while fulfilling residency/fellowship ACGME requirements.

How do we address the notion that anesthesiology residency is reserved for only those students that have amazing board scores? The students with average board scores are also interested. How do we still pursue anesthesia residency?

**Dr. Reece-Nguyen:** I most certainly did NOT have amazing board scores and yet here I am! It is true that anesthesiology residency is quite competitive, but many programs now employ holistic application review strategies that acknowledge applicants are so much more than their standardized exam scores. Many of the best anesthesiologists I know had mediocre test scores, yet they are praised for their clinical excellence, research, and patient care.

**Bottom line:** Scores do not define you or your ability/worth as a future anesthesiologist.

An unfortunate reality is that many programs will continue using arbitrary score cut-offs before even opening the rest of the application. Some folks believe these cut-off scores should be made public since applicants are required to pay PER program application fees. These costs are already prohibitive for many, so it is only fair that we don’t allow applicants to spend money applying to a program that will immediately reject them without opening the application.