EAST Presidential Address: EAST—a legacy of inclusion

Andrew C. Bernard, MD, *Lexington, Kentucky*

I am going to talk to you today about legacy, and I hope to convince you that everyone can create a legacy. Everyone has the opportunity to make something lasting and something special. To create a legacy does require intentionality. You have to combine an idea with passion in order for it to become a legacy. EAST, because of its size and reach, allows you to magnify that effect and create a much greater legacy, and it is of that which I hope to convince you.

Author Shannon Alder writes, "Carve your names on hearts, not tombstones. A legacy is etched into the minds of others and the stories they share about you." We leave legacies every day as trauma surgeons. We save lives. In a day's work, we create the legacy of a human life. We encourage patients. We tell them that they will get better and leave a legacy of hope. We comfort patients and families and leave a legacy of compassion at a time of often great pain and sorrow. We do these things as a matter of routine. But a legacy could be many other things. It could be an educational program, a lectureship, or a scholarship. Because legacies are born from passion, they are individual, and so the possibilities are endless.

EAST and EAST members have a long history of producing legacies. I am going to share with you some ideas combined with passion that became legacies, something very special and lasting. An entire volume of the *Journal of Trauma and Acute Care Surgery,* would be required to describe them all, so this list is not all-inclusive.

Perhaps one of EAST's most notorious legacies is practice management guidelines. Mike Rhodes was the president in 1993. The Institute of Medicine and the Agency for Healthcare Policy and Research had just been formed, and they had just described practice guidelines. Mike Rhodes' vision was to have practice guidelines for trauma that would help us effect quality trauma care and cost-effective trauma care.[1] He challenged the organization to do this, and now EAST is a world leader in guidelines.[2]

More importantly than being a world leader, we have changed and saved lives of innumerable patients around the globe. Consider how many students and residents are more knowledgeable and confident because of EAST guidelines. Consider for how many patients, trauma care was made higher

From the Division of General Surgery, Department of Surgery (A.B.), UK College of Medicine, Lexington, Kentucky.
Presented at the 32nd Annual Scientific Assembly of the Eastern Association for the Surgery of Trauma; Austin, Texas; January 16, 2019.
Address for reprints: Andrew Bernard, MD, Division of General Surgery, Department of Surgery, UK College of Medicine, C207, 800 Rose St, Lexington, KY 40356; email: andrew.bernard@uky.edu.

DOI: 10.1097/TA.0000000000002351

quality and more efficient because of EAST guidelines. This is a great legacy from EAST.

Babak Sarani was a young EAST member who after listening to a critical care podcast had the idea of trauma podcasts. He approached his boss at the time, EAST Past President Bill Schwab, and shared his idea. Although Dr. Schwab initially thought it was "kooky," he said, "okay, give it a shot." Babak approached EAST President Pat Reilly, who put him in touch with another young EAST member, Chair of the Information Technology Committee, who helped Babak shepherd his proposal all the way through EAST.

That young Information Technology Committee Chair was Past President Bruce Crookes. Bruce helped Babak all the way. They connected with EAST Executive Director Christine Eme, who located funding and bought a microphone, and now EAST has posted more than 115 podcasts. That's a great legacy. Dr. Sarani's first interviewee? Mike Rhodes, talking about practice guidelines.

The EAST Injury Control and Violence Prevention Committee just held its eighth Community Outreach event, another fantastic success. Shahid Shafi was chairing Injury Control and Violence Prevention Committee when these events first began. Wendy Greene was on the ground floor on that first event. When asked to tell the story of how this idea combined with passion became the legacy that it is, Dr. Greene gives credit to all the people who turned out that first day and took a chance, and to Christine Eme. EAST now leaves a legacy in every community we visit for the Annual Scientific Assembly, touching the lives of those in the community with injury prevention initiatives that are timely and relevant. We'll never know the lives we have saved and injures we have prevented. That, to me, is part of what makes these legacies so exciting.

EAST's Mentoring Program started in 2012, and we have now made 151 mentoring pairs. We have the largest organizational mentoring program in surgery. When I called Vince Gracias and asked him to tell me the story of this legacy, he said that Ron Gross gets the credit. One can see a theme here. Often when I asked somebody about the legacy, they preferred to give the credit to a fellow EAST member and friend.

One of the most exciting EAST legacies in the making is INVEST-C (Investigative Research Team Core) "Hackathon." Imagine being an unfunded EAST member with aspirations to become an independently funded investigator. You are awarded the opportunity to have two days in a room with EAST members who are funded investigators and are committed to helping you become funded.

EAST INVEST-C mentors help aspiring investigators with every step—hypothesis development, writing specific aims, designing the best methods, identifying necessary institutional resources, idea refinement, budgeting, and writing the pitfalls section. INVEST-C gathers annually in Chicago, at the EAST offices in the American College of Surgeons. They pile into a board room and hack away at research proposals. With each INVEST-C, a half-dozen young investigators receive an enormous boost to their careers. This is not a small spend for EAST. It costs about $20,000 annually. EAST has hosted two Hackathons, and we are already realizing a return on the investment, with several participants becoming funded.

How does EAST fund special programs like INVEST-C? We do so through another legacy, the EAST Foundation. The EAST Foundation is now called the EAST Development Fund. The Foundation was started in 2002 with this simple goal: ensure the future of trauma care. The purpose of the EAST Foundation was to garner, manage, and disperse funds, hoping to raise $1,000,000 by 2012. This year, EAST saw $90,000 in individual giving, from all of you putting the EAST Development Fund balance close to $1,500,000. This is a legacy that produces other legacies. If you have ever contributed to the Development Fund, thank you. This is your legacy.

EAST's Research Scholarship was established in 2002 by Phil Barie who went on to become EAST President. The Surgical Infection Society had a similar scholarship and that inspired Dr. Barie. EAST partnered with Wyeth Pharmaceuticals, who funded the Scholarship for many years. Now funded through the EAST Development Fund, almost 20 research scholarship have been awarded.

I will share with one final EAST legacy with you, and that is the Oriens Award. "Oriens" is Latin for *east*. Started by Bill Chiu and Jennifer Knight Davis and now in its 10th year, the Oriens Award is an essay contest. The essayist writes why they want a career in trauma and acute care surgery. Winners receive travel to the EAST Annual Scientific Assembly. They read their essays from the podium at the Oriens Session. If you haven't heard or read these essays, you are missing something very inspirational.

It's important to note that Bill Chiu shepherded the idea of Jennifer Knight Davis (a young EAST member serving on the Career Development Committee) to establish the Oriens Award.

Figure 1. EAST founders Kimball Maull, Burton Harris, Howard Champion, and Lenworth Jacobs.

Bill Chiu pushed the establishment of the Oriens Award so that aspiring trauma surgeons could realize meaningful, exciting experiences. Creating meaningful experiences is a thread that runs through all of these EAST legacies. Those who created legacies knew their work would benefit many people they would never even know.

EAST members are changing society. We're not just wearing Hawaiian shirts and having fun, although we are doing a lot of that. We are changing society with what we do, and we're doing that very profoundly.

EAST's greatest legacy is the legacy of EAST itself. Four trauma surgeons, Kimball Maull, Burton Harris, Howard Champion, and Lenworth Jacobs, were young trauma surgeons in the mid-1980s (Fig. 1). There weren't trauma departments, and there was hardly any trauma mentoring. Trauma centers were only 10 years old. There was one surgical association, the American Association for the Surgery of Trauma, and it was the old guard. It was difficult to get in, and it was difficult to get a paper on at the American Association for the Surgery of Trauma meeting. These four envisioned a young trauma surgeons' organization.

Not everybody agreed with that, but they persisted. They envisioned an inviting, family-friendly meeting with a membership that was welcoming and friendly, where everyone was included, and everyone succeeded. In a history of EAST written for our 25th Anniversary, Howard Champion wrote, "All of us owe a great deal of gratitude to our founders who have toiled unselfishly in order to develop an association based upon congeniality and concern—for our patients, for each other, for the future of trauma surgery."[3] This is what I'm going to be discussing for the rest of my address—concern for each other and concern for the future of trauma surgery.

This is what Kimball Maull, our very first President, wrote in his presidential address: "As citizens, we are all accountable, but as surgeons we bear a heavy responsibility to educate, to influence, and to speak out."[4]

Last year, on Friday night of the EAST meeting, the last night, I received a call from an EAST member. He said, "Something is bothering me." I asked, "What's bothering you?" He said, "On my travel out here, I saw a great deal of media discussion about equity on the red carpet (in the film and television industry), and that's important conversation." I replied, "Yes, I agree." He said, "It's a discussion being had largely by women." I said, "I noticed that." Then he said, "I think we have the same problem in surgery." I said, "I tend to agree." Then he said, "I think EAST is the association to do something about this."

I thought really hard about what that mindful, passionate EAST member said. I was certainly aware that equity and inclusion in surgery were an issue that people discussed. But I never really understood it fully. Moreover, I had never really envisioned myself as being part of the potential solution. As I continued to think about the issue of equity and inclusion in surgery, and as I discussed it with peers, it became very clear to me that EAST has a role to play here, but more than that, EAST has to play a role. This organization was founded on inclusion and everyone feeling like they were important, and so inclusion is what I'm going to talk about.

In his book *Radical Inclusion*, Martin Dempsey, who is the past chair of the Joint Chiefs of Staff, and his coauthor, Ori Brafman, discuss the fact that today's leadership has to be based upon confidence and trust.[5] Gone are the days when one can lead simply by control. To lead effectively today and build a team, you must have loyalty and engagement. Dempsey and Brafman lay out their Tips 1 and 2 for building an effective team. Tip 1 is belonging—every member of the team has to feel they are included. Tip 2 is meaning—everyone on the team has to feel like what they are doing is valuable. Whether talking about a trauma team, a department, an organization, an association, or a profession, for us to succeed, it is critical that our members feel included.

What is the difference between diversity and inclusion? Diversity has been compared to "being invited to the party," whereas inclusion is analogous to "being asked to dance." Inclusion is what we want. We want everybody dancing. But you might be thinking to yourself: "Isn't this fixed?" Are equity, diversity, and inclusion in surgery still issues? We've been hearing about diversity and inclusion for a long time. As trauma surgeons, we address problems in the course of seconds or minutes. A problem may require hours, if solving it takes us a long time. We trauma surgeons are quick and deliberate. Equity, diversity, and inclusion have been discussed for years. So are they still really issues?

I'm inspired by the cover of *Time Magazine* from October 8, 2018, where the editor has penciled the words "and women" into the Declaration of Independence in the phrase "that all men are created equal. But the subtitle is ominous, reading, "Can We Get There?" The subtitle doesn't read "Are We There?" or "When Will We Get There?" but "Can We Get There?" Equity clearly remains an issue evoking some uncertainty.

Consider the objective data on progression of women from matriculation of medical school all the way to becoming deans.[5,6] (Fig. 2) Fifty percent of matriculates into medical school are women. More women than men graduate, which is encouraging. But fewer women enter residency. And fewer still finish residency. Even fewer get academic appointments and progress to associate and full professor. A far, far minority become department chairs or deans.

One might examine these data and conclude that it will simply take time to move the cohort that is 50% women entering

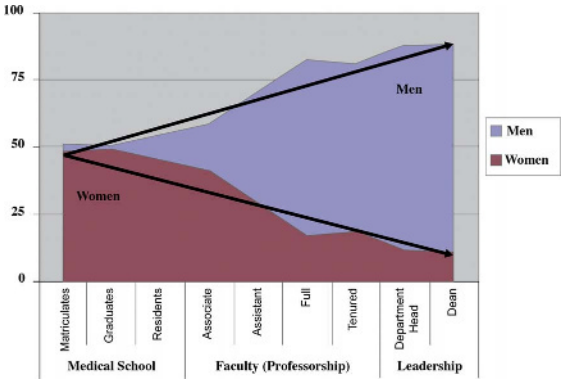

Figure 2. Percentage of women and men at stages of advancement from medical school matriculation to dean. Adapted from Zhuge et al[6] and reprinted from *Journal of Surgical Research,* 219, Greenberg CC, Association for Academic Surgery presidential address: sticky floors and glass ceilings, ix–xviii, Copyright (2010), with permission from Elsevier.

medical school through the academic continuum to professor, chair, and dean. However, the time it takes from initial appointment to promotion to professor is only 10 to 12 years, 14 years at most. These data were published in 2015. Efforts toward professional equity in medicine have been occurring for more than 20 years. This is clear and irrefutable evidence that we're not there and that we're failing to progress women through the academic ranks.

Another disparity between men and women in medicine is pay.[8] Physicians are, on average, the highest-paid profession. But the difference between women and men is approximately $70,000 annually. Female physicians get paid two-thirds of what men get paid. For surgeons, the gap is $83,000. We must acknowledge that many factors go into determining salary distribution of effort, research time, time off, and so on. There are lots of factors that must be considered when comparing salary. Consider then a more homogeneous population—physician scientists on K Awards. National Institutes of Health K Awards require 75% time commitment to research. I've never known a K Awardee who isn't working exceptionally hard to capitalize on that 75% research time. That leaves 25% that's variable including clinic time, operating room time, education, and administration. Still, within this relatively fairly homogenous population, the pay gap is still over $30,000 per year.[9]

After correcting for all of these factors—specialty, institutional characteristics, academic productivity, academic rank, work hours, and so on—the difference is still $13,000.[10] Said a different way, one-third of the pay gap between male and female physicians is purely because of gender. If the males in our profession were getting paid $13,000 less because they were male, I believe they would think themselves ill-used.

Salary isn't the only factor to consider in professional reward. One-third of women report that sexism is a barrier to advancement, while only 3% of men report such a barrier.[11] One-third of women report spending 20 to 40 hours per week at home on household duties in addition to being a busy surgeon, while 7% of male surgeons report such responsibility and commitment after work hours. After controlling for professional hours, operating room time, type of practice, and years since completion of residency, women ENT surgeons rely less on their spouse than male ENT surgeons do and still are getting paid 15% to 20% less.[11]

Inequity between women and men surgeons is not limited to annual promotion and monthly salary, but it affects many aspects of everyday life for our peers and trainees. Meyerson et al.[12] examined self-reported autonomy using the Zwisch Scale. The Zwisch Scale is a phone app on which residents and faculty report autonomy and performance during a case.[13] When you correct for specialty of attending, case type, case difficulty, level of training, and gender, using a multivariable regression, we see significant bias against female residents with respect to autonomy. Female residents have less autonomy.

Another potential effect of inequity in surgery is confidence among female residents. Self-reported confidence on anticipated laparoscopic skill performance is lower among female general surgery residents and obstetrical residents.[14] But on actual skill performance, there is no difference. As teachers, mentors, and peers, we should be mindful of the fact that everyday thoughts and experiences of our female peers and trainees are different than those of our male trainees and peers and that we have potential to positively impact that.

Caprice Greenberg did a beautiful job of describing the evidentiary basis for inequity in surgery in her "Association for Academic Surgery Presidential Address: Sticky Floors and Glass Ceilings."[7] She also described how women are more likely to burn out, that home life is a deterrent to female surgeons, and the simple fact that males tend to be overrated, and women tend to be underrated in performance evaluations in surgery.

Gender schemas are sociocultural behavior norms or expectations that have been described in children but have also been applied to professionals, including physicians and surgeons. In one study, investigators asked two dozen providers to list the qualities of an effective code team leader.[15] Among other traits, they listed a deep, loud voice and a clear, direct mannerism, characteristics of a traditionally male gender schema. In a follow-up question, female providers were asked how they execute those qualities clinically. Female providers reported behavioral rituals in which they suspend gender norms, venture outside a traditionally female gender schema, and then assume a different gender norm so they can accomplish the clinical task. Often those providers apologize afterward for venturing outside their gender schema (Table 1).

Because our profession has contemplated and worked toward professional equity for some time, and it has still not

TABLE 1. Interventions to Decrease Gender Disparity in Surgery

Systemic Interventions in Surgery	Individual Actions
Transparent, objective compensation plans	Look for opportunities to acknowledge women's contributions through "amplification"
Blinded practices for evaluating manuscripts and grants, hiring, and promotions	Recognize and acknowledge microaggressions and comments or assumptions based on gender schemas
Explicit, purposeful, and fair distribution of uncompensated teaching and service workload	Before you say something to a woman, think how it would sound if said to a man
Equal leave policies and tenure clock extensions	Actively encourage women to apply for leadership and promotion, and sponsor them when they do so
Objective measures of success and milestones for promotion that are defined a priori so that everyone knows the rules	Leaders have a moral obligation to ensure equitable negotiation and recruitment packages
Institute educational programs on implicit bias and its impact	Most importantly, admit that you have gender bias and educate yourself on how to mitigate the impact

Individual actions can be implemented immediately. Adapted from Greenberg.[7]

arrived, we must ask ourselves whether we are taking the right approach. Are our methods flawed? To a certain extent, they may be. We tend to focus on formal complaints, things we can put on a report or a dashboard. For example, we say, "We have this many harassment complaints this year, that is fewer than last year, and therefore we are better." Such an approach may fail to address real issues.

Perhaps more important than formal complaints are subtle but very powerful cultural norms, accepted behaviors, and nonverbal messages that we send to our peers and receive from our peers. We focus on the measurable complaints and individuals. We profess that we have identified a bad actor, have managed that individual out of the organization, and that now we're better because we eradicated that problem. But this issue is much more complex. This issue is cultural. It is organizational, and the reality is that organizations don't, in general, perceive an endogenous incentive to change. We all come from organizations, and you are all in the position to our peers, our staff, and our leadership and say, "In our organizations, we're going to change this culture."

So what's our current state on equity in medicine and surgery? Fifty percent of female medical students are going to be harassed according to a recent report from the National Academies of Science, Engineering, and Medicine (NASEM) entitled "Sexual Harassment of Women-Climate, Culture, and Consequences in Academic Sciences, Engineering, and Medicine."[16] One of the conclusions is very concerning. This NASEM report says that medicine is not prepared to take meaningful steps toward addressing harassment. That unfortunate and painful indictment means we have much work to do, beginning with a commitment to change.

Is this NASEM report on sexual harassment a valid charge? Considering that question, one must acknowledge another NASEM report released in 2016. Entitled, "A National Trauma Care System: Integrating Military and Civilian Trauma Systems to Achieve Zero Preventable Deaths After Injury," this report lists 11 charges.[17] None of us have questioned the basis for the report or its charges. We have taken them to Washington. We advocate for them. What would make us think that the data and the recommendations in the NASEM report on the national trauma system are any less valid and relevant than the report on sexual discrimination? One of those charges regarding climate and culture in medicine is that we need professional society involvement. EAST can be that professional society that gets involved.

Jo Buyske is the executive director of the American Board of Surgery. In 2005, she wrote an editorial on women in surgery.[18] In her editorial, she discussed about how Claude Organ had written an editorial on women in surgery in 1993, and in his editorial, he hoped that very soon we would be finished writing editorials, appointing task forces and committees and writing papers about women in surgery, because maybe we would finally have resolved the inequity.[19]

Dr. Buyske described difficulty writing her editorial, and she was honest. She described growing up in surgery and having not seen it. She had never felt "different." She wrote: "A subterranean sense of being different is at the heart of our discussion about women and surgery." Her point was that women in surgery generally don't want to be considered different or to require assistance above and beyond a male colleague. Dr. Buyske goes on to emphasize that the issue of gender differences in surgery isn't about the ability to do the work. The more she looked at the literature, and the more that she talked to her peers, the more she realized that male and female surgeons are different in some ways. Her conclusion was that together we should figure out how to tolerate those differences and even celebrate those differences. In the end, gender differences should not prevent individuals from having equal opportunities to progress and achieve their goals in the surgical profession.

Generational differences exist among women in how they perceive gender discrimination as a barrier to leadership. Approximately one-third of men think that discrimination is an issue preventing women from progressing and that proportion is the same for men under age 50 compared to men older than 50.[20] Among women over 50, about half believe that gender discrimination is a barrier to advancement compared to about 75% of women under age 50. So gender's role in professional advancement is seen differently among different age groups, that fact must be acknowledged and dialogue about the issue should be taken in this context.

More fundamental is the simple question of how males and females respond to the statement, "There are too few women in either high political office or top executive positions."[21] Overall, 60% of respondents believe this statement to be true. When results are analyzed by gender, half of men and 70% of women agree that there are too few women in either top executive positions or top political office. These data aren't surprising to most of us. But these data highlight a crux of addressing inequity in any profession. If a male is in a position of high political office, executive leadership, or a position of power (e.g., chair) and their perspective is that there doesn't need to be more women at the top, there aren't going to be. Male-dominated professions and societies are inherently self-propagating.

Consider the following analogy: You're doing a case with a resident. You don't think the resident needs to do the case. They obviously think they need to do the case. Since you are in a position of power, you have to be intentional about allowing the resident to do the case, or they're just going to be watching.

From these data, it should be no surprise then that women favor same-sex mentors. Sixty percent of women say they would rather have a female mentor.[11] Based upon data shown here, women are going to tend to be more mindful of the necessity for women to get promoted. Eighteen percent of men think they need same-sex mentors. They have less to lose.

I have carefully considered whether EAST needs to take a position on and commit effort to equity and inclusion. The American College of Surgeons has promulgated statements on parental leave and salary equity.[22,23] The American Surgical Association has produced an outstanding 70-page white paper on how to achieve equity and inclusion in surgery.[24] The executive summary was published by Michaela West and others.[25] So, does EAST still have a role to play in equity in surgery? Consider that there are numerous organizational statements, reams of research, and guides and white papers on how to execute toward a more equitable profession. But this is all strategy. Equity is a cultural problem. And, as the saying goes, "Culture eats strategy for breakfast." When President Eisenhower passed the Civil Rights Act in 1957, we weren't finished. We were just getting started. We were starting to get serious about racial equity, and now, 60 years on, we still don't have racial equity in the

America. So does EAST need to do this? Yes, EAST definitely needs to do this.

People ask me why I care about equity in trauma surgery and from where my passion comes. I'm a white male. But to a certain extent, I am somewhat of a minority. I'm a Kentuckian. By that, I mean that I'm not from a historically famous trauma program like the University of Pennsylvania or the Baltimore Shock Trauma Center. I wasn't Bryan Cotton's fellow. Kenji Inaba wasn't my fellowship director. I'm just a regular guy from Kentucky. How did I become president of this large organization of trauma surgeons? How did I come to represent the most innovative, creative, aggressive, and enjoyable group of professionals in surgery? It's because some people decided they would give me a chance, based upon what I was willing to do and able to do and not just my background as a surgeon from Kentucky.

The more I have considered equity as an issue and discussed the issue with peers, the more I have become resolved that advancing equity in surgery is an important endeavor. Early in my EAST presidency, I had a conversation with a female peer of mine. I asked, "What do you think about the idea of the Equity Task Force?" She started speaking and about 5 minutes later; she stopped to take a breath. She said, "I'm sorry, and that's probably more than you wanted to hear." I said, "No, that's exactly what I want to hear, because it tells me it's real, and it tells me that we're doing the right thing."

A conversation with one of my residents further galvanized my commitment to advancing professional equity through EAST. On Christmas morning, I was standing in the trauma room. It was about 5:30 AM. The resuscitation resident was going to show me the admissions from overnight before we went to Morning Report. We were just standing there chatting. She looked tired, in the third trimester of her pregnancy. I asked, "Heather, when do you go on holiday break?" She replied, "I don't go on break." I asked, "What do you mean you don't go on break? Everyone gets a holiday break sometime." She said, "I don't get holidays, because, if I take holidays, I don't get a full 4 weeks of maternity leave." "Wait," I said. "Since when is 4 weeks full maternity leave, and what does that have to do with your holidays?" She said, "I have to use all of my vacation and my holidays in order to get maternity leave, or I have to lengthen my residency."

There are two problems with this scenario. First, we have permitted a culture where a resident feels like it's wrong or a failure for her to stay an extra couple of months after she's supposed to finish her training in order to have a reasonable maternity leave (by most other industry standards). Number two, leaders in surgery today are contemplating how we can have competency-based completion of residency.[26] For example, if a resident is competent at four-and-a-half, or four-and-a-quarter, or four-and-three-quarter years, they can graduate. This young lady is PGY 5. She's a clinical 3, and she's already spent 5 years including two in the lab. But we can't figure out a way to get her proper maternity leave? I believe our profession is capable of more attention to the issue of maternity leave than we have given it.

This young surgical house office must give up an entire year ahead of vacation in advance in order to get a mere 4 weeks of maternity leave. That's the first year of her child's life. She ought to be taking her new baby to the beach in that year and watching her kid eat sand, because that's one of the most wonderful things in the world to do when you have a new baby. Many of us have had this wonderful experience. She's going to have to miss out on that because, as surgical residencies, we can't get our act together. We can be better.

There are two important concepts about which everyone should be conversational. The first is implicit bias. Verna Myers, a diversity expert and author of "What if I say the Wrong Thing?" argues that implicit bias is present in all of us.[27] She goes on to emphasize that although we may argue that we do not consciously hold biases, in situations become stressful or we come fearful, we tend to revert to implicit biases that we simply cannot escape. All of us must be aware of our biases and manage them. We will never be colorblind, and we will never be gender blind.

The second important concept is that of microaggressions. Microaggressions are small acts of prejudice that may be conscious or unconscious. Columbia Professor Derald Sue breaks microaggressions into three subtypes.[28] Microassaults are analogous to racism. Microinsults are more insidious and subtle. Finally, microinvalidations judge based upon a certain gender, race, ethnicity, social class of other group. Microaggressions may be racial or related to sexual orientation, disability, gender, environmental, or economic. They are common in our organizations and cumulative and can significantly detract from a team member's sense of belonging and purpose, limiting the team's potential.

How then can we enhance diversity, equity, and inclusion in trauma surgery? We need qualitative and quantitative assessment in our teams, departments, and organizations. Then we need to repeat those assessments to monitor our progress. We need policy. We may not need more policy, but we need action on existing policies. We need follow-through. We need leadership, mentorship, and sponsorship. Sponsorship is a step above mentorship and consists of actively advocating for or proposing someone. Sponsorship doesn't require one to advocate in front of someone else, but rather simply to advocate—actively promoting someone who is female, someone of color, someone with a different sexual orientation. The HeforShe Movement is an example of sponsorship. Actress Emma Watson, spokesperson for HeforShe, when speaking before the United Nations in 2014, said when in doubt, we should ask ourselves, "If not me, who? If not now, when?" This is her testifying before the UN on the HeforShe movement, and Tom Varghese is a great role model for this too, particularly in thoracic surgery, this advocacy for, in this case in particular, women in surgery.

Caprice Greenberg laid out several systemic and several individual actions that we can take to enhance equity in our organizations.[7] Systemic interventions begin with transparent, objective compensation. Men and women surgeons should get paid the same for the same work. Next, we need blinded manuscript review, grant review, hiring, and promotion. It should not be about gender or color or anything else. We need explicit, purposeful distribution of uncompensated work. Who is going to fill out the student evaluations? Who is going to give resident conference? These tasks should be equally distributed, whereas sometimes these fall disproportionately to the females in the group. Leave policies should be equal. Clock extensions are important for consideration of milestones. If an individual

takes 3 or 6 months off to have a baby, for example, then their clock extension on promotion needs to be lengthened. Finally, we need organizational and departmental education programs on bias and how to manage it.

As an individual, you can amplify individuals you feel might not get a fair opportunity because of their background or their personal characteristics. Call out microaggressions. Challenge gender schema assumptions. Ask yourself, "How would this sound if I said it to a man?" If it would sound weird saying it to a man, don't say it to a woman. Encourage women to apply. That goes along with sponsorship, pushing people out there. Ensure equitable negotiation and recruitment. Speak up. Admit that you have gender biases and talk about them. We can do all of these things individually.

What else can we do? We need language to talk about equity, especially for difficult conversations. We need dissemination, and we need training. The good news is that EAST does all of these things really, really well, and so now we have an EAST Task Force on Equity, Quality, and Inclusion. One of the challenges this group is going to have to face is fear. In a recent article entitled, "Men's Fear of Mentoring in the #MeToo Era," the authors describe how 75% of executives describe fear as a barrier to mentoring women.[29] Many executives will not meet with a woman they don't know. Many executives won't meet with a woman alone at all. This is for fear of an impact on their career if an allegation is made, even if they are later exonerated. We live in a culture of fear. But fear will only potentiate and propagate this problem.

The sociologist, David Altheide, writes that fear is a social construct that is then manipulated by those who seek to benefit from it.[30] That's exactly what this article describes. But we can surmount this. We are trauma surgeons. We save peoples' lives together, working together. We can figure out how to create an environment where everyone can communicate and not have to worry about fear in this sort of context.

But this will take work. In an editorial published recently in *JAMA*, two female trainees discuss how all providers need to become more comfortable speaking up.[31] They describe a scenario in which they are making rounds with a male attending, the male attending tells the patient that the team will be back later to check on them, and the patient says, "Okay, you can leave the pretty lady."

This statement is obviously not okay. But the situation makes us uncomfortable, and we have to become comfortable speaking up. Those are uncomfortable conversations. However, consider that we regularly receive training including standard language intended to drive up our patient experience scores. If we can be taught standard language for that, surely we can teach each other helpful language on how to deal with microaggressions when we see them in our daily practice. We need training, and we need role-playing. We need empowerment of staff, residents, students, and faculty. We need to set examples and be leaders so we can set a new standard and change culture.

Maybe we need a pamphlet on what constitutes harassment and what doesn't, so we don't need to be so afraid anymore, like in this example. Doug Wood, Chair of Surgery at the University of Washington, says "Be kind. I am going to try to get there." I have had that same sort of experience as I have learned about equity in surgery and how it affects people I know and work with and to whom I am close.

This can be your legacy, that EAST and its members embrace diversity. There will be an outstanding plenary session tomorrow afternoon, and I highly recommend it to you. You will hear some vignettes, some personal stories, and some data. This session will be very impactful.

I recommend Verna Myers' TED Talk on implicit bias to you.[27] I also recommend Caprice Greenberg's presidential address.[7] It is full of data on which to base a conversation or if you need more data to be convinced.

Trauma surgery as a profession is full of challenges. We face challenging cases, lose patients, work long hours, and navigate administrative hassles. We have family and relationship issues and personal finance concerns. These are realities. These are things we cannot change. But we're surgeons, and we rise through all of these things. There are things we can change. Imagine a world where we and our peers don't have to tread on eggshells, looking over our shoulders, because of our gender or our color. Imagine that future in trauma surgery.

This is what I see. This organization was founded to create an environment where individuals could succeed and where individual successes are celebrated. We teach leadership. So we should just ask ourselves if this is an organization where we're going to treat everybody the same, regardless of background. Is the leadership that we will teach leadership that judges not on background or personal characteristics, but on work effort and accomplishments and creativity and scientific merit? That is our legacy, and that is how it should be.

DISCLOSURE

The author declares no conflict of interest.

REFERENCES

1. Rhodes M. Practice management guidelines for trauma care: presidential address, Seventh Scientific Assembly of the Eastern Association for the Surgery of Trauma. *J Trauma*. 1994;37(4):635–644.
2. East Practice Management Guidelines. https://www.east.org/education/practice-management-guidelines. Accessed April 22, 2019.
3. History-About EAST. https://www.east.org/about/history. Accessed April 22, 2019.
4. Maull KI. Dispelling fatalism in a cause-and-effect world: 1989 Eastern Association for the Surgery of Trauma presidential address. *J Trauma*. 1989;29(6):752–756.
5. Jena AB, Khullar D, Ho O, Olenski AR, Blumenthal DM. Sex differences in academic rank in US medical schools in 2014. *JAMA*. 2015;314(11):1149–1158.
6. Zhuge Y, Kaufman J, Simeone DM, Chen H, Velazquez OC. Is there still a glass ceiling for women in academic surgery? *Ann Surg*. 2011;253(4):637–643.
7. Greenberg CC. Association for Academic Surgery presidential address: sticky floors and glass ceilings. *J Surg Res*. 2010;219:ix–xviii.
8. What's Your Pay Gap? http://graphics.wsj.com/gender-pay-gap/. Accessed April 22, 2019.
9. Jagsi R, Griffith KA, Stewart A, Sambuco D, DeCastro R, Ubel PA. Gender differences in salary in a recent cohort of early-career physician-researchers. *Acad Med*. 2013;88:1689–1699.
10. Jagsi R, Griffith KA, Stewart A, Sambuco D, DeCastro R, Ubel PA. Gender differences in the salaries of physician researchers. *JAMA*. 2012;307(22):2410–2417.
11. Grandis JR, Gooding WE, Zamboni BA, Wagener MM, Drenning SD, Miller L, Doyle KJ, Mackinnon SE, Wagner RL. The gender gap in a surgical

subspecialty: analysis of career and lifestyle factors. *Arch Otolaryngol Head Neck Surg*. 2004;130(6):695–702.
12. Meyerson SL, Sternbach JM, Zwischenberger JB, Bender EM. The effect of gender on resident autonomy in the operating room. *J Surg Educ*. 2017;74(6):111–118.
13. George BC, Teitelbaum EN, Meyerson SL, Schuller MC, DaRosa DA, Petrusa ER, Petito LC, Fryer JP. Reliability, validity, and feasibility of the Zwisch Scale for the assessment of intraoperative performance. *J Surg Educ*. 2014;71(6):90–96.
14. Flyckt RL, White EE, Goodman LR, Mohr C, Dutta S, Zanotti KM. The use of laparoscopy simulation to explore gender differences in resident surgical confidence. *Obstet Gynecol Int*. 2017;2017:1945801.
15. Kolehmainen C, Brennan M, Filut A, Isaac C, Carnes M. Afraid of being "witchy with a 'b'": a qualitative study of how gender influences residents' experiences leading cardiopulmonary resuscitation. *Acad Med*. 2014;89(9): 1276–1281.
16. National Academies of Sciences, Engineering, and Medicine, Policy and Global Affairs, Committee on Women in Science, Engineering, and Medicine, Committee on the Impacts of Sexual Harassment in Academia. *Sexual Harassment of Women: Climate, Culture and Consequences in Academic Sciences, Engineering, and Medicine*. Washington, DC: National Academies Press; 2018.
17. National Academies of Sciences, Engineering, and Medicine. *A National Trauma Care System: Integrating Military and Civilian Trauma Systems to Achieve Zero Preventable Deaths After Injury*. Washington, DC: The National Academies Press; 2016.
18. Buyske J. Women in surgery: the same, yet different. *Arch Surg*. 2005; 140(3):241–244.
19. Organ CH Jr. Toward a more complete society. *Arch Surg*. 1993;128(6):617.
20. Younger women are more likely than older women to see gender discrimination as a barrier to leadership. https://www.pewsocialtrends.org/2018/09/20/women-and-leadership-2018/pst-09-20-18_gender-leadership-00-04/. Accessed April 23, 2019.
21. Women and Leadership 2018. https://www.pewsocialtrends.org/2018/09/20/women-and-leadership-2018/. Accessed April 23, 2019.
22. Statement on the importance of parental care. https://www.facs.org/about-acs/statements/84-parental-leave. Accessed April 23, 2019.
23. Statement on gender salary equity. https://www.facs.org/about-acs/statements/101-gender-salary-equity. Accessed April 22, 2019.
24. Ensuring equal diversity and inclusion in academic surgery. http://www.americansurgical.org/files/2018/Equity.pdf. Accessed April 23, 2019.
25. West MA, Hwang S, Maier RV, et al. Ensuring equity, diversity, and inclusion in academic surgery: an American Surgical Association white paper. *Ann Surg*. 2018;268(3):403–407.
26. Eberlein TJ. A new paradigm in surgical training. *J Am Coll Surg*. 2014; 218(4):511–518.
27. Verna Myers: How to overcome our biases? Walk boldly toward them. https://www.bing.com/videos/search?q=verna+myers&view=detail&mid=80B5873AC9226FD9F5BB80B5873AC9226FD9F5BB&FORM=VIRE. Accessed April 23, 2019.
28. What is the definition of microaggression. https://www.bing.com/videos/search?q=microaggressions+video+examples&&view=detail&mid=E25EBBDA9699EA697188E25EBBDA9699EA697188&&FORM=VRDGAR. Accessed April 23, 2019.
29. Soklaridis S, Zahn C, Kuper A, Gillis D, Taylor VH, Whitehead C. Men's fear of mentoring in the #MeToo Era—what's at stake for academic medicine? *N Engl J Med*. 2018;379(23):2270–2274.
30. Altheide DL. *Creating Fear; News and the Construction of Crisis*. New York: Aldine De Gruyter; 2002.
31. Killeen OJ, Bridges L. Solving the silence. *JAMA*. 2018 Nov 20;320(19): 1979–1980.
32. Dempsey M, Brafman O. *Radical Inclusion: What the Post-9/11 World Should Have Taught Us About Leadership*. Jackson, TN: Missionday, LLC; 2018.