

American Neurotology Society

Diversity and Inclusion Newsletter

Increasing the Diversity of our Training Programs

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In this issue, we will discuss the challenges of increasing diversity in our training programs, including issues such as pipeline development, tokenism, and implicit bias disguised as “fit.”

Our society has become increasingly multi-cultural. In order to remain relevant and provide the highest quality healthcare for our patients, our subspecialty needs to evolve. Improving the diversity of the healthcare and research workforce, including efforts to increase the ranks of underrepresented minorities in medicine (URM) and women, is critical to addressing health disparities and improving all areas of education, clinical care and research. Medical students and residents report that diversity enhances their educational experience, providing them with opportunities to teach each other about beliefs and values of their communities and increasing their overall cultural competence when they enter the workforce ([Fairmont, Whitla](#)). The race and gender of a physician has implications for patient interactions, with some studies suggesting patients perceive more positive interactions, competence and trustworthiness in gender- or racially-congruent physicians and may be more compliant with recommendations ([Derose, Saha](#)). Physicians from URM are more likely to work in minority and medically underserved areas. The American Association of Medical Colleges recognized the challenge and importance of diversity and inclusion of the healthcare workforce in its [2020 Strategic Plan](#), highlighting two specific action items: 1) equipping medical schools to become more inclusive and equitable and 2) increasing significantly the number of diverse medical students.

Diversity is particularly challenging for Otolaryngology. While 13% of the US population identifies as black/African American and 18% as Hispanic, only 2% of otolaryngologists identify as African-American and 3-4% as Hispanic. Why? One of the primary reasons for the disproportionate representation of racial and ethnic minorities in otolaryngology is the “pipeline,” i.e. the limited diversity of medical students overall as well as those specifically interested in our field. In 2018-19, only 6% of graduates from medical school were African-American and 5.3% Hispanic ([AAMC](#)). From this already disproportionate number of students, Otolaryngology has a hard time recruiting students of URM groups into our specialty. The percentage of otolaryngology residents who self-report as African-American is 2.3% and as Hispanic is 6.2%. ([Lopez](#)) In the past 15 years, more than one-third of U.S. otolaryngology residency programs matriculated no more than one URM resident in their programs ([Newsome](#)). Otolaryngology has the lowest percentage of African-American residents compared to other surgical specialties ([Ukatu](#)).

The reasons for the relative paucity of otolaryngologists from URM groups and discrepancy in the number of students from URM groups to match in otolaryngology are not clear. It is well documented that students from URM groups are more likely to have limited early exposure to otolaryngology, especially for students of Historically Black Universities and Colleges, fewer opportunities for mentorship and sponsorship, and fewer role models in our field. Developing an academic portfolio that is competitive for otolaryngology takes time. Students who do not have early exposure, mentorship, or advocacy during the application process will be at a

ANS strives for a diverse and inclusive culture to drive creativity, exploration and innovation and to better connect us to each other and to our patients

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significant, possibly unsurmountable, disadvantage. Several programs have initiated programs to mitigate some of these barriers, including sponsoring travel stipends for away rotations and conferences and mentored clerkships for URM candidates. Other disadvantages include discouragement due to perceived competitiveness of otolaryngology residencies, implicit bias in counseling and over-reliance on scores in evaluating applicants. Underperformance on standardized tests is a considerable barrier for URM students applying to otolaryngology that has its origins well before medical school and has been shown to persist in graduate training, despite little correlation to performance ([Faucett](#)). Many programs are using behavioral based interviews and weigh noncognitive measures more heavily when evaluating candidates.

While many factors may seem outside our control, our intent and genuine commitment to diversity and inclusiveness cannot be underestimated. The ANS leadership has accepted the challenge and has promoted specific actions to increase diversity in our specialty (see Your DI Committee at Work below.)

The F Word

“He’s just not a good **fit** for this job.” Our residency and fellowship programs invariably develop a certain “culture” and it is often easier to find people who fit within that culture than candidates who might challenge or disrupt it. Fit may unintentionally act as a proxy for unconscious bias. Eric Shapell and Benjamin Schnapp wrote an excellent article in the Journal of GME describing this phenomenon which we encourage everyone to read before interviewing applicants this season: [“The F Word: How “Fit” Threatens the Validity of Resident Recruitment”](#). While fit can often help appropriately match programs with applicants who would benefit from the environment, strengths, and opportunities of a program, over-reliance on fit may result in missed opportunity for innovation, growth and development. Likewise, applicants who seek a comfortable fit may be unintentionally limiting their own personal potential for challenge and growth. Because we are all primed to favor people who are similar to us, we must counterbalance that implicit bias so that we do not unintentionally disfavor people unlike us. While a good fit may be most comfortable, it is the “productive friction” of diverse thoughts and ideas that allow us to innovate and produce. The following may help avoid the negative consequences of recruiting for “Fit”: 1) explicitly define recruitment goals as well as the values and characteristics that best meet the program’s identity and needs; 2) understand your own implicit biases and check your impressions against evidence, and 3) consider qualified candidates who may not seem to be a good “fit” in light of unique characteristics or perspectives they might bring to the program.

**Be aware of bias
arising during
interviews**

Anchoring
 Negative Emphasis
 Confirmation Bias
Implicit Bias
 Stereotyping
 Horn Effect
 Unconscious Bias
 Gut Feeling
 First Impression
 Contrast Effect
 Halo Effect
 Cultural Noise
 Similar to Me

Tokenism

Tokenism is a perfunctory effort to be inclusive (such as hiring a single individual from a minority group) as a means of preventing criticism as opposed to a meaningful effort to improve diversity. It can interfere with true progress. Tokenism also has several negative consequences for the “token” including reduced satisfaction, greater visibility and performance pressure, risk of stereotyping and discrimination and higher attrition. Without specific intent and commitment, the odds are unfavorable for hiring a minority candidate. In a Harvard Business Review (HBR) article, Johnson concluded that to increase the potential of hiring a minority applicant, the candidate pool must include more than just one “diversity candidate” (see also this video: <https://hbr.org/video/4984622531001/why-so-few-diversity-candidates-are-hired>). When an applicant pool contains only one woman or minority candidate, the probability of hiring that candidate was nil; however, the odds of hiring one of these individuals increased 79 times with the addition of just one more female or minority candidate. This effect held regardless of the size of the pool. The authors concluded that a *single* “diversity” candidate appears to unconsciously emphasize that individual’s differences, while the addition just one more minority candidate had the opposite effect.

Successful models for diversity require both intent and commitment, and an analysis by HBR suggests the effective initiatives focus on voluntary diversity training, mentoring and outreach efforts by recruiting effectors ([Dobbin](#)). Similarly, the NIH Diversity Program Consortium advocates targeting 3 levels at once- students, faculty and institutions- to increase diversity in the applicant pool for medical school and residency, recruit and retain diversity faculty and promote an institutional culture of inclusiveness.

Your DI Committee at work

1. Developed a Pledge for Diversity for ANS leaders
2. Updated ANS Profile page to collect demographic information to help steer a data-driven diversity plan
3. Added line item on ANS Profile page to allow members to indicate areas of expertise and interest in speaking and leadership opportunities
4. Established a diversity and inclusion education page on the ANS website
5. Planning a virtual seminar on disparities in otology/neurotology
6. Developing a travel grant for students of URM
7. Promoting ease of access to meetings for people with hearing impairment
8. Secured a budget to fund these and other DI initiatives

Derose KP, et al. Does physician gender affect satisfaction of men and women visiting the emergency department? J Gen Intern Med. 2001;16(4):218-226. doi:10.1046/j.1525-1497.2001.016004218.x

Dobbin F, Kalev, A. “Why diversity programs fail.” Harvard Business Review July-August 2016 <https://hbr.org/2016/07/why-diversity-programs-fail>

Fairmont I, Farrell N, Johnson AP, Cabrera-Muffly C. Influence of Gender and Racial Diversity on the Otolaryngology Residency Match. Otolaryngology–Head and Neck Surgery. 2020;162(3):290-295. doi:[10.1177/0194599820901492](https://doi.org/10.1177/0194599820901492).

Faucett, E.A., et al. (2020), African American Otolaryngologists: Current Trends and Factors Influencing Career Choice. The Laryngoscope, 130: 2336-2342. doi:[10.1002/lary.28420](https://doi.org/10.1002/lary.28420)

Johnson SK, Hekman DR, Chan ET (2016). “If There’s Only One Woman in Your Candidate Pool, There’s Statistically No Chance She’ll Be Hired.” Harvard Business Review. April 26, 2016. <https://hbr.org/2016/04/if-theres-only-one-woman-in-your-candidate-pool-theres-statistically-no-chance-shell-be-hired?referral=00060>.

Lopez, E.M., et al (2020), Recent Trends in Female and Racial/Ethnic Minority Groups in U.S. Otolaryngology Residency Programs. The Laryngoscope. doi:[10.1002/lary.28603](https://doi.org/10.1002/lary.28603)

Newsome H, Faucett EA, Chelius T, Flanary V (2018). Diversity in Otolaryngology Residency Programs: A Survey of Otolaryngology Program Directors. Otolaryngol Head Neck Surg, 158(6):995-1001. doi:[10.1177/0194599818770614](https://doi.org/10.1177/0194599818770614)

Saha, S., Beach, M.C. Impact of Physician Race on Patient Decision-Making and Ratings of Physicians: a Randomized Experiment Using Video Vignettes. J GEN INTERN MED 35, 1084–1091 (2020). <https://doi.org/10.1007/s11606-020-05646-z>

“Why So Few ‘Diversity Candidates’ Are Hired.” Harvard Business Review. June 24, 2016. <https://hbr.org/video/4984622531001/why-so-few-diversity-candidates-are-hired>.

Whittle, Dean K., et al. Educational Benefits of Diversity in Medical School: A Survey of Students, Academic Medicine: May 2003 - Volume 78 - Issue 5 - p 460-466

Ukatu, C.C., Welby Berra, L., Wu, Q. and Franzese, C. (2020), The state of diversity based on race, ethnicity, and sex in otolaryngology in 2016. The Laryngoscope. doi:[10.1002/lary.28447](https://doi.org/10.1002/lary.28447)