Psychol. 2001;6:64-80). Women who experience microaggressions at work are three times more likely to regularly think about leaving. And a majority of women report sexual harassment, discrimination, and microaggressions at work, with higher rates for non-white women (asamonitor.pub/3bW2JTX).

Many popular books – *Lean In* and *Nice Girls Don't Get the Corner Office* – provide solutions aimed at "fixing" women. But, "It's not women who are broken; it's society that's broken" (asamonitor.pub/2zV998I). Hard work and excellence are required for success, but they cannot always overcome the negative impact of gender, racial/ethnic, and other biases on opportunity. The most effective solutions are focused on recognizing and interrupting unconscious bias in recruitment and building workplace cultures where diverse ideas and contributions are encouraged and welcomed.

It is not easy to change long-entrenched models of recruitment and advancement. Expanding the pool of applicants by reaching out beyond normal recruiting pools to encourage qualified candidates from diverse backgrounds to apply is effective, but only if those applicants are not immediately screened out by the search committee. This problem can be addressed by having a search committee that is broadly representative and trained in best practices. Clear, objective criteria should be established before files are reviewed, recognizing that bias often leads to different interpretations of "objective" information (*Psychol Sci.* 2005;16:474-80). Multiple studies have demonstrated that, given identical CVs except for the name, women and people of color are consistently rated as less qualified. Distracted or rushed reviewers tend to make more stereotyped assessments, while attention to bias makes assessments more equitable. An equity advocate on the search committee, empowered to call attention to bias, can reduce the impact of bias on assessments.

Evaluation of the existing structure and culture for bias and barriers is necessary to build an inclusive culture. If, instead, new hires are pressured to "fit in" to the prevailing culture, it dilutes the value of diverse perspectives. In addition, the experience is exhausting, and the individual is likely to either disengage or leave. Connecting new hires with a cohort from across the institution creates a supportive network. All members of the department have the responsibility to recognize and respond to sexual harassment, discrimination, and microaggressions; bystander and other training provides tools to meet that responsibility (*JAMA Surg* 2019). This is especially true for leaders, whose behavior and attitudes set the standard.

Increasing diversity in the anesthesiologist workforce, though challenging, is critical for addressing health care inequities and improving the care of all patients. Unconscious bias is a barrier to recruitment of a diverse workforce, and also reduces opportunities for advancement. Discrimination and microaggressions are barriers to creating an inclusive environment and lead to high turnover. Leaders have the power to interrupt bias and create a welcoming culture. That effort will pay dividends in performance. ■

New Initiatives in the Association of University Anesthesiologists: From Exclusivity to Diversity

Valerie E. Armstead, MD, DABA
Maya J. Hastie, MD, EdD

The Association of University Anesthesiologists (*Anaesthetists* was replaced with *Anesthesiologists*) formed in 1953 and was the brainchild of four distinguished academic anesthesiologists who, at the time, represented three Ivy League institutions on the Northeast coast of the United States (asamonitor.pub/2ZDvr9U). The initial exclusive nature of the research-focused organization was born out of necessity due to the economic, political, and social issues that impacted health care and the emergence of the then-new specialty of anesthesiology (*Anesth Analg. 1992;74:436–53*).

Over time, the organization that had a stringent set of nomination requirements and an absolute membership cap of 100 members or less in 1970 has relaxed its nomination criteria to limitlessly include candidates who have scientific achievements outside of the laboratory or primarily have achievements in education. Interestingly, embedded in the original 11 proposals written by Dr. Austin Lamont (co-founder of the University of Pennsylvania Department of Anesthesiology & Critical Care) for the foundation of the organization was prescient language that addressed the possibility of dealing with issues that would be recognized as falling under the umbrella of diversity and inclusion. Dr. Lamont wrote with parenthetical comments added by Dr. Emmanuel Papper:

"*…consideration of other matters of interest (e.g., socio-economic relations, residencies, teaching, etc.) should have no place in the programs of the group's meetings. There is no reason, however, why the members of the group should not decide informally among themselves to stay over an extra day to discuss these matters if they wish. Should the members of the group eventually prove to be sympathetic and congenial and should the matters mentioned above … be still of moment at that time, consideration should then be given to enlarging the purposes of the group. But, at least as regards socio-economic matters, it seems likely that any stand this group might adopt would be supported by a considerable number of anaesthetists who would not be eligible for membership in the group*" (*Anesth Analg.* 1992;74:436–53).

Of note, one of the organizations with whom the original AUA was at odds was the American Medical Association (AMA), which was a segregated organization at that time. Ironically, at the time of the writing of this article, the president of the AMA is an African American woman. In essence, despite its regrettable history of segregation and lack of inclusion, the AMA seems to have responded to its 21st century diversity wakeup call.

Therefore, while the underlying good intention of the AUA has been to pursue a path of diversity and inclusion, it is apparent that the timeliness of enacting this change is overdue. In recognizing that in education as well as in industry, organizations that have diversity function better, the AUA formed a diversity task force, spear-headed by the immediate past president, Dr. Jeanine Wiener-Kronish and facilitated by Dr. Robert Whittington. The task force had its first session within the schedule of the 2019 AUA meeting in Montreal, Canada.

A major challenge in addressing issues of diversity and inclusion that has been identified among professional organizations such as the AUA is a lack of data to determine the scope of the task. Therefore, a survey of AUA members was conducted in October 2019 to determine the demographics of AUA members. The survey instrument was sent to 1,111 reg-

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Valerie E. Armstead, MD, DABA
Professor of Clinical Anesthesiology, Temple University Lewis Katz School of Medicine/ Department of Anesthesiology, Philadelphia.

Maya J. Hastie, MD, EdD
Associate Professor of Anesthesiology, Program Director, Adult Cardiothoracic Anesthesia Fellowship, and Co-Director, Faculty Development and Career Advancement Program, Columbia University Vagelos College of Physicians and Surgeons, New York, New York.

Diversity: New Initiatives

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istered members of the AUA. Of those, 475 responses were collected with a robust response rate of 43%. The respondents to the survey mostly identified as men (74%), as Caucasian (78%), and as 51 years of age or older (68%). In addition, 43% of all respondents were older than 61 years of age. Around 25% of AUA members who responded to the survey were women. Less than 3% of respondents identified as either African American or Hispanic.

Underrepresentation of women and minorities in the AUA is a symptom of their overall underrepresentation in academic anesthesiology. The causes of this underrepresentation are complex and continue to be explored. Similar to other societies in anesthesiology, the AUA is taking a bold stance to reflect on its current state and to look at ways of increasing diversity.

> **"Underrepresentation of women and minorities in the AUA is a symptom of their overall underrepresentation in academic anesthesiology.... Similar to other societies in anesthesiology, the AUA is taking a bold stance to reflect on its current state and to look at ways of increasing diversity."**

Efforts to increase diversity may come at a potential cost for underrepresented groups. The phenomenon of service fatigue of underrepresented minorities, women, and LGBTQ individuals becomes evident when those individuals are tapped to represent their identity on committees in addition to performing employment duties. This service fatigue is recognized as a potential source of stress. Lack of cultural competency in the workplace also subjects these individuals to microaggressions that can take a mental as well as physical toll. On the other hand, the sense of accomplishment and pride of being a member of an organization with lofty goals for achievement in academic anesthesiology, despite recognized or unrecognized challenges, are often viewed as a satisfying means to an end (asamonitor.pub/36I48wI).

Most importantly, the AUA recognizes that advocacy, mentorship, empathy, and geniality from its members form the basis of great relationships that engage current members and attract new members. The AUA lauds members who have encouraged individuals to join despite their trepidation of not being considered worthy or not having AUA members in their academic institutions to assist in the nomination process. AUA members who take ownership in the AUA member nomination process by writing letters of nomination or recommendation and have encouraged other members of the AUA to do so are essential to promoting diversity and inclusion.

Sometimes it takes a village, but the extra effort of individuals to contribute what they can will help raise the future generation of academic anesthesiologists in an ever-increasingly diverse world. ■

Recruiting for Diversity

Lori A. Dangler, MD, MBA, FASA
Thomas F. Rahlfs, MD, FASA

An anesthesiology group is only as exceptional as its people, which necessitates a strong recruitment and hiring process. All involved must understand the skills and experiences needed to deliver quality care in an ever-changing environment and be able to adapt effectively to recruit the appropriate candidate for each position. Some of the most important individual factors in determining top talent are practical knowledge and experience combined with attitude and motivation.

Anesthesiologists must not only have the skill set to lead care teams, they must also possess a unique skill set that enables them to serve as leaders throughout their institution as well as externally through engagement in organized medicine.

> **"At MDA, we believe we are the first to use EI in the hiring process for faculty anesthesiologists and are challenging the traditional status quo."**

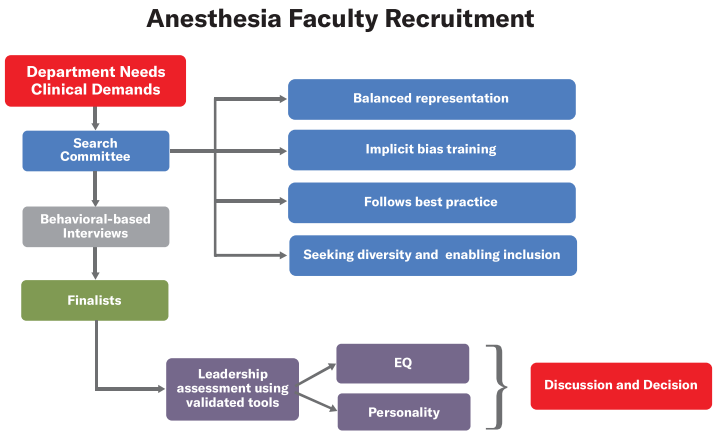

Figure. MD Anderson Cancer Center Anesthesia Faculty Recruitment Process

Experts say emotional intelligence (EI), defined as the ability to perceive, manage, and express one's emotions and to recognize and react appropriately to the emotions of others, is an invaluable social skill successful physicians should possess to effectively deliver on quality patient care (*Working with Emotional Intelligence*. 1998).

"Best-in-class" talent management occurs when HR processes become well integrated and aligned with organizational strategic plans. Here we describe how the Department of Anesthesiology and Perioperative Medicine at MD Anderson Cancer Center (MDA) in Houston, Texas embraced responsibility for reworking processes required to attract talented professionals into the workforce.

Like other businesses, growth in demand has fostered the need for new anesthesiology positions at our institution. Finding prospective employees was the first step; however, finding the *right* employees from the prospects has become the challenging second step. MD Anderson's mission statement is "Making Cancer History," so the obligation to ensure

Lori A. Dangler, MD, MBA, FASA
Associate Professor, Department of Anesthesiology and Perioperative Medicine, University of Texas MD Anderson Cancer Center, Houston.

Thomas F. Rahlfs, MD, FASA
Professor and Chair, Department of Anesthesiology and Perioperative Medicine, and Deputy Head, Division of Anesthesiology, Critical Care and Pain Medicine, University of Texas MD Anderson Cancer Center, Houston.