

TRANSCRIPT: AUG 10, 2022 University of Minnesota Medical School Dean's Lecture Series:

“OUR HOUSE: TRUST AND BELONGINGNESS AS KEY INGREDIENTS FOR ACADEMIC HEALTH CENTERS”

Presenter: Jill Foster, MD Professor of Pediatrics, Associate Dean of DEI Pipelines, Division Director for Pediatric Infectious Diseases, University of Minnesota

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Mya N Wilson DHA: So good morning everyone and welcome to our August installment of the lecture series. This session has been recorded and will be shared out within two days to all those who have registered, and will also be found on the news events and training tab of the [ODEI website](#). As you can probably see the live transcription has been enabled. It's not perfect, as this is an auto transcript, but we are working with what we have. Any feedback or accessibility issues; you can forward those to the Dean's Lecture Series [email address](#). I will get that in the chat in just a second. We do ask that you use the Q&A section instead of the chat section, and we will try our best to get to everyone's question. If we are unable to, we will work with our presenter to get unanswered questions posted to the [Dean's Lecture Series website](#). I am going to post the Dean's Lecture Series website page, as well as our email address, in our chat. And I will now turn it over to Vice Dean Núñez to introduce today's speaker.

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Ana Núñez MD: Good morning everybody, Happy August! I don't know about you, but it sort of feels like fall is kind of nipping in the air, but it is lovely out there. Thank you for joining us on this terrific day, we have a really fascinating presentation to bring to you. This is Dr Jill Foster: Dr Foster has been at the UMN Twin Cities for about two years and (has) focused her efforts on development of pipelines for those who are underrepresented in medicine and science, as well as COVID related issues, especially in the space of vaccine hesitancy. Prior to Minnesota she was at Drexel University College of Medicine, Director and Founder of the Dorothy Man Center for pediatric and adolescent HIV. And (she has been active) in medical education, as well as taking a...five year detour (from) academic medicine to go to industry with sponsored philanthropic public health initiatives around blood borne viral diseases. So we are thrilled to have Dr Foster come and present to us and her topic is “Our House: Trust and Belongingness as Key Ingredients for Academic Health Centers.” So we look forward to getting some insights about when we talk about that inclusion thing from Dr Foster's talk. Welcome Dr Foster!

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Jill Foster MD: Thank you Dr. Núñez.

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Jill Foster MD: So (you've) already heard the topic of what we're going to do here so where we're going to go for the next little bit of time is, I want to talk about how essential belonging

myths and trust are. For effective functioning in our academic health centers I want to outline how systemic factors interfere with us building belongingness and trust, and discuss a little bit about what we can do about it, and I want you to think as I talk about how we can give the gifts of benefit of the doubt, and go with the tenet that belongingness should be assumed (as) we go through a very rigorous process of who we admit and who we hire. And I think that we should assume that everyone that we bring in the door belongs here and not that people have to prove that they belong. And then I want to talk about the gift of grace where you know we're not all perfect and especially not all the time. And while this presentation is focused on learners, I think it really applies beyond that and I think any place that I'm talking about - our classrooms or the school, we should also talk about anywhere in the environment, where we all work within this Academic Health Center.

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Jill Foster MD: So belongingness, little mini review here of DEI: So, Diversity is basically "Everyone is invited to my house" - we have everybody with different backgrounds and different, you know - different creeds. Inclusion is really the "Mi Casa es Su Casa" - It's "my house is your house." And then beyond that is Equity, which is that potential barriers to your visit have been removed. You know: Do you need a ride? Do you need help getting up the steps? Do you need to not have steps there? - And if you can get all three of these right, then you should end up having a really good environment that's fertile to sow the seeds of belongingness. But I'm going to take it one step further, which you know alludes back to the title of this, let's not say it's - you know - "my house is your house" - let's say it's OUR House. Because "my house is your house" is sort of like we got house rules and you've got to come into my house and adjust to my house - Instead of this idea that it's Our House and we make Our House and the culture of Our House; and what belonging in Our House means is different, as the new people come in - that all changes as we get to Our House.

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Jill Foster MD: Alright, so those of you who took psych...you know there's Harlow's wire experiment with baby animals. We had baby primates that were raised in an environment with two different kinds of mothers. One was covered with wire and provided nourishment, though, and the other one is nice and warm and fuzzy. What we found is that these little baby animals prefer the cloth mother, even though she did not provide food - they would go to the wire mother for food, but then always referred back to this warm cloth mother. And especially when they were anxious, they would cling to the cloth mother. So I'm going to talk about belongingness thinking about it as this warm fuzzy place that you can feel safe: you feel that someone has your back.

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Jill Foster MD: That you're wanted there, that it's the right place for you and it's a place that you can grow and learn - because I think those are all the components that we hope we have in our academic medical center. And I think living in Minnesota, the environment is going to be harsh. It's harsh working in medicine right now, it's hard working in academic medicine wherever you are. And all that I'm talking about today is not specific to the University of Minnesota or even Minnesota, it's about academic medicine in general. But I think you should

think about it when we have a really, really cold winter, which you think we're kind of in a cold winter part of things right now with COVID and Monkeypox and just all the usual stuff - is that belongingness is that...warm coat and the warm hat and mittens and boots that you put on.

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Jill Foster MD: To make it be that you can survive in that hard place. It's not that we're saying we're going to get rid of the hard place a little, we should, for any of the places that we CAN make things less hard, but belongingness is that warm fuzzy thing that you put on to stay warm. So, trust and belongingness go hand in hand...and...giving a little bit of a definition of belongingness: Belongingness is...knowing that you're a fit and feeling that you fit into a specified environment. Trust that goes with that, is the belief that this belongingness and the good feelings, they're going to be reliable - that there's a truth in it; that there's the ability of the strength of someone, that there's relationships that are all built on that, that this is going to last and that the people that are in charge of us have our best interests in their hearts.

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Jill Foster MD: So what kind of environment have we created for our learners and ourselves? Do we have a cloth environment or do we have a wire environment - and we're going to kind of go back to that as I proceed. And I think that the symptoms of the deficient belongingness in our academic settings is: depression and suicide, the "imposter syndrome" which I'm going to go a lot into - (and there's a reason I put it in quotation marks), hazing behaviors, ...dropping out, checking out, flunking out, ...people coming in - people going out: poor retention; students not making it, and employees not making it.

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Jill Foster MD: So I don't think this is a surprise to most but we're really having a crisis around depression and suicide right now. This is a study done with college students back in 2020. It'll move in right at the beginning of the pandemic. ...About half of them showed moderate to severe levels of depression, a little over a third of them had moderate to severe levels of anxiety and almost one in five had suicidal thoughts. In that...this is not going to help with learning: difficulty concentrating, fear and worry about your academic progress, fear and worry about your performance...none of these things are going to make you thrive, ...they come from a feeling of not belonging and they also are going to lead to having difficulty in feeling(s) of belonging, even if the belonging is there.

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Jill Foster MD: So there's a lot of talk right now about the "imposter syndrome." So the figure on the right - I just did a pubmed search for "imposter syndrome" and there's... 11 pages of this, and it's something that appears to be something new, (there) appears to be a pandemic of it as well. There are just pages and pages of it. So, "imposter syndrome" (authors are Mullangi and Jagshi) is a psychological term that refers to a pattern of behavior wherein people, even those with adequate external evidence of success - so these are people that are doing well, who even so, doubt their abilities and have a persistent fear of being exposed as a fraud.

Especially that concept of fraud, like “people are going to find out that I don't belong here; I didn't have what it took to be here.”

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Jill Foster MD: And it's kind of the way you know this is you see people - like these are smart people - I mean we pick smart we hire smart people, we take smart people into the Medical School. And yet - we look at them, and you know they're afraid to speak up in a meeting, they're not asking for opportunities, and even when you give them an opportunity they're kind of hesitant - they sort of you know, stand back a little, and it's this fear that just keeps reinforcing itself of “I try this and I fail” and “I'm going to be exposed as this fraud”. Traditionally what people do is like “What's wrong with these people?”, you know “they're smart people, they're doing well what's wrong with them” - What is this “imposter syndrome?”.

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Jill Foster MD: You know - “they're too perfectionistic, they're lacking in self confidence, they weren't prepared, clearly - not a good fit here, not attending to their self care.” It's all over the Internet, Google this and you'll find all these ways to “fix” your “imposter syndrome,” what can we do to fix those people with their “imposter syndrome.” I want to think about it a different way, I want to say, “What's wrong with us?” What's wrong with us is that we have set up an environment where so many people feel “imposter syndrome.” ...Are we expecting elite performance from everyone at all times? You know that “these are good students, these are good employees - what's “wrong” with them that they're not perfect, all the time?”

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Jill Foster MD: We're not open to difference, we start feeling that everything is so mission critical. We have to only hire the sure bets and in our concept of what is a sure bet, ... we hire people that aren't the sure bet and then we start treating them differently. I'm going to go a little bit more into that. We're not providing enough praise and reward so ... We get in our own path of “... I am overwhelmed - I'm not getting enough praise....” ... even senior people have “imposter syndrome”. And we're not providing enough praise and rewards and.... I think there's an epidemic of burnout and that we're not always being as attentive to burnout in those people below us in the hierarchy and paying attention to that, and I think that it would go far- I mean we can't change individual people, but I think it would go far if we start looking at all of these things, because these things...we can modify, we can modify these things.

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Jill Foster MD: So I wanna look at it. It's sort of the different nourishment of people, so I think that there's some people who get the wire moms and some get the warm and fuzzy one, so you know here's kind of an ideal here, you know ,new employees starts and ... you have an adjustment period, you intensively monitor, make sure that they're doing okay. ...A little bit into this now we see, “well here's your next opportunity” - this is the idea of the stretch goal - so stretch goal is ... 10 tasks are probably reasonable, but we're gonna ask you to try for 15 so that you're always striving, you're always trying to get for more, but ... knowing in the back of

your mind, even if they accomplish eight, that feels pretty good and we're going to give them praise for doing eight.

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Jill Foster MD: We look at people that we say, "Wow, this person shows leadership potential - let's develop them, let's do everything we can," and they're here for a number of years and you're like, "Oh my God, look at this person, look how well they've done, they're a leader among men" ...success breeds success. Well, you know there's an alternate path to that, that other people get, other people...get the wire mom.

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Jill Foster MD: So it becomes this "prove that you belong here" - and how many times have you heard "oh that person's a diversity hire" or "that person's an affirmative action hire" and those people don't get all the warm fuzzy stuff and they get well, "I'm not sure why they're even here" and "sink or swim," and then they need to still keep proving that they belong here, there's penalties for not acting normally - I'm going to talk a little bit more about that. Instead of offering them the stretch goal, and if they don't make the stretch goal instead it's like: "well you know they only did 11 things."

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Jill Foster MD: And "I don't think they're really ready yet for the next opportunity..." and then ...they've been here for a number of years and they've gone through this for ...a couple of years and then "they're just not ready yet," and "they're just not a team player" - nobody really let them **on** the team, but now there's the question that's - "not really a team player."

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Jill Foster MD: And these are, of course, two extremes, but a lot of people fall in between, but I think people really need to do some soul searching and how many times have we done the bottom one rather than the top one? So the other part of that, I think that leads to this - that it's part of our medical culture to teach up to the level of incompetence. We put students out, we take students for two years and jam pack basic sciences into them and then just as they're getting good at that and at the peak of their knowledge and when they take their step one boards, we then toss them out into the floors: they get good at medicine, we move them to surgery, they just figure out surgery and we move them to OBGYN.

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Jill Foster MD: We talk about house staff, you just get good at IV's and now we're going to have you put in central lines. So every time somebody gets good at something we move them on to that place where now they're not going to be good at it - and you know that, with the rapid cycles that we do for our learners, that becomes a cumulative stress. On top of it is the Socratic method in teaching versus hazing.

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Jill Foster MD: So the Socratic method when done well, is you ask a challenging question - you build on the first question, you ask some more questions and then you go a little bit deeper. You go for conceptual inquiry and then you only stop when you get to the place where they don't know any more answers. And so many learners walk away with "I didn't know the answer." They don't walk away with, they got the first nine questions. Well the average intern might have only gotten the first four questions right but they got nine and they go away remembering that they missed that 10th question and thinking that they need to do something differently.

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Jill Foster MD: Well, hazing can also become humiliating and the term out there that people use is pimping. So it's when the Socratic method is used by a position of a person up in power who starts asking impossible questions, just to establish our hierarchy and embarrass our learners.

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Jill Foster MD: I was talking recently with a medical student from my former life, who is in Minnesota at a different Medical School doing research rotation and she talked about how they're going to have a lab meeting on Monday and she goes "the guy in charge of this lab - he's a really scary guy" and you know, she's African american, and she said, you know i'm really scared about how this meeting is going to go and I'm like, "You got it" and I talked to her afterwards, and she said "He just kept asking me questions and more questions and more questions. And you know it's like I have read everything that this man wrote in preparation for this. And more and more questions and then I realized he's asking me questions about stuff that wasn't even in this field."

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Jill Foster MD: And she says she got them all right and at the end of it, he said "that was perfect" - so that was really good, he did the "that was perfect, you did a great job", but then he kind of messed it up because then he turned to all the other people and said "why can't you be as good as she is?" So, like maybe not the best part of it and (you can) go on Twitter and ask about the Socratic method and you'll get a variety of answers - that it's not such a good thing, but it **can** be a good thing if it's done right and it **can** be a thing that can really increase belongingness

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Jill Foster MD: So here's the scenario: Dr. A, a 60 year old infectious disease full professor leading a case conference of a patient with fever and fulminant hepatitis. The Doctor A's been doing infection control for monkeypox and COVID for the last two years, is exhausted (from

that), and is so thrilled: on rounds, interesting case, got learners, got teaching awards in the past, is so excited and wants to talk about this. Well now you got the fellow, the 32 year old fellow and their fourth week in a row being on call and four more consult patients to see before going home. Potentially not so interested in hearing the teaching that Dr A has.

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Jill Foster MD: And then we get student Dr C who's a 24 year old on their second week of clinical rotations. And is somewhere in between, eg "I want to make sure I ask lots of really good questions and listen here and answer all the questions right" And the "I just want to go home and hide under a chair" because this person looks like they got a lot of energy here. So I saw this yesterday on Twitter "senior resident when rounds go for four hours and the Med student asks a question" (shows picture of a chameleon using their paw to keep a frog's mouth shut...). Alright so all the people in this have different expectations, different ideas of what this whole experience is about.

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Jill Foster MD: And I think we have to look at the goal here, nobody's coming into this with bad goals. Everyone here wants to learn, they want to do the best that they can do. But you know, this is a setup for "imposter syndrome". You know, Dr A is like "Hey, I'm supposed to be good at teaching and nobody here wants to hear what I want to say - Here was my chance to do something fun and to feel good about things. And maybe I'm not in the right place, maybe I'm not as good as people thought I was." The fellow just wants to go home, they're supposed to go home once they finish those consults and be out of here - and the student doctor is caught in between that whole dynamic and feeling like "This is my chance, I could have gotten Dr A to write me a letter for residency..." even though they're only in the second week of Clinicals and odds are, everyone goes home unhappy and feeling unfulfilled and wondering why are we doing this anyway, and maybe they're the fraud.

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Jill Foster MD: So let's look at two different student Doctor C's. So the first one went to Harvard. Both parents are doctors, siblings are doctors, shadowed their parents' colleagues while in college and did a semester abroad studying the Spanish healthcare system, so you know - fairly typical applicants who we see.

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Jill Foster MD: Second one graduated Mankato State, parents are agricultural workers, siblings still working in the fields as they did during summers. Worked as a nursing assistant all through college to make expenses. Now both of these students entered at the middle of our pack. Both had a MCAT of 510 and GPA of 3.7. Pretty much the middle of the pack for our entering class. So is belongingness one size fits all? Is the thing that each of these students are going to need to feel belonging, to feel fulfilled, to feel like they're in the right place - Are they going to be the same type of thing? No! And we can talk about this more in the Q&A. Does how they fit into the

larger team matter? Yeah, I mean depending on who the rest of the team is, does the rest of the team make them feel that they belong there, so they can thrive.

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Jill Foster MD: Or is the rest of the team going to view them potentially as a goner, or like a diversity hire, or... "how did you get here anyway?" And so, how the whole team functions is more important than even how individual people function. And then, "What am I fitting into?" Who gets to decide who belongs and what you need to belong? And I want you to take a second and pull up a picture. I mean I'm a really visual person - picture who you thought these two students were. Picture who these students are.

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Jill Foster MD: You know, come up in your mind. So now, I'm probably going to flip something on you. These are the pictures. Is this the picture that you thought came up with these students? (Student 1: Hispanic looking male, Student 2: White looking male) My guess is that the pictures were probably reversed for a good number of you. well you know I said they're agricultural workers, farmers! You know farmers are agricultural workers. He comes from a pioneer family that settled here, which is again even that is going to be different than somebody in Mankato who is a migrant worker family.

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Jill Foster MD: And so it's so hard to tell: A. hearing the story and B. even looking at the person, what is their story? And with a few switches, this could be the same person in two different parts of their lives, (ie) went to Mankato state and grew up on a farm. And then went to Harvard and got a master's degree, and you know, the parents are doctors but still on a farm in Mankato... And so this really has to be individualized.

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Jill Foster MD: So what is normal for being a physician? You know the two pictures could not be more different. On the left, we have Julia (...I'm showing my age...) who..you know it was pretty bold that you had this ... single mom, black woman who was a nurse. And the picture on the right: I don't think anybody's surprised to see that one of the doctors is a black woman. So things change over time and we have to make sure that we're adjusting: that some people are still in the 70s, and some people are now, and titrate things based on that.

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Jill Foster MD: So let's go back to the students again. A first versus final impressions. These aren't necessarily those two students, these are just two students. So for student on the left they start out strong, 85These grades are the exact same grade (overall for the two students). The first one's kind of all over the place. The second one kinda starts out slow, has a 74 for the first course, great, and then an 80, 85, 86 and 95. They both end up in the exact

same place, they both hit the finish line as the 75th percentile which is really good on Step 1. But, my guess is, if you go back to the beginning, someone's going to look up that person who got the (first grade of) 85 and think that's the winner, he's the one we want to invest in, and the (first grade of) 74 is like maybe we shouldn't have taken him. And we have to be thinking about this as a sort of grace and benefit of the doubt. That we're really looking at where can people get to, not where they are right now.

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Jill Foster MD: So MCAT and GPA. I mentioned them a couple times. We use them to drive a successful diverse workforce. I mean you kind of have to have some metrics, but we have to think about how we're using them. So MCAT scores definitely predict performance on Step 1 MLE, we know that, but do MLE scores predict success as a physician? All right, they DO predict the US News and World Report rankings and those are very important to schools. And so there's a lot of emphasis placed on MCAT scores, but we have to be thinking about where are we going at the end of this.

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Jill Foster MD: The other question, though, is, right now in most places MCAT scores do predict your Step 1 MLE score - but does it have to be that way? Is it immutable? And I want to give an example of Howard University and Morehouse University examples where that doesn't have to be true. And the question is, some people will then say, well, we need to have more Howard's and more Morehouses, those are both historic black colleges/universities, but I'm going to make the point that I think we need to become more and more house-ish rather than creating more and more houses or maybe we need to do both. And then the other question being here is, is our goal a homogeneous group of high MCAT and GPA scores? Let's just forget all admissions processes, just take all the people at the top of the MCATS and GPA.

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Jill Foster MD: But we want diverse individuals with diverse goals. We want people to go into different things. We don't want a whole class of people who at the end of it want to be, neurosurgeons or whatever is considered (ie) your dermatologist or whatever, ...the most competitive things that you need those high scores for. We want to have a diverse workforce to do a lot of different things and think differently. So, looking at these things - is that part of this "how to avoid the checking out, burning out, flunking out"

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Jill Foster MD: So Morehouse, what did Morehouse do? So the graph on the left is entering MCAT scores. That's all great, right. They took a lot of people that were not sure bets, that scored down on the lower end. But they did stuff so that by the time two years later or three years later (because some students were given a little bit longer to do it) - they had normalized their curve on Step 1 scores, so it didn't have to be that people (who) came in with low MCAT scores weren't going to do well on this Step 1 and weren't going to do well later.

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Jill Foster MD: And they did this with three different things. One is that they looked at the milieu, they said hey we have courses that people are doing really poorly in and instead of saying, "What's wrong with our students that they're doing poorly?", they went back instead and said, well, maybe the course wasn't good, maybe the lecture wasn't good, maybe it's really hard, maybe we need to go back and repeat those lectures and do something different, and make sure that all our learners are on it. I don't think that's a bad thing for any Medical School. They did a lot of looking at the structure of how they were doing things. They looked at the curricular content and how the curricular content was tested.

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Jill Foster MD: And they did really close monitoring of the students, not looking in a judgmental way of you're in, you're out (eg) "Oh, you were a loser, why did we admit you?" - but instead looking at what's going on with you- maybe they're hungry, maybe they're having a hard time adjusting, maybe they have an undiagnosed learning disorder, maybe they're not studying well and need some help with studying skills. They looked at every student as somebody who belonged there and was worth the investment of trying to figure out why they weren't working at their maximum potential.

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Jill Foster MD: So...how we need a lot of people doing a lot of different things. If you talk to premeds, I talk to a lot of pre-meds and high school students and almost all of them want to either be a family doctor or surgeon. Well you know that's not going to be good for our workforce. So we need Medical School to be a place that's kind of like a Harry Potter sorting hat - where people are going to end up, we need to fill all of these specialties; medicine, family, surgery, pediatrics. A lot of it becomes students feeling like where they belong - part of it is the content.

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Jill Foster MD: I did not expect to become a pediatrician. I fell in love with pediatrics, but I also fell in love with pediatricians. I loved working with pediatricians. I love this group of people who are happy to go to work every day - and weren't upset if some patient peed on you. You know it felt like a place that I fit and I belonged, and it was also a group of people that worked really hard on making sure that you felt like you belonged because they're used to working with children.

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Jill Foster MD: So you know other people - that's not for them, but they'll fall in love with their neurosurgery or fall in love with the emergency department. And so we need to give students the room to believe that they belong in Medical School so they can find out where they belong for the rest of their career. So this is called professional identity formation. So it's...your

representation of self, you achieve it in stages - where people learn the norms of the medical profession are internalized resulting in an individual thinking, acting and feeling like a physician - and feeling like they belong as a physician. So how do we nurture our students to be their authentic selves? We go through this whole long process to choose them,

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Jill Foster MD: ...through a holistic process looking for people who are interesting and have interesting environments and interesting backgrounds and then we bring them in and a lot of places try to turn them into people that all look alike and think alike like an army marching forward. We have to be thinking very closely about (this) when we are teaching them professionalism and enforcing professional standards:

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Jill Foster MD: Are we just gaslighting our students, so that we want them to be little mirrors of ourselves, or at least our ideal images of physicians? It's hardly ever a student on rounds who looks like a mini me; who seemed so smart and you know may even be a gunner and the others in the rounds hate, to not give that student honors but maybe it's another student that ...you need to give honors to as well. So I want to talk for a minute about code switching. Code switching is adjusting one's style of speech, appearance, behavior, and expressions in ways that they'll optimize the comfort of others in exchange for fair treatment, quality service, and employment opportunities.

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Jill Foster MD: To some degree, we all code switch. You know I'm not going to go to work in flip flops, shorts and a T-shirt. I'm going to put on different clothes. I wrote this lecture in shorts and a T-shirt but I'm dressed differently now to present it. However, there's a whole different view of what code switching is for students who are minorities, of what the cost is of being allowed in to feel like you belong. So the benefits of code switching are: it's faster and better acceptance, just got fewer hassles, and you get better grades and evaluations. There's some good studies showing that the people that look like what we want them to looklike, especially students that are white get better grades, and I have a study for that.

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Jill Foster MD: The cost of this, though, is that they start feeling alienated from your own group. It depletes your cognitive resources. We want our students thinking about acid base balances while they are on rounds, not are they using the right words and are they not standing up straight or are they dressed appropriately that day. It's distracting from the mission and it leads to burnout. And the level of code switching is inversely proportional to the diversity of an organization. The less diversity you have in an organization, the more people have to code switch.

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Jill Foster MD: And here's an example of what I'm talking about. They're talking about in the article; you have two people named Lamar and L'Keisha who instead say call me Matt and Renee. The respondents were then asked to rate their professionalism and workplace behaviors and these cases that were on paper and one used code switching behaviors; using English, using standard English slang, avoiding natural hair, changing their name, and white participants overwhelmingly rated the code switchers higher in professionalism and behaviors.

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Jill Foster MD: These were some of the comments: "You should be allowed to keep your name" Oh, how generous of you. "But slang and that hair are unprofessional for the workplace", so the person feels that... "it's not our house, it's my house and this is what you'll need to do." When's the last time that a white person with kind of an unusual name was told that their name was funny or that they were "allowed" to "keep" their name? Another comment: "La'Keisha sounds obviously 'black'". For whatever that means. "And some may even think 'ghetto', but Renee is more conservative". They like Renee a lot better than L'Keisha. This may sound extreme, but the study pretty much showed this across the board.

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Jill Foster MD: So that kind of leads us to what we refer to as the minority tax, that sometimes the cost of belonging is not cheap. It's hard to belong. A lot of folks - you just automatically belong. You know I struggled - I mean I'm a first gen physician, came from a family that farmed in this country for 400 years, and you know people look at me and assume a lot. There's a lot of also different assumptions when you don't look like me and that minority resident physicians and their training experiences - there has been a lot of attention to this, there was a great grand rounds last week or a couple weeks ago...

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Jill Foster MD: ...in pediatrics about this. Minority residents (who) have a daily barrage of microaggressions and bias. They're tasked to "be the race/ethnicity ambassador" with more task after task after task. Serve on this committee, review this mentorship, all these different things that you're going to have to do, in addition to all your other work and then get your other work done. This constant negotiation of my professional identity - how much can I be myself today? How much, you know, what am I going to need to do to fit in?

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Jill Foster MD: Dismissal rates are higher than white residents, 5% of all residents are minorities and yet (constitute) 20% of those who were dismissed. And grading evaluations are lower than (for) white residents. The normalized (results) based on Step 2 scores: and minority residents got fewer words like superb, wonderful, did great, and got lower grades than white residents. Again - not universal and not something that you can fix but it's out there. So what can we do for professional identity formation? How can we do it better? Because we do need

to have standards. We can't have everybody coming in T-shirts and flip flops - they might be just as good a doctor, but I think the public would have a problem with that.

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Jill Foster MD: And we need people to have a code of ethics that is about what is going to help patients, not about what is going to make them fit in with other people. So we need learner input. It needs to focus on what are the common goals that we hope everyone has and then, what are the individual goals? How is this person different from the others, and what might they need to do differently for their identity formation? We need faculty to recognize that it's hard and remembering that we're not necessarily creating them in our image. And...we need to work on achieving the excellence that they all have the potential for, keeping our high professional standards, but maintaining their authenticity and remembering it's a journey more than it is a destination.

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Jill Foster MD: So how do we build these structures? ...What are some...concrete things we can do to promote belongingness and build trust? By fixing the environment. So we can look at the environment through the lens of all students. Take a moment and say, "if I was a black student, if I was a Latino student on this rotation, or in this setting - how would I feel?" Assess the curriculum for problem areas, proactively go back and add curriculum to enhance learning. If you have a module that every year everybody only gets 20% of the questions right, go back and look at your module. You need to do something different with it. We need to do monitoring bi-directionally. Identify students with issues early and provide action plans for them - and in a non judgmental way. Not the "uhh, you know, I don't know why you're here". We need to promote effective educators.

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Jill Foster MD: Your promotion needs to not be based on the weight of grants and publications, but (on) who are really good educators to attend to that core mission of medical schools. Identify the problem educators, we all know who they are, and remediate them and exclude them until they're remediated or permanently remove them. We know the people who would say racist things and sexist things. And we know the people that are dusting off a lecture that they gave 20 years ago and just giving it again. Let's not include those people, they're everywhere. And mentoring - we need to ensure that there's representation in the mentoring force. And yet, not put all of the mentoring responsibilities on those folks who are already overburdened with tasks. And I like the "it takes a village" model for diverse needs at different times, maybe.

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Jill Foster MD: So: don't get assigned to just one mentor. Maybe I'm mentoring a cocktail party where students can go - without the cocktails - or maybe with. And you go from person to person and students at one point, they need one kind of a mentor and another point may need a different kind of a mentor. And we create these models that work that way. So it's "**nuestro**

casa”: open the door to belonging. We must be intentional for it to happen. Do not utilize a one size fits all approach. Proceed with grace, giving the benefit of the doubt. And we all benefit when there's trust and belongingness in the environment. And we all need warm fuzzies sometimes. Thank you, and this is my contact information - and I'll now flip it back to Dr. Núñez:

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Ana Núñez MD: All right, Dr Foster, thank you, as we wait in terms of questions, as promised, I always have questions right. So there's a couple things that I wonder. You talked about relationships built on trust. We know that lots of places that great people gravitate to in terms of academic settings - it's the purpose, right? Research and discovery, training, education, clinical care, and outcomes: that's where people gravitate so they come to the place because of mission. But you're talking about somehow we have to go from that common purpose and flip it into...the trust piece. So talk a little bit about how we can do that because, maybe what gets us here is the mission, but not necessarily the belonging, and I don't know if I'm being clear or not, but it seems to me that there needs to be a little cross walking that happens.

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Jill Foster MD: You know I think this is just something about not just talking the talk, but walking the walk. ...We talk about all of these fine ideals. Again, I'm not just talking about here - I hear this when I go to national conferences and it's the same problems everywhere. We set these lofty ideals, but then we don't have people living those ideals. We don't have people that are in charge, and in charge could be the intern with a medical student or it could be the PI on a lab or could be a Dean. That what you say, you mean - and to the best of your ability you're going to be authentic in it, you're going to try to do it the best you can.

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Jill Foster MD: And if you can't do it, you own up to that - you can't do it and talk about why you can't do it. And not try to always do everything on your own. You know you have to be part of a team and get input from the rest of your team, I mean, medicine is a team sport. And I fall into Baby Boomer category. And I learned this, you know I did HIV for a number of years, and HIV is a totally different field and everything is a team and consumer environment and I had to learn differently how to be a doctor in that world - and I just think we have to be less impressed with ourselves and more impressed with the wisdom of the group.

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Ana Núñez MD: So we have one question that says: Can you talk about the concept of psychological diversity.

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Jill Foster MD: Well, psychological diversity is people thinking differently and so I think that is what I think it refers to. That people come to things in a different way and that people process things differently. Like a simple part of this is ... the Myers Briggs type, so something like StrengthsFinder. That different people see things differently and or do it (differently). We did an exercise in the group I worked with, planning a party and one group of people who are like: the grand concept, what are we going to do, and the other people are like: who's going to send out the invitations and how many chairs do we need. You need everybody and it's not that one person reigns supreme. And that to really do good work and to see all of the people that we're serving you need to have that diversity of thought. Hopefully that's what the person that buys psychological diversity.

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Ana Núñez MD: And I just want to ... add to that because I think that's really important, having the leadership skills to be able to create that group and be able to ... take advantage of all of the talents. Unfortunately, I think, for a lot of us and some folks here who have been doing work in this space - there's not formal training in medicine or from the HR space about how to be ... a leader. To be able to ... optimize that and yet we need leadership skills to be able to recognize everybody in the team and get the most of it. David Handler says, "how do we make these intentional efforts academically rewarding to those who are engaged, as in resulting in promotion and tenure?" You know: it's good to do, but how do we make it count? I think that's what David ... is asking here.

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Jill Foster MD: I mean, I think we have to - again, have to be right up front with it. I think a lot of places talk about how we really, really value teaching. But then everyone knows that the people who are the best teachers, that getting a golden apple or whatever the equivalent of the teaching award is, is not it's like your credible formula is like you know equal to you know to two R01s, or you know something like that- it's walking the walk And that if you say teaching is important than you promote your good teachers, you create the academic tracks in your promotion and you make it really visible that that is rewarded. Because people will say well yeah you said that but then here's this person over here with five teaching awards who the residents are so thrilled every time they come on service and they're still an assistant professor 20 years later. And so it's doing the things that you said you were going to do, and creating the structures and systems so that it can happen.

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Ana Núñez MD: So I also think it ... expands that where there has to be metrics of what does everybody - you come to work every single day - core citizenship, what do you have to do across missions. And then, what is more, and what is most? So that we have metrics that matter so that everybody says, well if you make noise, then you can communicate and that's not necessarily the case. Sabrina Scroggins asks a really interesting question and I think it really hits on an important topic here. "How do we better approach the monitoring and action plan without the learner feeling judged? It's still very hard for learners that feel inadequate to feel accepted just for needing a good intervention". Great question, so what do you think about that?

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Jill Foster MD: Yeah that's that's a great question and yeah I keep coming back to this ... same thing of being authentic with them. ... Sometimes it involves sharing one of your own stories, telling them where you had a hard time. I think we all get really involved in ... our day to day, and when we're dealing with the learner with issues or a staff person with issues you gotta slow down. You gotta listen more than you talk. I think those are ... the general principles. I mean I used to work with a post bac program where I shared with all of them. Like my first MCATS were awful, I didn't even bother to apply to Medical School because they were so awful and yet I graduated at the top of my class and seem to have done okay since then. And so, ... in order to see a student or an employee in a vulnerable spot - sometimes you need to be a little vulnerable too.

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Ana Núñez MD: You know the things I'll add to that which - again I think is a terrific question Sabrina, thank you. There's two things; Number one is we talk about how we're well aware that the playing field isn't level. In terms of where our learners come in, or lives, that you know people had to do to get where they are, and some people easy peasy - some people not. But then when they come because maybe they didn't go to a great school, maybe they didn't have the best advising, so on and so forth - it's almost as if once they walk in the threshold everybody has to be exactly the same. And we know they're not and so to unleash some of that untapped potential that you talked about you need ... the help and the skills to be able to ... get there.

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Ana Núñez MD: But often that gets viewed as “Oh, you're not enough, you're being remediated from how life has given you disparities” - right, but it's somehow your fault, not ... the systems in terms of doing that, and I think that we have to ... reconcile that. The second piece is, we also have to ... attack a little bit the mythology in terms of medicine and science. Everybody's perfect, you know you'd never do bodily functions because you're that superhuman. You know you never make a mistake, etc - you're sort of a 24/7 .. thing. I think we have to blow that up because you've been talking about authenticity of person. And I think we need ... an authentic authenticity, in terms of our culture. COVID's taught us a lot of things, and that is that we aren't superhuman:

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Ana Núñez MD: That we are subject to getting sick and having vulnerability and ... needing ... variability in terms of time and space to ... do our work. And so we have to ... rather than, say “Yeah that happened — let's go back to the previous.” We actually have to say that we aren't perfectionistic, we are human, we screw up: sometimes we do great, sometimes not. But how do we create a system that ... accepts our humanity, rather than saying if you're not perfect, ... what's wrong with you. So I think that there are issues there that we have to ... pay attention to that ... address how we address some of those challenges, when people are able and have

great talent to unleash it in ... a strength based way — kind of the stuff that you talked about that Morehouse was doing.

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Ana Núñez MD: But I also think we culturally have to ... do it like - timeout: let's get real, let's get authentic as a culture in terms of what we can and can't do. David Rothenberger says "What are the most immediate opportunities available to underrepresented minority faculty to take down some of those barriers to achieve DEI and what's stopping us?" Great question David.

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Jill Foster MD: I'll leave that mostly to our Vice Dean. I think the most immediate thing I see is the promotions process ... and I sort of alluded to that, are really making these academic processes real. And I think the movement from that really needs to come from the full professors. It often seems like it's the assistants and associates who are trying to get promoted, who are the ones making the most noise. But it has to come from the full professors who say, "we got to this place through this whole process but we're going to make sure that we bring people up from below that are potentially from a different process" and actually get out there and advocate for it. That's the first thing I think, and I think the second thing is just bringing this grace to your day to day. You know there's the whole thing of the starfish and the beach, and someone says, look at all these starfish and the beach, how can ... throwing one back and then another one back, how are you going to make an impact? And they're like, well you know that's all I can do, ... is be intentional in your interactions with your students and with your employees and when you're on rounds and ... Practice the gift of benefit of the doubt and grace when you have learners on rounds, even though it's much more fun to deal with the ones that are ... "right there." Pay attention to the other people on rounds.

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Ana Núñez MD: So I'll add to that and ... talk about... I think some of the available opportunities for underrepresented faculty is networking and gathering to find out who else is here. We live in very big space across multiple buildings, multiple clinical sites, multiple educational sites and so on, and it seems really difficult, especially ... in this COVID endemic space that we're in to do that oomph of energy of let's come together and talk: whether it's our SADI affinity groups or whomever. Give that energy to do that, because that connection in terms of ... the "us" I think is really, really important to move forward in terms of DEI including ... recruiting ... folks, helping our workforce, and making a better inclusive environment. I think that what's stopping us is ... that inertia of; people are tired legitimately and "one more thing is one more thing".... but I think ... that connection, ... as the acronym in real life (IRL) we get an energy with that and I think overcoming that to ... be able to do that is really important. I'm going to take the second piece David in terms of the barriers for DEI here.

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Ana Núñez MD: And that actually has to go with the previous question about how do we get it: David said, "how does it count?" And I think the "how does it count" needs to look at 7-12s and the full professors that Jill was talking about. Those full professors need to ... take leadership about making 7-12s. What are those baseline things that everybody should be doing in diversity equity inclusion - what are more, what are most, in terms of saying that everybody has to do something in terms of promotion. So we do have some of our faculty that are doing some interesting work about what "counts" for promotion and tenure across five different departments so we're looking forward to their work, but we need everybody to ... be engaged in terms of doing that.

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Ana Núñez MD: So we're heading down to the wire. I'll just point out to you this is now our second Associate Dean for Diversity Equity and Inclusion that hasn't had the opportunity to meet with you in terms of the Dean's Special Seminar. Dr Mary Owen, who is our Associate Dean for Native American Health, one of three in the country, spoke to you last year. Dr Jill Foster, who's our Associate Dean for Pathways and Pipelines in terms of working with the BA/MD program and multiple other areas in the DEI office. And we have other folks: Dr Belinsky in Research and Gender Equity, as well as our Assistant Dean, Dr Mustafa in terms of Clinical Equity are also ... on deck. So you can hear about what they're doing, some of their ideas and so that we can get to know the ... folks in our unit in ... the Office of Diversity Equity, and Inclusion. We hope this is useful. As always, we want to hear from you what are other topics? I will mention that, with our two learning and development folks., we do have the opportunity for more access so far as implicit bias and other training. If there's departmental trainings that you want, please reach out and let us know. And we have lots of lots of good stuff coming down the pike. We appreciate you being with us, Dr Foster. Thank you so much for all your comments and we'll give you all of six minutes back to sort of start your day so enjoy the day and be well. Take care, everybody. Bye bye.