Outcomes achieved included a revision of the mission statement to include a commitment to diversity, creation of the medical center’s first gender-neutral bathroom, and enhanced curriculum review to improve inclusiveness. Student-led collaboration with administrators ultimately improved the sense of trust and belonging for diverse groups at the institution.

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The Importance of Diversity in Obtaining Trust With Faculty

To the Editor: I identify as a Hispanic, white female, and as a first-generation immigrant. I am also a first-generation medical student. My medical school mentor identifies as a southern woman of African descent. She is not the first in her family to attend college, and though she has earned a PhD, had she attended medical school, she would not have been the first in her family to earn an MD.

On the surface we seem to be complete opposites; however, the intangible things we have in common have allowed her to earn my trust and have helped me to relate to her on a level that I have not shared with many other faculty members or even my peers. That trust, combined with her willingness to self-disclose, has given me a safe space to divulge difficulties. It has also given her the courage to share opinions that I sometimes have not wanted to hear, but which have served me well in the long run. The trust and openness of this relationship have had a pivotal—and positive—influence on my mental well-being during training.

Reflecting on this and other relationships I have had with previous mentors, I realize trust, diversity, and inclusion are key components for increasing levels of trust between medical students and faculty members. Even more, these components may sometimes be crucial for the survival of students as we navigate medical school, especially those of us who struggle during our training.

At the start of medical school, medical students’ mental health is on par with their nonmedical peers, but research suggests that medical students’ mental health declines during their training. Finding ways to encourage trainees, in particular trainees like me—first-generation students from groups underrepresented in medicine—who may be reticent to seek the support they need, is crucial! Academia needs to appreciate the important benefits that come from having diverse and inclusive faculty and staff who “get” some of the unseen challenges many of us trainees confront on a regular basis while we simultaneously navigate academic and clinical demands. This ability to relate is particularly important for students who face difficulties during their time in medical school and need someone to nudge them to be open about those difficulties. Trust is the key to establishing the rapport necessary both to alleviate students’ fears of being judged or misunderstood and to get them the support and guidance they need.

I feel fortunate to have found a faculty member to whom I can relate and whom I trust. This relationship has made all the difference for me—and is something I hope all trainees are able to experience as they navigate medical training.

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Physician and Gay: Am I Safe at Work?

To the Editor: It was just another day in the clinic. While I was examining a young child, her mother said she was glad she got a “usual straight” doctor for her child, rather than the other (aka homosexual) kind about whose competence she was not sure. And just like that, it was no longer just another day. One wayward statement, inconsequential to the speaker, left me in internal turmoil. As a gay physician, I was torn between my duty toward my patient and my desire for personal integrity.

Homophobia in the workplace can seem almost too strong a label to address what may be perceived as a trivial incident. Often perceived as too insignificant to address, these incidents persist in the psyche of those of us who identify as lesbian, gay, bisexual, transgender, or queer (LGBTQ). Such incidents are a nagging reminder of how LGBTQ people continue to be perceived as different, as somehow diminished, on account of their sexuality. Often lacking an avenue to express these feelings, an LGBTQ physician may suppress these feelings, leading to a sense of exclusion and disenfranchisement at work. Many LGBTQ physicians still report social ostracization in the workplace, as well as harassment by colleagues and patients/the community. Workplace safety for the LGBTQ physician remains a moving target; much work is yet to be done. These guidelines, which should help broaden horizons and foster mutual respect, necessitate that all residency programs take concrete steps to ensure that a diverse workplace is also inclusive and safe for all. One action we medical professionals can take—beginning in medical school and continuing through residency and beyond—is sensitizing others to what working in an all-inclusive environment means. Simulation is a useful tool for adult learning that is used in medical education.
training. Simulated encounters may be especially helpful in illustrating cases of “casual” homophobia which can be difficult to address or even to explain. A resident-driven committee focused on diversity and inclusion can help empower trainees to voice their concerns in a safe and nonhierarchical space. With support from leaders, such resident-led committees can be harbingers of change by identifying problems at the grassroots level, by finding feasible solutions developed by stakeholders, and by engaging colleagues who may feel marginalized because of their gender or sexual orientation.

The journey to a truly inclusive workplace for LGBTQ physicians will be arduous, but is certainly worth making.

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Recruitment and Retention: A Guideline to Help Build Trust With Minority Candidates

To the Editor: As I embarked on the interview trail in search of a family medicine residency program, I created questions to evaluate each program. I struggled with one topic: determining how my minority status would affect my education at a particular program.

For instance, if a patient requested strictly Caucasian physicians, how would my program respond? I did not trust that a program director would broach the subject.

Ideally, asking the question should be easy: Will my blackness be an issue with faculty, co-residents, or patients in this program? In actuality, bias is real; it is why I wore a hair weave during interviews instead of my Afro. Some associate Afros with Angela Davis, the African American writer and social activist, and with the Black Panthers, the grassroots group from the 1960s who formed to protest police brutality. I wanted to be viewed as friendly and nonthreatening. How do I ask the question without shifting the way the interviewer perceives me? Ultimately, I decided to ask each program director how he or she defined diversity and inclusion and what it meant to him or her.

Academic institutions that are serious about recruitment and retention of minority candidates must build trust with candidates and convey that they will be protected and supported. I acknowledge that not all candidates want to be singled out as a minority, so I propose program directors take the following steps:

1. Participate in bias training. Having a clear understanding of your biases will help you leave them at the door prior to the interview.
2. Assume that the candidate knows his/her minority status, and feel empowered to assess the candidate’s level of comfort in discussing issues of race, equality, and bias. Be direct and state that the candidate will be one of few minorities in the program. Ask, “Are you concerned about what, if any, effect this will have on your training?” Alternatively, this can be asked via survey prior to the candidate presenting for the interview.
3. Acknowledge the candidate’s minority status and state plainly that his/her education should not be impacted by his/her minority status. Stress that at any time, if the candidate feels as though his or her status as a minority is an issue, it should immediately come to the attention of the program director.

I feel as though these three steps will begin to build trust with candidates and convey that the program values diversity and inclusion and has prioritized supporting residents from all backgrounds.

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Their Trust Is Worth the Weight

To the Editor: I did not imagine I would go to work feeling a heavy weight on me most days. I suspect the weight has been there since the beginning of my career. I am, after all, a black female surgeon. Our recent sociopolitical climate has made the weight of the roles I play in my patients’ lives even more apparent. I play a role as a physician and surgeon. And, for many patients of color, I am trusted to play a role as ally and advocate.

My training as a physician prepared me to protect patients from harm. The same education did not prepare me for the nuanced role that I would play for my patients of color.

Without knowing my credentials, and sometimes without hearing me speak, my patients of color trust me simply because I look like them. I have wondered why this trust is so freely given to me.

Diving in more, I learned that patients of color often distrust that medical resources will be meted out fairly. Frankly, they are right to do so. Patients of color are not well represented in clinical trials, and treatments are not equitable. For example, Hoffman and colleagues1 have detailed the undertreatment of pain for black patients compared to their white counterparts.

I do not believe the medical community purposefully underdelivers for patients of color; however, many physicians desperately undervalue how deeply the experience as patient, for people of color, is interwoven with life in a country with systematic structures that hold their bodies as secondary.

The topics of bias, trust, and quality of treatment as they relate to patients