INTRODUCTION

In the last 20 years, the United States has seen an increase in minority groups that has far outweighed initial projections. Roughly four of 10 Americans identify themselves as a race or ethnic group other than White, and the decade of 2010–2020 was the first in our nation’s history where the White population declined. This meteoric rise in minority groups makes solving healthcare disparities one of the most important aspects in improving our healthcare system. As has been described, minority physicians are critical in serving minority populations for several reasons. First, minority patients feel more comfortable with minority physicians. Second, minority physicians disproportionately care for minority communities. Considering these facts, medical schools throughout our country have increased recruitment efforts of underrepresented minority medical students. Unfortunately, this recruitment has not translated to an increase in racial diversity throughout subspecialty surgical programs such as orthopedic surgery, neurosurgery, otorhinolaryngology, and plastic surgery.

Specifically, the field of plastic surgery has many healthcare disparities that could benefit from an influx of Black, LatinX, and Indigenous surgeons. Access to complete breast reconstruction remains disproportionately low for minority and low-income patients with breast cancer. Interdisciplinary cleft lip/palate care and differential treatment of aesthetic and functional rhinoplasties between racial/ethnic groups could also improve with more representative surgeons to serve these populations, just to name a few.

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In 2009, Butler et al conducted the first comprehensive review of the status of diversity within plastic surgery, which concluded in a call to action for the furthering of diversity within the field. Although many have sought to study diversity within plastic surgery since then, no study since Butler et al has looked at the entire pipeline: residency-applying medical students, residents, and attending physicians. A follow-up study, showing the progress made since this sentinel article, has yet to be made available in the scientific literature. Furthermore, no study has qualitatively evaluated the efforts made by medical institutions to improve minority recruitment—namely medical schools.

The goals of this study were twofold: first, to evaluate the progress made in diversity recruitment within the field of plastic surgery between 2010 and 2020, including residency-applying medical students, residents, and attending physicians; second, to qualitatively study medical school diversity recruitment offices and establish a set of actionable recommendations for plastic surgery residency programs seeking to recruit more diverse residents.

METHODS

A two-armed process was implemented for quantitative and qualitative data collection. With respect to quantitative data, racial demographics were provided by the Association of American Medical Colleges (AAMC) for medical students, integrated plastic surgery residency applicants, and academic faculty from 2010 to 2020. Racial demographic data for integrated plastic surgery residents from 2010 to 2020 were gathered from the Accreditation Council for Graduate Medical Education. Due to growth in the total populations within the study groups, groups were broken into two (2010–2014 and 2015–2020), and proportional averages were compared using two-tailed, heteroscedastic t-tests. The percentages for integrated plastic surgery applicants, integrated plastic surgery residents, and plastic surgery faculty were stratified by racial representation and plotted in lined scatter plots. Compound annual growth rates were then calculated for each subgroup. Analysis was completed with STATA statistical software (StataCorp LLC: Release 15. College Station, Tex.).

Interviews were conducted with four standardized questions, compiled by the senior authors and with the aid of multiple plastic surgery faculty members. Standardized questions were as follows: 1. In your own words, could you briefly describe the importance of diversity within the medical field? 2. What, if any, challenges have you seen students face as they looked to apply into subspecialty surgical programs? 3. What are the three most impactful things your office does annually to recruit diverse candidates during the application process? 4. What recommendations would you give to a plastic surgery program looking to increase diversity and inclusion within their program?

The top 20 medical schools based on the U.S. News & World Report were then selected and were emailed up to three times to participate in the interview. Eight total institutions were interviewed. Institutional leaders in diversity and inclusion were asked of their current policies and their expert opinions regarding measures to improve diversity in integrated plastic surgery residency programs. All responses were de-identified. Once the data were collected, a detailed thematic analysis was achieved by authors JAH, CIK, and DPF to extract key content from each interview. At the completion of content abstraction, recommendations were synthesized by authors JAH, CIK, and DPF. Recommendations from conducted interviews were reviewed over multiple days to ensure holistic synthesis of the data.

RESULTS

t-tests comparing proportional averages of years 2010–2014 to 2015–2020 of all enrolled medical students showed a statistically significant increase in the “other (including multi-racial)” group (9%–10%, P = 0.02) and a reduction in the “Native Hawaiian or other Pacific Islander” group (0.2%–0.1%, P = 0.04). Notably, there was no change in the “American Indian or Alaska Native,” “Asian,” “Black or African American,” or “Hispanic, Latino, or of Spanish origin” groups between the two halves of the decade. Within the cohort of medical students applying into integrated plastic surgery, there were no statistically significant differences between 2010–2014 and 2015–2020 in any of the demographic groups. With respect to integrated plastic surgery residents, we saw a significant increase in residency positions throughout the decade (472–820, P < 0.01). Within integrated plastic surgery resident demographic groups, the only significant finding was a reduction within the “Hispanic, Latino, or of Spanish origin” group (4%–3%, P = 0.01). Among plastic surgery faculty members, there was a significant increase in the overall number of faculty members throughout the decade (439–506, P = 0.01). There was an increase within the “Asian” (16%–19%, P = 0.01), “Hispanic, Latino, or of Spanish origin” (4%–5%, P < 0.01), and “other” (4%–5%, P = 0.02) groups. Correspondingly, there was a reduction in the proportion of “White” faculty members (74%–70%, P < 0.01). However, it should be noted that due to such a small sample size, the AAMC groups “Black or African American,” “Native Hawaiian or other Pacific Islander,” “Asian,” “Black or African American,” “Hispanic, Latino, or of Spanish origin,” “other” (4%–5%, P = 0.02) groups.
Once interviews were completed, thematic analysis yielded four major themes: (1) Diversity in healthcare is vital; (2) metrics-focused resident selection stunts growth; (3) there is a need for minority mentorship; and (4) pipeline recruitment programs affect change. After completion of thematic analysis of diversity and inclusion officer interviews, a final synthesis of the data yielded three key recommendations, targeted to residency program leaders, for the improvement of diversity and inclusion within the field of plastic surgery: (1) reduce metrics-focused selection, (2) foster medical student mentorship, and (3) establish minority-focused, funded sub-internships and grants. The thematic analysis and three recommendations, with a supporting quote, can be seen in Table 2.

**DISCUSSION**

Diversity is one of the most important aspects of our world. Diversity of plants and animals prevents mass extinction in times of environmental stress. Diversity of thought within business promotes innovation that changes the world. Diversity of people similarly has brought forth important additions to societies domestically and internationally. We strongly believe that healthcare is no different: diversity among patients and physicians alike has great benefit. Clearly, these benefits have also been appreciated by medical schools throughout our country, as there has been a significant rise in diversity recruitment initiatives within the last 20 years. However, in 2009, Butler et al highlighted the absence of such diversity within the field

### Table 1. Racial Demographic Data of Medical Students, Integrated Plastic Surgery Residency Applicants, Integrated Plastic Surgery Residents, and Academic Plastic Surgery Faculty between the years 2010–2014 and 2015–2020

| Medical Students | Race/Ethnicity | 2010–2014, No. Avg (%) | 2015–2020, No. Avg (%) | P | CAGR |
|------------------|----------------|------------------------|------------------------|---|------|
| American Indian or Alaska Native | 449.4 (0.6) | 181.6 (0.2) | 0.0717 | −11.98% |
| Asian | 17595.8 (21) | 19557 (22) | 0.6213 | 1.89% |
| Black or African American | 5429.8 (7) | 6093 (7) | 0.5791 | 2.02% |
| Hispanic, Latino, or of Spanish origin | 5442.2 (7) | 5338.6 (6) | 0.4607 | −0.54% |
| Native Hawaiian or other Pacific Islander | 175 (0.2) | 71.4 (0.1) | 0.0396 | −11.56% |
| White | 47383 (38) | 46886.4 (52) | 0.0017 | −0.22% |
| Other (including multiracial) | 7961 (9) | 9383.8 (10) | 0.0207 | 2.99% |
| Unknown | 1154.5 (1) | 822 (1) | 0.1833 | −2.05% |
| Totals | 81924.4 | 89719.4 | <0.001 | 1.64% |

| Plastic Surgery Applicants (Integrated) | Race/Ethnicity | 2010–2014, No. Avg (%) | 2015–2020, No. Avg (%) | P | CAGR |
|------------------------------------------|----------------|------------------------|------------------------|---|------|
| American Indian or Alaska Native | 3 (0.8) | 6 (1) | 0.1834 | −8.76% |
| Asian | 73.4 (17) | 89 (19) | 0.2133 | 2.50% |
| Black or African American | 25.8 (6) | 29.6 (6) | 0.7627 | −3.31% |
| Hispanic, Latino, or of Spanish origin | 32.8 (8) | 40 (8) | 0.7852 | −1.53% |
| Native Hawaiian or other Pacific Islander | 0.4 (0.1) | 0.6 (0.1) | 0.5183 | — |
| White | 234.4 (55) | 252.2 (53) | 0.5287 | −2.00% |
| Other (including multiracial) | 25.2 (6) | 24.2 (5) | 0.4795 | −3.68% |
| Unknown | 55.6 (12) | 35.8 (7) | 0.0368 | −8.76% |
| Totals | 435.3 | 477.4 | 0.6275 | −1.20% |

| Plastic Surgery Residents (Integrated) | Race/Ethnicity | 2010–2014, No. Avg (%) | 2015–2020, No. Avg (%) | P | CAGR |
|----------------------------------------|----------------|------------------------|------------------------|---|------|
| American Indian or Alaska Native | 1.5 (0.3) | 3.4 (0.4) | 0.1385 | 11.61% |
| Asian | 54 (11) | 108.4 (13) | 0.0516 | 12.64% |
| Black or African American | 14.25 (3) | 21.2 (3) | 0.2275 | 5.54% |
| Hispanic, Latino, or of Spanish origin | 16.5 (4) | 24.6 (3) | 0.0139 | 9.43% |
| Native Hawaiian or other Pacific Islander | 6.4 (0.1) | 0.4 (0.0) | — | — |
| White | 240.5 (51) | 430.8 (53) | 0.1155 | 10.72% |
| Other (including multiracial) | 22 (3) | 39.2 (4) | 0.2267 | 6.39% |
| Unknown | 122.75 (26) | 198.4 (24) | 0.3363 | 6.89% |
| Totals | 471.5 | 820.4 | 0.0014 | 9.72% |

| Plastic Surgery Faculty | Race/Ethnicity | 2010–2014, No. Avg (%) | 2015–2020, No. Avg (%) | P | CAGR |
|-------------------------|----------------|------------------------|------------------------|---|------|
| Asian | 72.2 (16) | 97.2 (19) | 0.0118 | 6.77% |
| Hispanic, Latino, or of Spanish origin | 17.8 (4) | 24 (5) | 0.0036 | 3.70% |
| White | 324.8 (74) | 354.2 (70) | 0.0046 | 2.23% |
| Other (including multiracial) | 19.4 (4) | 25.6 (5) | 0.0218 | 6.79% |
| Unknown | 5.2 (1) | 5.25 (1) | 0.4482 | 0% |
| Totals | 439.4 | 506.4 | 0.0119 | 3.20% |

*The AAMC groups Black or African American, American Indian or Alaska Native and Native Hawaiian, or other Pacific Islander within the “other” grouping to maintain anonymity.

CAGR, compound annual growth rate; No. avg, average number of individuals for the 5 years;
of plastic surgery. This article was descriptive in nature and concluded in a true call to action, which sparked further academic interest in the years to come. The senior authors of this article sought to both describe the progress of diversity recruitment within plastic surgery throughout the last decade and conclude with actionable recommendations, amassed from a synthesis of medical school diversity and inclusion officer interviews, for residency program leadership.

**Plastic Surgery Diversity and Inclusion**

To gain a comprehensive picture of diversity and inclusion within the field of plastic surgery, it was important to evaluate all components of the pipeline: residency-applying medical students, residents, and attending physicians. In our study, no statistically significant differences in the demographic categories of residency-applying medical students between 2010–2014 and 2015–2020 were found. Furthermore, when evaluating current integrated plastic
surgery residents over the same period, the only statistically significant finding was a reduction in the “Hispanic, Latino, or of Spanish origin” group (4%–3%, \( P = 0.01 \)). However, faculty data (which was made difficult to evaluate due to the previously mentioned grouping of the “other” category) showed a statistically significant increase within the “Hispanic, Latino, or of Spanish origin” group (4%–5%, \( P < 0.01 \)) and “other” (4%–5%, \( P = 0.02 \)) groups, and a proportional reduction in “White” faculty members (74%–70%, \( P < 0.01 \)). Importantly, the integration of this pipeline throughout the decade must not go without mention. Residency-applying medical students become residents, who then subsequently become faculty members. To this point, there should be no surprise in the similar results found between applying medical students and current residents, unless there was a preferential selection of diverse residents, which was not observed. Although faculty data throughout the decade show promise, the pipeline of diversity must be improved.

Based on these quantitative data, there is a need for the increase in diversity throughout the field of plastic surgery. Further qualitative data from diversity and inclusion officer interviews yielded recommendations on how diversity recruitment can be maximized.

Diversity Recruitment Recommendations

Importantly, enrolled medical student data suggest no significant increases in diversity between 2010–2014 and 2015–2020. This finding should not deter from the important diversity recruitment efforts made by my medical institutions. These data are averages throughout the country and are not representative of individual medical institutions—specifically those with diversity and inclusion offices.

After the completion of interviews with diversity and inclusion officers and subsequent thematic analysis, three key recommendations for programs seeking to increase diversity recruitment were formed.

1. Reduce metrics-focused selection

There needs to stop being unnecessary hurdles blocking minority students from achieving success in the residency application process, like standardized exam scores.

Metric-focused selection during the plastic surgery resident recruitment process has anecdotally been viewed by some as a “must.” During the last year, integrated plastic surgery applicants applied to 62 programs on average.\(^\text{26}\) The de-emphasis of standardized examinations in the application process is already taking place at a national level, exemplified by the USMLE Step 1 examination recently being converted to pass/fail.\(^\text{27}\) The additional removal of standardized exam score cutoffs for application review would increase the pool of qualified candidates and thus require a more holistic application review. In the same light, placing great importance on publication volume, another frequently-highlighted metric, may give a false view on the quality of an applicant, which could skew away from applicants of color—frequently with less social and academic support. Simply put, we do not feel there is a strong correlation between exceedingly high standardized exam scores or publication volume and quality of resident. Prior examination scores help predict future examination scores but fail to put into perspective the quality of a developing clinician and surgeon. Although difficult, program directors and chairs across the country must work to limit numerical “cutoffs” in application review to promote diverse applicant recruitment.
Table 2. Summary of Major Themes Analysis and Final Recommendations with Supporting Quotes from Diversity and Inclusion Officer Interviews

| Theme | Supporting Diversity Officer Quotations | Recommendations |
|-------|----------------------------------------|-----------------|
| Diversity healthcare is vital | Diversity drives excellence towards our core missions of teaching/learning, research, and clinical service. People from diverse backgrounds are more likely to address health disparities, and treat underrepresented minorities. People of color, are more likely to listen to physicians of the same background... a unique kinship forms between physicians and their specific communities. | Reduce metrics-focused selection |
| Metrics-focused selection stunts growth | The lack of a holistic recruitment process is a major hurdle for our students. Each program needs to have a real reckoning on what is important and valuable. Do the test scores really make a great surgeon? Does research and having 15 publications improve how someone will perform throughout residency? Our application reviewers are blinded not standardized exam scores. We have also expanded the selection committee to increase diversity of thought when evaluating applicants. | Foster medical student mentorship |
| Need for minority mentorship | Students in medical school look to see who else looks like them… when you don’t see people, it’s difficult to picture yourself there. Not having mentors to help [minority students] is a key issue… most of us need some kind of role model or mentor to show us what success looks like. | Programs need a mentorship program with future candidates because diversity recruitment is about true inclusion and a sense of belonging. |
| Pipeline programs affect change | We have created outreach programs to draw minority applicants and give as much financial support as we can, to prevent any economic barriers. We prioritize being direct and recruit minority students through a paid for UIM sub-internship for many specialties… this is one of the most effective efforts that we have. A lot of people from diverse backgrounds don’t even think of applying… first look programs and campus visits have increased our applicant numbers significantly. | Establish minority-focused, funded sub-internships and grants |

2. Foster medical student mentorship

Programs need a mentorship program with future candidates because diversity recruitment is about true inclusion and a sense of belonging.

Medical student mentorship throughout medicine has long been a topic of interest and can very easily be seen as a method for fostering the future of the field. However, mentorship is quite challenging when considering a small and operatively busy subspecialty such as plastic surgery.28 Early establishment of minority medical student mentorship, whether from residents or faculty, plays a strong role in recruitment efforts. Albeit small, there has been an increase in minority faculty over the course of this past decade and their impact on recruitment efforts is invaluable. The involvement of plastic surgery residents and faculty members in medical student education and interest groups is vital.

Specifically, minority students could greatly benefit from the establishment of a research mentorship with plastic surgery residents and faculty. We believe some of the most enriching relationships formed with students, and eventual residents, began with academic projects. The system of mentorship is one reliant on investment, from both sides of the respective and is a time intensive process with longitudinal results. Thus, we must establish a culture of mentorship as an expectation, rather than a sign of a high-quality resident or faculty member. As a field, we should stay steadfast and invest in the mentorship process, and subsequent recruitment will follow.

3. Establish minority-focused, funded sub-internships and grants

We provide as much financial support [for minority applicants] as possible to make sure that there aren’t economic barriers to accessing our program. I’d say this has been the most impactful thing we have done.

The integrated plastic surgery application process is exceedingly expensive. Although articles have been written to estimate such costs, it is not truly appreciable until personally-experienced.29 The first costs experienced by applicants are in the form of sub-internship application, travel, and housing. With costs for the essentially-required sub-internships in the thousands of dollars, it is easy to see how minority students may be deterred from applying into plastic surgery and other subspecialty surgical programs requiring the same. Some medical school diversity and inclusion offices have identified these costs as barriers to recruitment and offer financial aid to minority students seeking to apply for sub-internships. However, if plastic surgery programs aim to increase diversity recruitment, considerations to create financial support for these students would be beneficial.
We have also most recently seen an increase in the number of minority-focused research grant funding, which is a positive signal within our field moving forward. We would encourage the continuation and expansion of both national and regional grants to help get minority students out on the conference trail. As more research-focused grants for minority students are established, we can expect an advancement in the networking required to bolster minority student residency recruitment.

Program-funded sub-internships and national grants for minority applicants send a signal of support and begin to establish a level playing field for those with cost barriers, which often disproportionately impact applicants from minority groups.

Limitations to this study include the exclusion of the independent plastic surgery track, which is becoming proportionally smaller every year. Considering the increasing number of integrated plastic surgery residency programs over time, data abstraction was much more accessible for such programs. Further, AAMC faculty data included only academic faculty, leaving private practice plastic surgeons out of our analysis. AAMC data also bundled a number of academic faculty member demographic groups within the “other” category, making this difficult for comparison. Finally, the diversity and inclusion officer interview sample size was eight.

CONCLUSIONS

Although academic interest has been placed on recruitment of underrepresented minorities within plastic surgery, the last decade has not seen a significant increase in diversity within the field. To make a change moving forward, we propose the following: (1) reduce metrics-focused selection, (2) foster medical student mentorship, and (3) establish underrepresented minority-focused, funded sub-internships and grants. With these recommendations in mind, we believe the field could look forward to a decade of increasingly diverse young plastic surgeons.

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