Diversity and Inclusion in Academic Plastic Surgery: the ACAPS National Survey to Assess and Compare Attitudes, Knowledge, and Behavior in Faculty and Residents in Plastic Surgery Training Programs

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BACKGROUND: Developing a diverse, inclusive workforce is not just a moral priority, but there also exists a strong economic argument: more diverse teams yield higher performance and better financial returns. Academic medical centers, including surgical departments, have been slow to adopt strategies and programs that increase diversity. The American Council of Academic Plastic Surgeons sought to determine the status of diversity and inclusion in plastic surgery training programs.

METHODS: ACAPS administered a national, anonymous, incentivized, electronic, 18-question survey (Qualtrics) to all members (n=462), plus 1029 residents at 91 institutions. We compared responses of faculty versus residents, using chi-square analysis, with significance set at p<0.05.

RESULTS: 199 respondents completed the survey, including 45 program directors. The vast majority of educators and trainees (>95%) were fully/partially committed to diversity and inclusion, but only 63.9% felt confident in addressing concerns, and 56.2% reported adequate training. The most common types of discrimination, observed by the respondents, were related to body weight, gender, and race, whereas the most common forms of discrimination, committed by the respondents, were about body weight, medical condition, and immigration status.

CONCLUSIONS: While faculty members and residents are committed to diversity and inclusion, these groups differ considerably in terms of their own demographics and experiences. Both groups would benefit from institutional programming to educate physicians about how diverse teams can better serve diverse patient populations.

A Simple Way to Reduce Opioid Over-Prescribing by Plastic Surgery Residents

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BACKGROUND: Over-prescribing following surgery is a known contributor to the opioid epidemic, increasing the risk of opioid abuse and diversion. Trainees are the primary prescribers of these medications at academic institutions, and we previously identified over-prescribing in this population across the US and Canada. We hypothesized that a simple “intervention” could improve over-prescribing.

METHODS: All plastic surgery trainees at one institution completed an anonymous survey querying opioid-prescriber education, factors contributing to prescribing practices, and analgesic prescriptions written after eight common procedures. Oral morphine equivalents (OME) were calculated for each procedure. A simple 4-hour intervention was then administered to all residents in 1-hour sessions, during grand rounds over several weeks: (1) screening of HBO’s documentary “Warning: This Drug May Kill You”, (2) St. Louis Police Department on opioid abuse and crime; (3) experienced psychologist on treating patients with opioid addictions; (4) Pain Management Anesthesiologist on the basic science of pain and analgesia. Surveys were repeated several months after completing the intervention. Pre- and post-intervention prescriptions were compared using either students t-test or Mann-Whitney U tests, depending on data normality as determined by the Shapiro-Wilks test.

RESULTS: Response rate was >90% on both surveys. For all but 2 procedures (carpal tunnel release and abdominoplasty), there was a statistically significantly decrease in prescribed MME after the intervention. Residents more frequently adjusted prescriptions to specific procedures (from 53% to 95%, p=0.002). There was no change in the number of residents adhering to the “one-prescriber rule” (37% to 50%, p=0.408).

CONCLUSION: A largely passive intervention can improve over-prescribing by plastic surgery residents. Coordination of care issues remain a problem, such as following