Strengthening Our Societies with Diversity and Inclusion

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KEYWORDS

• Diversity • Inclusion • Gender • Leadership • Manels

KEY POINTS

- US medical societies have historically excluded women and other underrepresented minorities (URM) from serving as guests of honor and from moderating or serving on panels.
- This exclusion weakens both the society and the member, as the society fails to represent its membership, and the contributions of a significant swath of the membership are not recognized.
- Despite increasing percentages of women and URM members, with ascending experience and seniority, there was notable exclusion from these visible positions even in the modern era.
- Starting in the autumn of 2017, otolaryngology societies in the United States began deliberately including women and URM, some even going so far in 2018 as to establish a "no more manels" rule for all society meetings.

In 2018, the Joint Councils of the American Otological Society (AOS) and the American Neurotology Society (ANS) adopted a statement on diversity and inclusion for programs henceforth. That statement is published on their Web sites and in this edition of *Otology & Neurotology*. I think that it will stand as a landmark touch point in our societies that heralds the engagement of all our members as we all work to advance knowledge and skills in otology and neurotology. I am honored to be asked to write this piece explaining how and why we came to this point and to this decision.

During the 2017 fall meeting of the ANS, at the conclusion of the Middle Fossa Craniotomy: Spectrum of Application and Technical Pearls panel, I stood at the

Actively working towards diversity and inclusion in organized medicine is challenging. The American Otological and Neurotology Societies acted by adopting a landmark statement in 2018. This article, which first appeared in Otology and Neurotology, establishes a baseline understanding of the historical limitations in organized otolaryngology and the willingness of societies to adapt and lead in shaping our profession's future.

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microphone and "complimented" the society for organizing an excellent "manel." I explained that a manel is a new term for an all-male (and usually all-white) panel.[1] The middle fossa craniotomy manel had a male moderator and 7 male panelists, of whom 2 were Asian American. I went on to say that I felt it was disrespectful of our society to disregard the diversity among its membership. I was rebuked from the podium by the president of the society and informed that there were plenty of women on the program.

Review of the program shows that there was 1 woman panelist of a total of 10 panelists and she presented a nonsurgical topic, 3 of 4 moderators were men, the 1 named speaker was a non-MD woman, and on the other ANS panel there was a male panelist who was presenting the work of a senior female member of our societies, work he had not participated in developing, as she sat in the audience next to me. When I asked her why she was not presenting her own work, she pointed out that ideally her post-doc should have been asked to present that work, as a way to mentor him up. In the audience were a host of woman at least as qualified, if not more so, to present at the only surgical panel, the one with 8 men on it. The 1 female comoderator was for the Fellows video competition, which can be classified as less surgical than educational.

It was difficult to stand at that microphone and give voice to the pain of being regarded as either invisible, second-class, or a token. It has been difficult to be made to feel this way for my entire career in medicine in general and otolaryngology in particular, and, of course, in my chosen niche in otology and neurotology. I have literally (used correctly, by the way) written some variation of "where are the women?" on every single program evaluation form since I began attending ENT (ear, nose, and throat) meetings. It has been some source of bemused amusement to the program committees at the AOS and ANS, as members have joked with me later that they read my (deidentified) comments. The first time I was asked to be a panelist, at the AOS in 2006, I remember that then-administrator Mrs Shirley Gossard called me to congratulate me that my comments had finally been paid attention to! I hadn't written them for myself, but for my gender and for my societies, but if this was the way to pave the path, so be it. Knowing that Shirley, and later Kristen Bordignon and Ashley Westbrook, had our backs has always given me great strength.

Several years ago, the guest of honor speaker at the Triological Society at the Combined Otolaryngology Spring Meetings (COSM), a respected senior otolaryngologist in charge of a residency program, essentially told the audience that the ENT physician shortage in the United States was directly attributable to the presence of women in our field, who, naturally and/or by his reckoning, work less. The late, brave Dr Linda Brodsky stood up at the microphone that time and told off the speaker and the leaders of Trio for propagating this nonsense. I remember us senior women counseling a large group of younger women outside the room who were horrified and felt entirely unwelcome in that Society, of which I am a proud member as well. I imagine that the senior women had heard such sentiments so often that, hurtful though they were, were not permitted to penetrate our psyches.

In June 2003, the Association of American Medical Colleges Executive Council adopted the use of the term "underrepresented in medicine (UIM), which is different from society's underrepresented minority (URM)."[2] The Association of American Medical Colleges states, "'Underrepresented in medicine' means those racial and ethnic populations that are underrepresented in the medical profession relative to their numbers in the general population." Why is it important for women and other UIM to be seen at the podium as moderators, panelists, and invited lecturers? Because that status provides the society's imprimatur on those individuals as leaders. Having

only white men up there sends a strong message that nonwhite, nonmales are welcome only to learn and not to teach.

In 2017, the ANS membership survey[3] revealed that 10% of the society's membership was female, with a median female membership year of 2011 versus 1995 for men. Women make up 30% of ANS's Young Members Group. Membership in ANS is possible after being 5 years out of neurotology training and taking the board examination in neurotology. This means that in 2018 the median woman neurotologist is 7 to 12 or more years out of training and at the peak of her clinical and academic productivity. In 2007, the ratio of men to women members was 18 to 1; in 2017, it was 9 to 1. In the history of the ANS, 2 women have served as secretary-treasurer, and they both went on to be president; 19 men have been secretary-treasurer, and 47 have been president. Since 2002, committee chairships have been held by 29 men and 2 women. Just as with the men, nearly all women physicians in the ANS perform otologic and lateral skull base surgery.

Nine percent of the active membership of AOS, the more "senior" of the 2 societies, is female. There have been 25 male secretary-treasurers of AOS; the current one is the first woman to hold that position. There have been 120 presidents of the AOS. The first woman president served in 2001, the second in 2016, and the third holds the office currently. There have been 2 presidents of Hispanic heritage; the remainder have been white. Similar to our male colleagues, all women physicians in the AOS perform otologic surgery, with rare exceptions. We are not the "medical" (read "tinnitus, dizziness, sensorineural hearing loss, education") arm of our societies or our profession.

To clarify the representation of women and other UIM at meetings of the AOS and ANS, I assessed the makeup of the invited lecturers and panels. Free papers are chosen on merit and should not carry potential for discrimination. Invited and/or named lecturers are chosen by the president of the society with input from other leaders. Panels are a way to highlight present and future key opinion leaders in any field. Panel topics and moderators are chosen by the leadership/program committee; moderators are asked to choose their panelists. I recall being at an ANS program committee meeting when the only other woman member presented a thoroughly thought-out and well-crafted idea for a panel, addressing educational needs expressed by the membership. Once we decided to proceed with that idea, the chair looked around the table and asked who should moderate it and another member of the committee immediately volunteered himself. When I pointed out that it was HER idea and SHE should be the moderator, the "compromise" reached was comoderation by both of them. It is clear, therefore, that this process may permit the exercise of both conscious and unconscious bias in the selection of speakers. What has the recent history of our society meetings been? Well, not good, in terms of diversity. Here are some facts and figures.

THE AMERICAN OTOLOGICAL SOCIETY

From 1993 to 2018 there were 44 invited and/or named lecturers. Two of the 26 guest of honor (GOH) lectures were delivered by women. The first was in 1999 and was a basic science talk given by a PhD. The second occurred just this year, delivered by an MD, PhD surgeon. Of these 26 GOH lectures, 2 were delivered by a speaker of Hispanic heritage, 1 by a speaker of Asian heritage, and the rest were delivered by whites. Twenty-three of the 26 GOH lectures have been given by otologic surgeons; the remainder were by PhDs. Of the MD lecturers, 19 of the 22 men had "only" an MD degree. The other 3 men and the 1 woman surgeon GOH lecturers held both MD and PhD degrees. This is shown in **Fig. 1**.

There have been 18 basic science lecturers at the AOS meetings, from 2006 onward, with a new category, the Clinician-Scientist Award Lecture, added in 2018. In

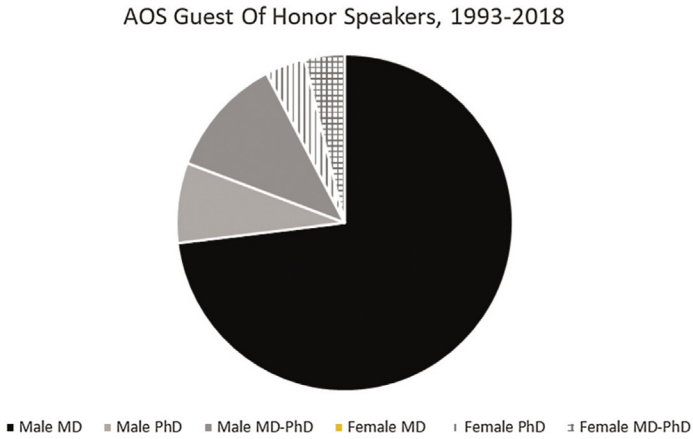

Fig. 1. AOS guest of honor speakers, 1993 to 2018. There have been 2 female speakers: 1 PhD and 1 MD-PhD. There have been no female speakers who hold only an MD. There have been 19 male speakers with only an MD, 2 male PhDs, and 3 male MD-PhDs.

2015, the Basic Science Lecture was renamed the Saumil N. Merchant Memorial Lecture, after the untimely death of our well-respected and well-beloved colleague, who happened to be Indian-American. Of these 18 individuals, 2 were women, 1 with a PhD and 1 with an MD. The PhD shared billing on her talk with 2 other (male) presenters, a PhD and an MD. That male MD has the distinct honor of being the only person to have been invited to give 2 different AOS Basic Science/Merchant lectures, 12 years apart, and is also the only non-white to have been invited: he is an Asian American. The one woman MD invited to give an AOS basic science talk did so in 2012.

Panel composition at AOS meetings was reviewed for 2010 to 2018. In this period, there were 14 panel moderators, 8 men and 1 woman on surgical topics and 4 men and 1 woman on nonsurgical topics. There were 28 men and 8 women MD panelists on surgical topics and 8 men and 4 women MD panelists on nonsurgical topics. Three non-MD men and 3 non-MD women served as panelists. There were a total of 3 Hispanic and African American individuals as moderators or panelists. The non-white group that had more prominent representation was Asian American, including both East and South Asians.

THE AMERICAN NEUROTOLOGY SOCIETY

The programs of the 2 meetings per year for the ANS were reviewed from 2010 to 2018 (spring meeting only for 2018). Of the 9 William F. House Memorial Lecturers, the 2011 lecturer was a woman. Of the 7 William E. Hitselberger Memorial Lecturers, the 2013 lecturer was a woman, a PhD. Of the 7 Franklin M. Rizer Memorial Lecturers, 2 were women and both were PhDs. This results in only 4 of 23 invited speakers in the past 8 years being women, and, in a surgical society in which 10% of the membership is female (and in a country in which 50% of the population is female), only 1 of 23 (4%) named lecture speakers was a woman.

Because the ANS has 2 meetings per year, there are a larger number of ANS than AOS panels. In the same 8-year period from 2010 to 2018, men were moderators for 22 surgical and 12 nonsurgical panels, and women were moderators for 4 and 8, respectively. For the surgical topics, 88 panelists were male MDs, 3 were male non-MDs, and 6 were female MDs. For the nonsurgical topics, 31 panelists were male

MDs (one of whom was not an otologist), 6 were male non-MDs, 5 were female MD otologists, 2 were female non-MDs, and 1 was a female non-otologist MD. Of note, 6 panels had 5 or more panelists (not including the moderators, who were all male) in which all panelists were men. Five of these panels were on surgical topics. One additional panel of 6 had the only woman on the panel giving one of the only 2 nonsurgical talks. The infrequent female moderator was only more likely than the men to have selected women panelists for the nonsurgical panels.

The panels presented at ANS (spring and fall) number a total of 47 since 2010. One was the combined AOS-ANS panel on superior semicircular canal dehiscence that was discussed previously. Of the remaining 46 panels, 12 were moderated by a woman neurotologist, either solely or shared with a man. One male moderator is of African American heritage; 3 of the women are of Asian heritage (2 were the same woman: me). Twenty-six panels were surgical either in part or in toto. One of those was moderated by a woman and 3 more had both a male and female moderator. One surgical session included in the panel count comoderated by a woman was a Fellows Surgical Video competition and, therefore, although it was surgical in nature, it was primarily about education. Of the 12 panels comoderated or moderated by a woman, 8 were on nonsurgical topics, including vestibular disorders, health care reform, pediatric unilateral hearing loss, and pediatric vertigo and tinnitus.

The panel data from both societies have been combined in **Fig. 2**. The data are clear that not only are women and other UIM not asked to moderate or serve on panels at anything approaching an equitable rate, the women in particular are assigned nonsurgical topics. This propagates the wrong assumption that women neurotologists are somehow the medical/educational branch of our field.

What are the downsides of excluding women from the podium? The ramifications are extensive. First, for the woman, it is disheartening to say the least when she works hard, produces science, and develops her expertise but is consistently overlooked for men who often have not achieved as much. Failure to recognize women (and people of color) in this manner prevents them from being considered key opinion leaders. This

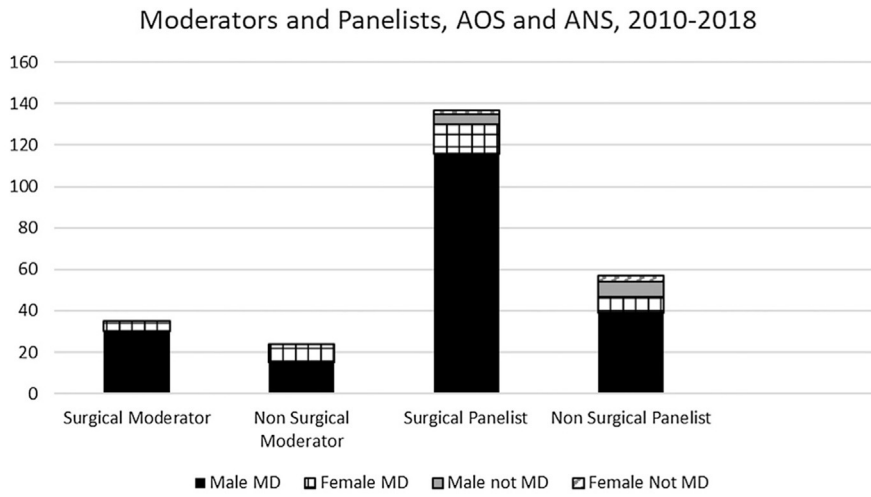

Fig. 2. Moderators and panelists, by sex and by degree, AOS and ANS, 2010 to 2018. "Surgical" means moderating or serving on a surgical panel; "nonsurgical" means moderating or serving on a nonsurgical panel. "Not MD" panelists held a variety of PhD degrees.

translates directly to less research[4,5] or consultant[6] funding, and a stunning drop in likelihood of them being considered for departmental chair or other leadership positions. This problem of underrepresentation of women at scientific meetings is, of course, not limited to our field.[7] Exclusion of women and people of color sends a clear message to those in practice and to trainees: "You are not welcome here as a teacher or full colleague. You may pay the entrance fee and sit there to learn from the worthy ones."

An argument I hear often, even in 2018, is that women are focused on children and family life. Luckily for society, many of us are raising wonderful families AND running busy surgical practices AND doing game-changing research AND writing papers. We are also disproportionately handed the uncompensated burden (pleasant though it may be, it is a burden of time, energy, and money) of educating the residents and medical students.[8] There are data to show that academic productivity of many women lags for a short while during the most intense periods of childbirth and early child rearing but catches up and surpasses that of men later.[9] Discounting a woman's potential early on is a huge cause of the leak, nay, water main break, from the academic pipeline. Societal data[10] show that low-income women lose 4% of their income per child and high-income women lose 10% of their income per child, whereas men gain at least 6% per child. So not only are we discounted professionally, we are penalized financially. Many women in surgical fields therefore chose not to have families. Those of us who made the choice to have children did so knowing the barriers we would face.

So, let's get back to that Fall 2017 microphone. Earlier in the day, in my role as immediate past president, I had raised the subject of manels at the American Academy of Otolaryngology-Head and Neck Surgery (AAO-HNS) Board of Directors meeting, and the board of directors decided to add language regarding sex and URM status on the program applications for the annual meeting from 2018 and going forward. One of my male colleagues, now newly attuned to manels, texted me to get into the ANS to see what he saw, cognizant now for the first time. The women in the ANS room had each other's email addresses in a single email thread, because we had had a networking event the evening before. If that meeting was in a movie or TV show, the rest of the attendees would have seen email bubbles rising up from all over the room. "What is this?!?" "Why only men?!?" "What the heck?!?" (and other unprintable expletives). One of the women texted the ANS Administrator that something was wrong with the panel. I typed in, with a picture of the manel, "If you're at ANS and this bothers you, make sure you note it on your evaluation form. #NoMoreManels." This oft-trending hashtag on Twitter was supported by others. The more I sat there, the more the panel went on, the more I realized that it has been more than 2 decades of me providing this same feedback (an observation echoed by at least one other woman on the thread) and here I was, in 2017, watching EIGHT men on a manel, seeing the 1 woman surgeon relegated to a nonsurgical topic, and seeing only 2 Asian American UIM and NO people from URM on the podium at all. Channeling my inner Linda Brodsky, buffeted by the power of my sisters in the room and my seniority in our field, I summoned the power that got me up to the microphone that day.

My words at that microphone gave voice to the unfairness I have witnessed since 1988. Back then, all of the women attending ANS and AOS could have fit into a Volkswagen Beetle and driven off into the sunset together. We didn't. Our numbers have grown. We have been welcomed by our colleagues, but only to a certain extent. After I spoke up, 2 otherwise rational male colleagues approached me and asked if there were any qualified women members of the ANS who could have been invited on the panel, and if we actually do skull base surgery. Yes, and yes. The membership process is the same for all of us.

I am proud to say that the leadership of our societies, both ANS and AOS, have answered the clarion call. Both societies' councils worked on the diversity resolution that is now an integral part of the mission statement of each society. We all owe a debt of gratitude to Dr Roberto Cueva, president of AOS, for drafting the statement, to Dr Moises Arriaga, president of the ANS, and to the councils of each society for fine-tuning and approving the statement, ensuring that it conveys the importance of inclusion and diversity on every single program to our membership and to our future.

Both unconscious and overt biases are difficult to identify and even more difficult to eliminate.[11] I commend the leadership of our societies, both AOS and ANS, for hearing my words, no matter how unpleasant my words made them feel, and for acting in a deliberate manner to eliminate bias from our programs and enable all of our members to have the same opportunities to shine. After the actions of the AAO-HNS, the AOS, and the ANS, similar actions have been taken by many of our sister societies in otolaryngology. As we turn the page to a more egalitarian tomorrow, I am proud to be part of these groups that are leading the way.

DISCLOSURE

The author has nothing to disclose.

REFERENCES

1. Sherwood J. On the radar: manel. Oxford Dictionary Blog. Available at: https://blog.oxforddictionaries.com/2017/07/05/on-the-radar-manel/. Accessed October 1, 2018.
2. AAMC Executive Council. The status of the new AAMC definition of "underrepresented in medicine" following the Supreme Court's decision in Grutter. Available at: https://www.aamc.org/download/54278/data/urm.pdf-. Accessed October 1, 2018.
3. Toh E, Angeli S, Cosetti M, et al. ANS inclusion and diversity initiative. St. Petersburg (FL): American Neurotology Society; 2018.
4. Eloy JA, Svider PF, Kovalerchik O, et al. Gender differences in successful NIH grant funding in otolaryngology. Otolaryngol Head Neck Surg 2013;149:77–83.
5. Lennon CJ, Hunter JB, Mistry AM, et al. NIH funding within otolaryngology: 2005-2014. Otolaryngol Head Neck Surg 2017;157:774–80.
6. Eloy JA, Bobian M, Svider PF, et al. Association of gender with financial relationships between industry and academic otolaryngologists. JAMA Otolaryngol Head Neck Surg 2017;143:796–802.
7. Kalejta RF, Palmenberg AC. Gender parity trends for invited speakers at four prominent virology conference series. J Virol 2017;91: e00739–17.
8. Willett LL, Halvorsen AJ, McDonald FS, et al. Gender differences in salary of internal medicine residency directors: a national survey. Am J Med 2015;128:659–65.
9. Eloy JA, Svider P, Chandrasekhar SS, et al. Gender disparities in scholarly productivity within academic otolaryngology departments. Otolaryngol Head Neck Surg 2013;148:215–22.
10. England P, Bearak J, Budig MJ, et al. Do highly paid, highly skilled women experience the largest motherhood penalty? Am Sociol Rev 2016;81:1161–89.
11. Koch AJ, D'Mello SD, Sackett PR. A meta-analysis of gender stereotypes and bias in experimental simulations of employment decision making. J Appl Psychol 2015;100:128–61.