Trauma Surgery & Acute Care Open

Voices of the Trauma Bay

Manuela Ochoa

Surgery, UT Southwestern, Dallas, Texas, USA

Correspondence to
Dr. Manuela Ochoa; manuela.ochoa@phhs.org

Received 16 November 2020
Accepted 2 February 2021

► http://dx.doi.org/10.1136/tsaco-2020-000644
► http://dx.doi.org/10.1136/tsaco-2020-000647
► http://dx.doi.org/10.1136/tsaco-2020-000650
► http://dx.doi.org/10.1136/tsaco-2021-000700

© Author(s) (or their employer(s)) 2021. Re-use permitted under CC BY-NC. No commercial re-use. See rights and permissions. Published by BMJ.

To cite: Ochoa M. *Trauma Surg Acute Care Open* 2021;**6**:e000646.

Essay Contest II: How can diversity, equity, and inclusion be improved in acute care surgery/the AAST?

I looked around the room in disbelief: "There are only three of us?" I ran the numbers in my head. Yes, only three Hispanic residents in the largest surgery program in the United States and one which actively pursues diversity. I thought of the times I interviewed around the country; there were very few of us. I wondered, why aren't we here to serve each other? I found it both surprising and disappointing given that such a vast percentage of our patients are Hispanic, many of them with very limited medical literacy, and often times no knowledge of the English language. I thought about my encounters with them—the surprise followed by a smile, then the sigh of relief—that is the intangible, invaluable connection created when I walk into the room speaking Spanish to my patients. It is the understanding that their voices will be heard.

Cultural, language, and access barriers are part of a tremendous public health problem that widens health disparities among minorities. Even in trauma care, differential outcomes have been identified despite universal access to emergent care protected by the Emergency Medical Treatment and Labor Act (EMTALA). The American Health Association Annual Survey has shown that counties with a greater percentage of Hispanic, Black, uninsured, and low-education individuals disproportionately lack access to emergency surgical care. Some studies have even shown higher odds of mortality for minorities, with our Black population facing the greatest toll.[1 2] In addition, according to the AHRQ 2018 National Healthcare Quality and Disparities Report, the highest percentage of uninsured patients are Hispanic, with approximately 27% of the Hispanic population being uninsured.[3]

As a member of an under-represented minority in medicine, I have the duty to represent my community and act to foster inclusion and equity for other minorities as well. This is not only because I feel responsible for helping my "own" but because I am also part of the systemic racism responsible for health disparities due to my own intrinsic biases. I often think about a Black male patient I once met in a trauma bay who died despite our best efforts. I remember looking at him as I closed his thoracotomy wondering how he had ended up in my hands, assuming perhaps it was the result of street violence. The next day, I read in the news that he had been shot by a police officer who mistakenly entered his apartment. I often wonder if the outcome would have been different if he had not been Black, if the odds were stacked against him from the very start, if perhaps he fell victim to the swiss cheese model of error that often plagues our misconceptions. I have learned more about racism, microaggressions, and biases in the past few months than I have over my lifetime. These are sometimes grossly obvious deviations, but usually only subtle "stabs" at ethnicity, culture, and language. I am responsible for recognizing them in myself and others and acting to dissipate them. Trauma care is where these can matter the most, as quick decisions are frequently made by instinct.

Diversity, equity, and inclusion matter because healthcare disparities are perhaps now more visible than ever. Acute Care Surgery and Trauma have become the center of many public health and safety catastrophes—most recently with COVID-19 as Critical Care physicians become frontline providers and head of COVID-19 units, as well as with increases in structural violence in recent months. In many ways, we are in a critical, essential position to address these complex problems. How are Acute Care surgeons in a position to help? Trauma surgeons are the sentinel—seeing the sickest, the frail, the underserved, and the uninsured, and treating all without the barriers that often burden other disciplines. This is where I want to be: in the epicenter, intimately involved in direct patient care looking through the microscope, while still being able to appreciate the larger, multifactorial issues with a bird's eye view.

The American Association for the Surgery of Trauma (AAST) can play a pivotal role in mitigating healthcare disparities. One important way is through inclusion by welcoming and actively promoting diversity within its membership and leadership. Moreover, the AAST can help advocate for language training and cultural competence in trauma scenarios, as well as research and education on health disparities in Acute Care Surgery. In addition, we must make resources available to underrepresented minorities who often face more obstacles to success and representation in medicine. This can be accomplished through mentorship opportunities and scholarships for minorities interested in Acute Care Surgery. Finally, as trauma is increasingly becoming the leading focus of research in global surgery, supporting the study of inequities in access to care and health literacy abroad is an excellent example of how the AAST can promote equity on a global scale.

The goal is to best serve our trauma patients. At their sickest and most scared, they are looking for a familiar face, for someone to

Trauma Surg Acute Care Open: first published as 10.1136/tsaco-2020-000646 on 31 March 2021. Downloaded from http://tsaco.bmj.com/ on January 25, 2022 by guest. Protected by copyright.

understand and be their voice when they cannot be heard. This is the place of a trauma surgeon, often the only surgeon the most vulnerable, uninsured populations can access. My hope is that with more inclusive representation and targeted language and cultural training, we will not be forced to go through a dimensionless phone-based interpreter or third party. We can work to create better understanding and connection through diversity, equity and inclusion. Only then will we be able to provide the same surgical care for all. Following the mission of the AAST's Inclusion and Diversity Ad Hoc Committee, we can work together to promote advocacy, education, and access to those that are underserved.

Contributors MO is the author of this essay.

Funding The authors have not declared a specific grant for this research from any funding agency in the public, commercial or not-for-profit sectors.

Competing interests None declared.

Patient consent for publication Not required.

Provenance and peer review Commissioned; internally peer reviewed.

Open access This is an open access article distributed in accordance with the Creative Commons Attribution Non Commercial (CC BY-NC 4.0) license, which permits others to distribute, remix, adapt, build upon this work non-commercially, and license their derivative works on different terms, provided the original work is properly cited, appropriate credit is given, any changes made indicated, and the use is non-commercial. See: http://creativecommons.org/licenses/by-nc/4.0/.

ORCID iD
Manuela Ochoa http://orcid.org/0000-0001-8506-588X

REFERENCES

1 Khubchandani JA, Shen C, Ayturk D, Kiefe CI, Santry HP. Disparities in access to emergency general surgery care in the United States. *Surgery* 2018;163:243–50.
2 Haider AH, Weygandt PL, Bentley JM, Monn MF, Rehman KA, Zarzaur BL, Crandall ML, Cornwell EE, Cooper LA. Disparities in trauma care and outcomes in the United States: a systematic review and meta-analysis. *J Trauma Acute Care Surg* 2013;74:1195–205.
3 Agency for Healthcare Research and Quality. 2018 National healthcare quality and disparities report. Content last reviewed April. 2020. https://www.ahrq.gov/research/findings/nhqrdr/nhqdr18/index.html.

Trauma Surg Acute Care Open: first published as 10.1136/tsaco-2020-000646 on 31 March 2021. Downloaded from http://tsaco.bmj.com/ on January 25, 2022 by guest. Protected by copyright.