the policy transparent, thereby allowing for more effective public debate.

Moving sex designations below the line of demarcation may not solve many of the problems that transgender and intersex people face. Controversies regarding bathrooms, locker rooms, and sports participation will continue, regardless of legal sex designations. Still, updating the process for reporting sex on birth certificates could be an effective first step.[1] Even if the government retains a dichotomous sex-classification system, the system would be based on self-identification at an older age, rather than on a medical evaluation at birth.

Many states now permit changes to sex designations on birth certificates, and some allow a third sex designation, "X." Since most people with intersex variations identify as a man or a woman, allowing a third option to be assigned at birth could prove problematic. In most states, amending a birth certificate is very burdensome; only 9% of transgender people who want to update their gender on the document succeed in doing so.[3] Some states reissue birth certificates on which original sex designations remain discernible.

Some intersex and transgender people benefit from the validation that changing a sex marker offers, but people could still have this opportunity if governments permitted optional sex designations on various identification cards. Leaving any sex designation visible on birth certificates sacrifices privacy and exposes people to discrimination.

In 1903, the American Medical Association defined the health care profession's duty to maintain the accuracy of vital statistics. Today, the medical community has a duty to ensure that policymakers don't misinterpret the science regarding sex and that medical evaluations aren't being misused in legal contexts. To protect all people, birth-certificate sex designations should be moved below the line of demarcation.

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Interviewed while Black

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Inside a conference room with a long wooden table, a Black residency applicant sat next to 12 other applicants on interview day. None of their peers were Black. Across the table hung photos of faculty members, including the program director, medical director, and department chair. None were Black. In the corner of the room, administrators and coordinators were monitoring the agenda. None were Black. Rosters with descriptions and headshots of the faculty interviewers were distributed. None were Black. Later, residents spoke to applicants over lunch, and nurses sat at their workstations during the tour. None were Black.

During the course of the interview day, the Black applicant was asked whether they were lost and twice was assumed to be anyone but an applicant. They were told that they had an unusual name and that they were articulate. Their hair was critiqued.

At the end of the interview, the Black applicant wondered, "Do I fit in here?"

We believe it is time to critically discuss the ways in which various aspects of the interview day affect Black applicants at the student, resident, fellow, and faculty level. Although the application process involves many components, the interview day is a concrete opportunity to determine compatibility between the applicant and the program. According to the 2018 National Resident Matching Program survey, the factors considered by the most program directors to be important for ranking applicants were "interactions with faculty during interview and visit" (96%), "interpersonal skills" (95%), and "interactions with house staff during interview and visit" (91%). There are private consultants, textbooks, online resources, and workshops to help applicants improve their interviewing skills

Concepts and Experiences of Black Applicants during Interviews.

Concept	Verbal Example	Nonverbal Example	Implication
Microaggression	A faculty member asks a Black applicant, "Did you play any sports in college?" after seeing that the applicant attended an Ivy League university.	Despite the Black applicant repeatedly being the first applicant to raise their hand, other applicants are called on first to ask questions each time.	The applicant feels their academic potential has been invalidated and dismissed.
Stereotype threat	When an interviewer mentions, "affirmative action facilitates recruitment of faculty from groups that are underrepresented in medicine," the Black applicant struggles to promote their own accomplishments.	During a slideshow, photographs of Black faculty members are featured only on the diversity and inclusion page. The Black applicant now feels less comfortable discussing interests in technology.	The Black applicant recognizes stereotypes portrayed (reliance on affirmative action, interests in diversity and inclusion); this causes the applicant to perform less well during the interview day.
Tokenism	During an interview, a faculty member states, "We are specifically looking for diversity. We don't want our team to be just a bunch of White males."	The Black applicant is given pamphlets about the diversity and inclusion office in interview-day folders. Other applicants don't receive the same information.	The Black applicant is made to feel like a metric instead of a colleague.
Imposter syndrome	The interviewer inadvertently mentions the accomplishments of another applicant, who is in fact just as qualified as the Black applicant. The Black applicant immediately feels as if they don't belong.	A successful Black applicant grows nervous looking at the awards and certificates hanging on an interviewer's office wall.	A competitive Black applicant doubts their qualifications for the interview and opportunity. Subsequently, the applicant comes off as nervous and insecure during the interview.
Homophily	During an interview, the applicants comment and connect on similar hobbies and lived experiences that the Black applicant does not share.	During the interview lunch, the Black applicant notices that the White faculty spend more time with the White applicants. The two Black applicants eat together.	The Black applicant anticipates a potential barrier to socializing with others in the program.

and help programs maximize the success of their recruitment efforts. Despite the resources available for interview preparation, there is substantial explicit and implicit bias in application processes that favors White applicants. This bias, combined with the importance of the interview day, makes it necessary to explore experiences of being interviewed while Black.

Five percent of physicians and 7.3% of medical students who matriculated in the 2019–2020 school year were Black, despite the fact that Black people make up 13.4% of the U.S. population. In 2019, the Accreditation Council for Graduate Medical Education released a statement prioritizing the recruitment and training of members of racial and ethnic groups that are underrepresented in medicine. Although there are many concerns that broadly affect Black people in medicine, such as institutional racism and inequality of educational opportunities, the experiences of Black interviewees in particular remain underaddressed. Being interviewed while Black involves a collision of microaggressions and feelings and experiences related to stereotype threat, tokenism, imposter syndrome, and homophily (see table). Many of these experiences are rooted in unconscious bias, whereas some can be born from overt racism. In turn, Black interviewees collect impressions that make them doubt that they will be welcomed and valued in medicine.

Black students have reported experiencing microaggressions — behaviors, comments, or questions that are intentionally or unintentionally hostile or demeaning — during medical training.[1] In one study, more than half of medical students reported experiencing microaggressions.[1] The effect of microaggressions on applicant performance is profound, and such experiences can adversely affect the Black applicant's chances of matriculating to a program or being hired in a department. During an interview, microaggressions can occur when comments and behaviors are grounded in biases, racism, or stereotypes.

The experience or fear of being stereotyped can undermine a Black applicant's ability to perform during an interview. Stereotype threat was defined by Claude Steele and Joshua Aronson in 1995 as "being at risk of confirming, as self-characteristic, a negative stereotype about one's group." In landmark research, Steele and Aronson demonstrated that Black participants performed worse than White participants

during a test when they believed that they were at risk for fulfilling stereotypes about Black people's intellectual abilities. When that stereotype threat was removed, Black participants performed similarly to their White counterparts. Stereotype threat has been found to be present in medicine. In a 2020 study of medical students, 82% of Black respondents had high scores on a measure of vulnerability to stereotype threat, as compared with 4% of White respondents.[2] When Black applicants see photographs of only non-Black graduates on the walls, they may perceive the threat of a negative stereotype, such as "Black people are not smart," and perform worse than expected.

Another challenge facing Black interviewees is imposter syndrome. In 1978, Pauline Clance described imposter syndrome as an "internal experience of intellectual phoniness in people who believe that they are not intelligent, capable or creative despite evidence of high achievement." Studies have revealed feelings of imposter syndrome in up to 82% of students, with minorities and women reporting such feelings at higher rates than White men.[3] Imposter syndrome can cause qualified Black applicants to feel unqualified and isolated.

A sense of isolation can lead Black applicants, who often interview without any other Black applicants present, to question the sincerity of their recruitment and interview opportunity. Tokenism entails making cursory strides toward diversity and inclusion. The recruitment of Black candidates merely to achieve a metric undermines the applicant's academic value and dismisses the difficulty associated with navigating medicine as a member of an underrepresented minority group. Awareness of tokenism and of the ways in which it can lead to depression, burnout, attrition, and a minority tax — extra responsibility placed on underrepresented minorities with a goal of achieving diversity — is warranted as early as interview day.[4] A clear demonstration of efforts to recruit, retain, support, and promote Black applicants better illustrates dedication to diversity in medicine.

Finally, it is widely recognized that people tend to associate with and gravitate toward others who have backgrounds and interests that are similar to their own.[5] This phenomenon, called homophily, drives much of Black applicants' discomfort and isolation. The concept of homophily was popularized by Paul Lazarsfeld and Robert Merton in 1954. Although the tendency to socialize with people like oneself creates opportunities for positive, lasting relationships, homophily can lead to applicants being excluded on the basis of differences.

The academic world is often isolating for and unwelcoming to Black applicants, and this lack of inclusion is compounded for Black women, Black immigrants, and Black lesbian, gay, bisexual, transgender, and queer applicants. Leaders in academic medicine must be cognizant of the identities of Black applicants, since they are not a monolithic group; they have individual identities and experiences associated with varying degrees of oppression and discrimination.

During the Covid-19 pandemic, as programs and departments have transitioned to video interviews, many people have discussed the potential effects of bias on applicants from underrepresented groups. It is unrealistic to expect deeply ingrained unconscious bias and systemic racism to be eliminated by a switch to virtual interviews.

Several strategies could improve the interview experiences of Black applicants. First, academic leaders must accept that inequitable treatment of Black applicants exists and will take time to correct. Second, everyone involved in the interview process from host institutions should be educated about microaggressions, stereotype threat, and other challenges and biases that disadvantage Black applicants. We recommend bystander and upstander training to prepare people to act when they witness discrimination, bias, or racism. Third, we favor careful and fair recruitment of diverse interviewers to create a welcoming environment. We also suggest incorporating work related to diversity and inclusion when describing the mission and values of the program or institution. On a wider scale, we recommend the creation of institutional databases — or, ideally, a national database — where applicants can report experiences of racism or bias while interviewing, which would be aggregated to protect their identity. Improving the experiences of Black applicants will be a first step toward increasing the diversity of programs and subsequently addressing the unmet needs of the diverse patient populations they serve.

During this interview cycle, there will be no conference room with a long wooden table. We still challenge programs to address the concerns of the Black applicant who wonders, "Do I fit in here?"

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The Caregiver

Arjun Gupta, M.D.

"This is going to be an *EGFR* or *ALK*!" I tell my cofellow after hearing about a new consult. It's been a busy few weeks, and a Friday evening consult would generally elicit a sigh. But this time is different. Almost a year into an oncology fellowship, we can spot the "good" consults quickly. We know certain tumors have molecular alterations and can be treated with targeted pills. We love caring for all patients, but a chance to avoid intravenous chemotherapy — no protruding catheters, no 2-day infusions, no weekly blood tests — seems especially gratifying. This consult sounds like a textbook case: a young never-smoker with metastatic lung cancer. If this were a board-exam question, we'd confidently answer, "Test for molecular targets." *EGFR* and *ALK* are such targets.

I go see the patient, Ron. He's lying still — the slightest movement makes him dizzy. His wife, Lara, is at the bedside, one hand on her husband's shoulder, the other whizzing over her phone, updating anxious family members. I introduce myself, and we chat. Ron is a previously healthy triathlete. He presented to the hospital reporting a few weeks of headaches and taste changes, expecting to get antibiotics for an infected tooth. But scans revealed cancer that had spread to his brain. I also learn that he's a Formula One racing fan.

On examination, I find hard supraclavicular lymph nodes. He's quite debilitated. We discuss next steps, including molecular testing. I explain that we may be able to treat him with a pill. Lara listens intently. She has a sage-like calm that I can't initially place; I later discover that she recently underwent cancer treatment herself. We schedule a clinic visit in 2 weeks, when the molecular test results should be back.

Three days before our appointment, tests confirm an *EGFR* mutation. I excitedly review the literature. The pace of drug development invigorates me — there have been several advances in the past decade. A few months ago, a more potent drug with superior brain penetration, osimertinib, was approved. We meet in the clinic and discuss this new drug — Lara has already read up on it. Ron is largely passive; he can hardly speak or hear. As we wrap up, Lara and I decide to communicate by email rather than the clunkier patient portal.

We have a frustrating time obtaining insurance approval for osimertinib. Our team twice appeals denials. Five days pass. Lara tweets at the insurance company, and we have clearance within hours. She emails, "Squeaky wheels sometimes get the car out of the ditch." I don't quite understand the idiom, but it sounds impressive. I thank her. She adds, "Happy to help advocate for other patients. Anytime."

Ron begins taking the osimertinib. I await an email indicating improvement — perhaps a spurt of energy, a regressing lymph node, or returning appetite. Instead, Lara writes, "Even brushing his teeth sets him back for a few hours. We are struggling."

We schedule an urgent appointment. Lara wheels her husband in. A proud athlete, he tries to stand up when I enter the room. Unsteady, he promptly falls back. Noticing his Formula One cap, I mention the latest race — Lewis Hamilton is snatching the championship from Sebastian Vettel. Ron smiles only weakly. We move on to medicine — there is much to unravel.

He's taking the steroids as prescribed, but his right calf is swollen. We find a nasty blood clot and discuss an injectable blood thinner. "How big is this needle?" he asks; he tries to sound casual, but his expression betrays his fear of needles. Lara comforts him and volunteers to