Diversity and Inclusion in Graduate Medical Education

William McDade, MD, PhD
Chief Diversity and Inclusion Officer
Accreditation Council for Graduate Medical Education
Disclosures

Employee of ACGME

Receive stipend from the American Medical Association as a trustee
ACGME Planning Committee for Diversity in GME

First meeting 2.19.2018
  Approved Charge
  Discussed the complexity of the problem
  Divided in to Subgroups
    Data
    Pipeline and Recruitment
    Retention, Well-being, Faculty Development
  ACGME as Convener and Partner

Obtained Initial Literature Review
Looked at early ACGME data on retention of diverse candidates
ACGME Planning Committee for Diversity in GME

William McDade, Chair
Donald Brady, ACGME Board
Nolan Kagestu
Adonteng Kwakye, Resident
Thomas Nasca, ACGME CEO
David Kountz
Frantz Duffoo
Renee Navarro

Edith Mitchell, ACGME Board
Sunny Nakae
Mark Nivet
Maria Soto-Greene
Bonnie Simpson-Mason
Steven Bowman
Rowan Zetterman, ACGME Board
DeLonda Dowling ACGME
Tim Brigham, ACGME
Committee Charge

The planning committee will consider current practices in US graduate medical education focused on enhancing the clinical learning environment as it pertains to diversity inclusion.

Immediate focus of the committee will be to consider data regarding demographic diversity in residency and fellowship training with respect to specialty; and, then to determine where significant disparity presently exists so as to determine mechanisms to achieve more equitable access to training in those domains.

Assess the current data regarding the clinical learning environment as it pertains to experiences of diverse trainees so as to establish whether there are particular risks to learning and well-being for these individuals due to the nature of their treatment while in training.
Committee Charge

A final focus of the planning committee will be to assess how potential changes with respect to diversity in graduate medical education can be used to address health disparities in the US.
Committee’s Deliberations

Initial work divided the committee into workgroups identifying four key areas:
- Data
- Physician Pipeline and Admissions
- Retention and Well-being
- ACGME as convener

Met over the course of the 2018 four times with the final meeting on 9.4.2018

–Reviewed comments from ACS regarding data on resident withdrawals/dismissals and possible roles ACGME might play in addressing its findings

–Developed a series of that were unanimously passed by the Board on 9.28.2018
ACGME Office of Diversity and Inclusion

EVP Chief Academic Officer for Ochsner Health System
Professor University of Chicago (Associate Dean, Deputy Provost)
Board member
- ACGME - Former
- AMA
- Joint Commission

ACGME Names First Chief Diversity and Inclusion Officer

March 15, 2019

ACGME News

Today the Accreditation Council for Graduate Medical Education (ACGME) announced William A. McDade, MD, PhD as the organization’s first Chief Diversity and Inclusion Officer. Dr. McDade will lead the ACGME’s internal and external diversity and inclusion activities. He will focus on national initiatives to diversify and include underrepresented groups throughout the medical education continuum with the goal of providing physicians with the knowledge and skills required to serve the American public in humanistic environments where clinician and patient well-being is promoted.

“Dr. McDade is a distinguished leader in the medical community, and we are fortunate to have him on board as we continue to embrace opportunities to enhance diversity and develop inclusive environments where everyone is prepared to meet the needs of the patients we serve,” said Thomas J. Nasca, MD, MACP, ACGME president and chief executive officer.

“In order to train the next generation of physicians to be prepared to care for the American public, we must ensure that opportunities to train in all areas of medicine are open to diverse populations,” said Dr. McDade. “Additionally, the clinical learning environment must be safe and inclusive for all residents and fellows to afford the best possible means to achieve this.”
Review of the Common Program Requirements

Concurrent with the work of the Planning Committee, the Board was driving a review of its Common Program Requirements overall. This was mostly driven by Section VI and modification of the clinical and educational work hours, but included other areas of importance.

Three new program requirements in Sections I.C, V and VI.B.6 bear directly on areas identified by the Planning Committee.
Changes to ACGME Common Program Requirements effective July 1, 2019
New Program Requirement I.C.

I.C. The Program, in partnership with its Sponsoring Institution, must engage in practices that focus on mission-driven, ongoing, systematic recruitment and retention of a diverse workforce of residents, fellows (if present), faculty members, senior administrative staff members, and other relevant members of its academic community. (Core)
What entities does it affect?

Programs
Sponsoring Institutions
Who is the target of diversity?

Focused primarily on racial and ethnic underrepresented minority individuals but is inclusive of diversity across a broad range of categories including gender, orientation, religion, age, ability, national origin or ancestry, among others.

The mission of the ACGME is to improve health care and population health by assessing and advancing the quality of resident physicians' education through accreditation.

Focus is to provide a workforce that is consistent with accomplishing this mission.
AAMC’s Underrepresented in Medicine Definition (URiM)

On March 19, 2004, the AAMC Executive Committee adopted a clarification to its definition of "underrepresented in medicine"

The AAMC definition of underrepresented in medicine is:

"Underrepresented in medicine means those racial and ethnic populations that are underrepresented in the medical profession relative to their numbers in the general population."

Adopted by the AAMC's Executive Council on June 26, 2003, the definition helps medical schools accomplish three important objectives:

- a shift in focus from a fixed aggregation of four racial and ethnic groups to a continually evolving underlying reality. The definition accommodates including and removing underrepresented groups on the basis of changing demographics of society and the profession,

- a shift in focus from a national perspective to a regional or local perspective on underrepresentation

- a stimulation of data collection and reporting on the broad range of racial and ethnic self-descriptions.

Before June 26, 2003, the AAMC used the term "underrepresented minority (URM)," which consisted of Blacks, Mexican-Americans, Native Americans (that is, American Indians, Alaska Natives, and Native Hawaiians), and mainland Puerto Ricans. The AAMC remains committed to ensuring access to medical education and medicine-related careers for individuals from these four historically underrepresented racial/ethnic groups.
Student Body Racial and Ethnic Composition and Diversity-Related Outcomes in US Medical Schools

Sommath Saha, MD, MPH
Gretchen Gutin, PhD
Paul P. Wimmers, PhD
LuAnn Willerson, EdD

Most medical schools in the United States explicitly seek to engender diversity within their student bodies. Academic leaders assert that diversity within their classrooms creates a robust learning environment, exposes students to a broad array of ideas, experiences, and perspectives, and thereby better prepares them to meet the needs of a multicultural American populace. Among the many student characteristics medical schools consider in promoting diversity, race is perhaps the most contentious. Race-conscious policies and programs have been used to achieve racial diversity, and particularly to increase the numbers of black, Latino, and Native American individuals who are underrepresented in the physician workforce. In recent years, however, these policies have come under increasing scrutiny as

Context Many medical schools assert that a racially and ethnically diverse student body is an important element in educating physicians to meet the needs of a diverse society. However, there is limited evidence addressing the educational effects of student body racial diversity.

Objective To determine whether student body racial and ethnic diversity is associated with diversity-related outcomes among US medical students.

Design, Setting, and Participants A Web-based survey (Graduation Questionnaire) administered by the Association of American Medical Colleges of 20,112 graduating medical students (64% of all graduating students in 2003 and 2004) from 118 allopathic medical schools in the United States. Historically black and Puerto Rican medical schools were excluded.

Main Outcome Measures Students' self-rated preparedness to care for patients from other racial and ethnic backgrounds, attitudes about equity and access to care, and intent to practice in an underserved area.

Results White students within the highest quintile for student body racial and ethnic diversity, measured by the proportion of underrepresented minority (URM) students, were more likely to rate themselves as highly prepared to care for minority populations than those in the lowest diversity quintile (61.1% vs 55.9%, respectively; P < .001; adjusted odds ratio [OR], 1.33; 95% confidence interval [CI], 1.15-1.57). This association was strongest in schools in which students perceived a positive climate for intercultural interaction. White students in the highest URMS quintile were also more likely to have strong attitudes endorsing equitable access to care (54.8% vs 44.2%, respectively; P < .001; adjusted OR, 1.42; 95% CI, 1.15-1.74). For nonwhite students, after adjustment there were no significant associations between student body URMS proportions and diversity-related outcomes. Student body URMS proportions were not associated with white or nonwhite students' plans to practice in underserved communities, although URMS students were substantially more likely than white or nonwhite/non-URMS students to plan to serve the underserved (46.7% vs 18.8% vs 16.2%, respectively; P < .001).
Can Cultural Competency Reduce Racial and Ethnic Health Disparities?

- Interpreter services
- Recruitment and retention
- Training
- Coordinating with traditional healers
- Use of community health workers
- Culturally competent health promotion
- Including family and/or community members
- Immersion into another culture
- Administrative and organizational accommodations

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Cindy Brach
Irene Fraser
director
Agency for Healthcare Research and Quality

This article develops a conceptual model of cultural competency’s potential to reduce racial and ethnic health disparities, using the cultural competency and disparities literature to lay the foundation for the model and inform assessments of its validity. The authors identify nine major cultural competency techniques: interpreter services, recruitment and retention policies, training, coordinating with traditional healers, use of community health workers, culturally competent health promotion, including family/community members, immersion into another culture, and administrative and organizational accommodations. The conceptual model shows how these techniques could theoretically improve the ability of health systems and their clinicians to deliver appropriate services to diverse populations, thereby improving outcomes and reducing disparities. The authors conclude that while there is substantial research evidence to suggest that cultural competency should in fact work, health systems have little evidence about which cultural competency techniques are effective and less evidence on when and how to implement them properly.

Medical Care Research and Review, Vol. 57 Supplement 1, (November 2000) 181-217

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<table>
<thead>
<tr>
<th>Patient Characteristic</th>
<th>Millions of Patients With a White Physician</th>
<th>Millions of Patients With a Black Physician</th>
<th>Unadjusted Odds Ratio (95% CI)&lt;sup&gt;a&lt;/sup&gt;</th>
<th>Millions of Patients With a Hispanic Physician, No. (%)</th>
<th>Unadjusted Odds Ratio (95% CI)&lt;sup&gt;b&lt;/sup&gt;</th>
<th>Millions of Patients With an Asian Physician, No. (%)</th>
<th>Unadjusted Odds Ratio (95% CI)&lt;sup&gt;c&lt;/sup&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td>All patients</td>
<td>62.2 (100.0)</td>
<td>3.3 (100.0)</td>
<td>5.9 (100.0)</td>
<td>9.8 (100.0)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-Hispanic whites</td>
<td>53.2 (86.8)</td>
<td>1.1 (34.7)</td>
<td>2.4 (41.5)</td>
<td>5.2 (53.7)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Minorities</td>
<td>9.0 (13.2)</td>
<td>2.2 (65.3)</td>
<td>12.30 (8.30-18.00)</td>
<td>3.5 (58.5)</td>
<td>8.20 (5.98-11.23)</td>
<td>4.6 (46.3)</td>
<td>5.40 (4.16-6.99)</td>
</tr>
<tr>
<td>Black, non-Hispanic</td>
<td>4.1 (7.1)</td>
<td>1.9 (63.9)</td>
<td>23.24 (16.28-33.17)</td>
<td>0.5 (16.8)</td>
<td>2.65 (1.81-3.87)</td>
<td>1.0 (16.3)</td>
<td>2.56 (1.90-3.44)</td>
</tr>
<tr>
<td>Hispanic</td>
<td>3.1 (5.5)</td>
<td>0.1 (5.3)</td>
<td>0.96 (0.49-1.88)</td>
<td>2.7 (52.6)</td>
<td>19.04 (13.47-26.93)</td>
<td>1.1 (17.7)</td>
<td>3.68 (2.62-5.18)</td>
</tr>
<tr>
<td>Asian</td>
<td>0.9 (1.7)</td>
<td>0.1 (5.1)</td>
<td>3.06 (1.15-8.17)</td>
<td>0.3 (9.0)</td>
<td>5.63 (2.67-11.86)</td>
<td>2.3 (31.2)</td>
<td>25.73 (16.92-39.13)</td>
</tr>
<tr>
<td>Other</td>
<td>0.9 (1.7)</td>
<td>0.1 (7.4)</td>
<td>4.60 (1.78-11.94)</td>
<td>0.02 (1.1)</td>
<td>0.61 (0.17-2.15)</td>
<td>0.2 (3.8)</td>
<td>2.25 (1.19-4.25)</td>
</tr>
<tr>
<td>Income</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>High/middle</td>
<td>48.9 (78.5)</td>
<td>2.1 (64.5)</td>
<td>1 [Reference]</td>
<td>3.9 (65.5)</td>
<td>1 [Reference]</td>
<td>7.0 (70.9)</td>
<td>1 [Reference]</td>
</tr>
<tr>
<td>Low</td>
<td>13.4 (21.5)</td>
<td>1.2 (35.5)</td>
<td>2.03 (1.46-2.75)</td>
<td>2.1 (34.5)</td>
<td>1.92 (1.44-2.55)</td>
<td>2.8 (29.1)</td>
<td>1.49 (1.23-1.81)</td>
</tr>
<tr>
<td>Medicaid</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>None</td>
<td>54.8 (93.2)</td>
<td>2.5 (78.4)</td>
<td>1 [Reference]</td>
<td>4.4 (81.8)</td>
<td>1 [Reference]</td>
<td>7.9 (85.2)</td>
<td>1 [Reference]</td>
</tr>
<tr>
<td>Medicaid</td>
<td>4.0 (6.8)</td>
<td>0.7 (21.6)</td>
<td>3.75 (2.72-5.18)</td>
<td>1.0 (18.2)</td>
<td>3.04 (2.29-4.04)</td>
<td>1.4 (14.8)</td>
<td>2.38 (1.85-3.06)</td>
</tr>
<tr>
<td>Any health insurance</td>
<td>58.8 (94.3)</td>
<td>3.1 (95.2)</td>
<td>1 [Reference]</td>
<td>5.4 (90.1)</td>
<td>1 [Reference]</td>
<td>9.3 (94.0)</td>
<td>1 [Reference]</td>
</tr>
<tr>
<td>Uninsured</td>
<td>3.5 (5.7)</td>
<td>0.1 (4.8)</td>
<td>0.83 (0.49-1.41)</td>
<td>0.6 (9.9)</td>
<td>1.83 (1.30-2.57)</td>
<td>0.6 (6.0)</td>
<td>1.07 (0.78-1.47)</td>
</tr>
<tr>
<td>English home language</td>
<td>60.6 (97.3)</td>
<td>3.2 (96.8)</td>
<td>1 [Reference]</td>
<td>3.9 (66.7)</td>
<td>1 [Reference]</td>
<td>7.9 (80.4)</td>
<td>1 [Reference]</td>
</tr>
<tr>
<td>Non-English home language</td>
<td>1.7 (2.7)</td>
<td>0.1 (3.2)</td>
<td>1.18 (0.51-2.69)</td>
<td>2.1 (33.4)</td>
<td>17.83 (12.80-24.82)</td>
<td>1.9 (19.6)</td>
<td>8.69 (6.19-12.19)</td>
</tr>
</tbody>
</table>

<sup>a</sup> Odds of patients in a demographic group reporting a black physician relative to non-Hispanic white patients reporting a black physician.

<sup>b</sup> Odds of patients in a demographic group reporting a Hispanic physician.

<sup>c</sup> Odds of patients in a demographic group reporting an Asian physician relative to non-Hispanic white patients reporting an Asian physician.
Does a Workforce that Resembles the Population Improve Health Care?

Predicated on the argument that health care delivery is largely biased toward same-race care activities. Substantial evidence exists to show:

- Minority medical students report a greater desire to practice in minority and underserved communities
- Minority physicians tend to practice in minority and underserved communities
- Minority patients prefer minority physicians
  - Trust, respect, communication, self-advocacy
  - Intention to adhere
  - Patient satisfaction
  - Clinical Outcomes?

- Minority medical scholars tend to study problems that impact minority communities
Does Diversity Matter for Health?

Black subjects were more likely to talk with a black doctor about their health problems

Black doctors are more likely to write additional notes about the subjects

CV disease impact was significant

Diabetes, cholesterol screening up

Flu shots were significant

Does Diversity Matter for Health?  
Experimental Evidence from Oakland*

Marcella Alsan†   Owen Garrick‡   Grant Graziani‡

September 2018

Abstract

We study the effect of diversity in the physician workforce on the demand for preventive care among African-American men. Black men have the lowest life expectancy of any major demographic group in the U.S., and much of the disadvantage is due to chronic disease, which are amenable to primary and secondary prevention. In a field experiment in Oakland, California, we randomize black men to black or non-black male medical doctors and to incentives for one of the five offered preventative --- the flu vaccine. We use a two stage design, measuring decisions about cardiovascular screening and the flu vaccine before (ex ante) and after (ex post) meeting their assigned doctor. Black men select a smaller number of preventative in the ex ante stage, but are much more likely to select every preventative service, particularly invasive services, once meeting with a doctor who is the same race. The effects are most pronounced for men who have little experience obtaining routine medical care and among those who distrust the medical system. Subjects are more likely to talk with a black doctor about their health problems and black doctors are more likely to write additional notes about the subjects. The results are most consistent with better patient-doctor communication during the encounter rather than discrimination as measures of doctor quality and effort. Our findings suggest black doctors could help reduce cardiovascular mortality by 10 deaths per 100,000 per year --- leading to a 19% reduction in the black-white male gap in cardiovascular mortality.

M Alsan, O Garrick, and GC Graziani, NBER Working Paper No. 24787, June 2018, Revised September 2018

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# ACGME Graduate Demographics
## 2016-2017 Academic Year

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>Pipeline (PGY-1) Programs</th>
<th>Continuing GME / Subspecialty Programs</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>White, non-Hispanic</td>
<td>13,105</td>
<td>6,544</td>
<td>19,649</td>
</tr>
<tr>
<td>Asian or Pacific Islander</td>
<td>5,369</td>
<td>3,219</td>
<td>8,588</td>
</tr>
<tr>
<td>Hispanic</td>
<td>1,459</td>
<td>781</td>
<td>2,240</td>
</tr>
<tr>
<td>Black, non-Hispanic</td>
<td>1,356</td>
<td>625</td>
<td>1,981</td>
</tr>
<tr>
<td>Native American/Alaskan</td>
<td>78</td>
<td>25</td>
<td>103</td>
</tr>
<tr>
<td>Other</td>
<td>1,446</td>
<td>1,029</td>
<td>2,475</td>
</tr>
<tr>
<td>Unknown/Missing</td>
<td>5,890</td>
<td>1,515</td>
<td>7,405</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>28,703</strong></td>
<td><strong>13,738</strong></td>
<td><strong>42,441</strong></td>
</tr>
</tbody>
</table>
White, Non-Hispanic by Specialty

2016-2017 Academic Year

- Internal medicine: 7156
- Family medicine: 6558
- Emergency medicine: 3934
- Surgery: 3936
- Pediatrics: 3148
- Anesthesiology: 2624
- Obstetrics and gynecology: 2721
- Radiology-diagnostic: 2520
- Psychiatry: 2330
- Orthopaedic surgery: 2325
- Pathology-anatomic and clinical: 1011
- Neurology: 993
- Otolaryngology: 859
- Dermatology: 822
- Ophthalmology: 741
- Urology: 741
- Internal medicine/Pediatrics: 693
- Neurological surgery: 687
- Physical medicine and rehabilitation: 662
- Plastic surgery-integrated: 395
- Radiation oncology: 372
- Preventive medicine: 177
- Plastic surgery: 173
- Child neurology: 167
- Vascular surgery-integrated: 134
- Thoracic surgery-integrated: 92
- Medical genetics and genomics: 54
- Nuclear medicine: 25
- Interventional radiology-integrated: 9
- Osteopathic neuromusculoskeletal: 8
Hispanic by Specialty
2016-2017 Academic Year

- Internal medicine: 1301
- Family medicine: 754
- Pediatrics: 502
- Surgery: 381
- Emergency medicine: 355
- Psychiatry: 330
- Obstetrics and gynecology: 204
- Anesthesiology: 234
- Radiology-diagnostic: 166
- Neurology: 125
- Orthopaedic surgery: 165
- Pathology-anatomic and clinical: 114
- Physical medicine and rehabilitation: 65
- Ophthalmology: 50
- Neurological surgery: 52
- Otolaryngology: 47
- Dermatology: 44
- Internal medicine/Pediatrics: 43
- Urology: 31
- Child neurology: 28
- Radiation oncology: 27
- Plastic surgery: 25
- Plastic surgery - integrated: 22
- Preventive medicine: 19
- Vascular surgery - integrated: 10
- Thoracic surgery - integrated: 7
- Nuclear medicine: 6
- Medical genetics and genomics: 5
- Interventional radiology - integrated: 0
- Osteopathic neuromusculoskeletal... 0

Percentages:
- Nuclear medicine: 9.1%
- Plastic surgery: 7.9%
- Child neurology: 7.0%
- Medical genetics and genomics: 7.0%
- Family medicine: 4.7%
- Obstetrics and gynecology: 4.0%
- Psychiatry: 5.9%
- Pediatrics: 5.5%
- Emergency medicine: 5.2%
- Preventive medicine: 5.1%
- Internal medicine: 4.9%
- Neurology: 4.0%
- Physical medicine and rehabilitation: 4.9%
- Surgery: 4.7%
- Pathology-anatomic and clinical: 4.5%
- Thoracic surgery - integrated: 4.3%
- Vascular surgery - integrated: 3.8%
- Ophthalmology: 3.0%
- Neurological surgery: 3.0%
- Radiation oncology: 3.6%
- Radiology-diagnostic: 3.5%
- Anesthesiology: 3.3%
- Dermatology: 3.1%
- Otolaryngology: 3.0%
- Urology: 3.0%
- Plastic surgery - integrated: 2.9%
- Internal medicine/Pediatrics: 2.9%
- Orthopaedic surgery: 2.8%
- Interventional radiology - integrated: 0.0%
- Osteopathic neuromusculoskeletal... 0.0%
Black, Non-Hispanic by Specialty
2016-2017 Academic Year

Preventive medicine 12.3%
Obstetrics and gynecology 7.4%
Family medicine 6.9%
Psychiatry 5.9%
Physical medicine and rehabilitation 5.5%
Plastic surgery 4.5%
Child neurology 4.3%
Anesthesiology 4.1%
Surgery 4.5%
Neurological surgery 4.4%
Internal medicine/Pediatrics 4.4%
Medical genetics and genomics 4.2%
Nuclear medicine 4.1%
Emergency medicine 4.1%
Internal medicine 3.9%
Pediatrics 3.9%
Dermatology 3.5%
Radiation oncology 3.2%
Radiology-diagnostic 3.2%
Orthopaedic surgery 3.1%
Urology 2.9%
Pathology-anatomic and clinical 2.8%
Plastic surgery - integrated 2.8%
Neurology 2.8%
Ophthalmology 2.4%
Vascular surgery - integrated 2.3%
Otolaryngology 1.9%
Thoracic surgery - integrated 0.6%
Interventional radiology - integrated 0.0%
Osteopathic neuromusculoskeletal... 0.0%
Table 8. Race and Ethnic Origin of Resident Physicians in ACGME-Accredited and in Combined Specialty Graduate Medical Education (GME) Programs on Duty December 31, 2017, by Specialty

<table>
<thead>
<tr>
<th>Specialty/Subspecialty</th>
<th>No. of Resident Physicians&lt;sup&gt;a,b&lt;/sup&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Black</td>
</tr>
<tr>
<td>Internal medicine</td>
<td></td>
</tr>
<tr>
<td>Adult congenital heart disease</td>
<td></td>
</tr>
<tr>
<td>Advanced heart failure and transplant cardiology</td>
<td></td>
</tr>
<tr>
<td>Cardiovascular disease</td>
<td></td>
</tr>
<tr>
<td>Clinical cardiac electrophysiology</td>
<td></td>
</tr>
<tr>
<td>Clinical informatics</td>
<td></td>
</tr>
<tr>
<td>Critical care medicine</td>
<td></td>
</tr>
<tr>
<td>Endocrinology, diabetes, and metabolism</td>
<td></td>
</tr>
<tr>
<td>Gastroenterology</td>
<td></td>
</tr>
<tr>
<td>Geriatric medicine</td>
<td></td>
</tr>
<tr>
<td>Hematology</td>
<td></td>
</tr>
<tr>
<td>Hematology and medical oncology</td>
<td></td>
</tr>
<tr>
<td>Infectious disease</td>
<td></td>
</tr>
<tr>
<td>Interventional cardiology</td>
<td></td>
</tr>
<tr>
<td>Nephrology</td>
<td></td>
</tr>
<tr>
<td>Medical oncology</td>
<td></td>
</tr>
<tr>
<td>Pulmonary disease</td>
<td></td>
</tr>
<tr>
<td>Pulmonary disease and critical care medicine</td>
<td></td>
</tr>
<tr>
<td>Rheumatology</td>
<td></td>
</tr>
<tr>
<td>Transplant hepatology</td>
<td></td>
</tr>
</tbody>
</table>

<sup>a</sup> Includes all residents, including those in GME programs that are not ACGME-accredited.  
<sup>b</sup> Data for Asian residents in the United States were not available for the 2017 data. 

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What is the Workforce Impacted by the New Requirement?

Residents and fellows
Faculty
Senior GME Administrative Staff
  - Program Coordinators
  - Institutional Coordinators

Leadership
  - DIO, PD, APD
  - Academic Chiefs
Relevant members of its academic community
  - Chief Diversity Officers
  - Education Specialists

Each Program/Sponsoring Institution should develop an intentional workforce plan with respect to diversity and inclusion
What Might Be Assessed to Determine Whether Practices are Engaged to Focus on Diversity and Inclusion?

Descriptions of processes (i.e. Initiatives, methods, procedures) used to address elements of the requirement will be described in the ADS Annual Update: Workforce Plan.

Initially, emphasis will be on ensuring processes are undertaken rather than outcomes achieved because actualizing diversity goals is a long-term commitment.

We have included new relevant questions to the Resident and Faculty Surveys.
Pipeline Problem

The Physician Pipeline is the metaphor describing the process of increasing the number of URM individuals who enter training pathways to become physicians.

ACGME Glossary definition of pipeline: specialties that lead to primary board certification with admission to PGY-1 years.
Pipeline Program

There are not enough URiMs that reach training in GME

GME heretofore believed itself to be more of a recipient of the product than a driver of the fountainhead of the pipeline

Can we turn a dribble into a gusher?
Residency Initiatives in Pipeline Flow

Brought 75 south side HS students to UCM as a resident initiative

Panel of med students, resident physicians, APNs, attendings in EM and senior faculty

Visit to trauma bays

Experiential learning session in the simulation center
What Constitutes an Ongoing Effort?

When reporting the ongoing activities of an effort, there must be reasonable tracking of outcomes for each effort or initiative.

The activity should not be a one-time, single event and should be able to demonstrate impact on workforce diversity outcomes as a result of the initiative (immediate or long-term).

Any given effort of a program in partnership with its Sponsoring Institution should constitute a larger effort aimed at addressing all elements of I.C.
What is Systematic Recruitment?

Multi-level

- Impacts each element of the workforce mentioned previously

Multifaceted

- Will require showing different approaches to address each category in its workforce plan
- Should address pipeline of candidates specifically
- Opportunity to address interprofessional collaboration

Should demonstrate implementation of best practices from the field
What is Systematic Retention?

A compliant program should demonstrate adequate support and mentorship for all trainees.

Workforce plan should address the removal of barriers that impede successful advancement of trainees.

Retention descriptions in ADS Annual Update must include descriptions of how the clinical learning environment addresses inclusion of diverse candidates.

Objective numerical outcomes will be used to assess success of retention efforts.
Inclusive Clinical Learning Environment
In the Minority: Black Physicians in Residency and Their Experiences

• Grounded Theory qualitative analysis of 20 PGY-2 residents at a northeastern medical center

• Discrimination

• Differing expectations

• Social isolation

• Career consequences and coping styles

In the Minority: Black Physicians in Residency and Their Experiences

Overt discrimination was rare

Participants perceived blacks to be punished more harshly for the same transgression and expected to perform at lower levels than white counterparts

Participants' suspicion of racism as a motivation for individual and institutional behaviors was tempered by self-doubt
Update on Minority Residents’ Experiences

• A daily barrage of microaggressions and bias

• Minority residents tasked as race/ethnicity ambassadors

• Challenges negotiating professional and personal identity while seen as “other”

Race, Ethnicity, and Medical Student Well-Being in the United States

Symptoms of distress are prevalent among medical students, but more non-minority students had burnout (39% vs 33%; P<.03)

Minority students were more likely to report that their race/ethnicity had adversely affected their medical school experience (11% vs 2%; P<.001) and cited racial discrimination, racial prejudice, feelings of isolation, and different cultural expectations as causes

Minority students reporting such experiences were more likely to have burnout, depressive symptoms, and low mental QOL scores than were minority students without such experiences (all P<.05)

Adverse experiences related to race appear to relate strongly to burnout among minority students and may be related to the increased attrition rates of minority medical students

Pipeline Dismissed by Ethnicity
### 2015-2016 Pipeline Dismissed by Specialty

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<th>Hispanic</th>
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<td>Surgery</td>
<td>12.9%</td>
<td>25.8%</td>
<td>6.5%</td>
<td>9.7%</td>
<td>41.9%</td>
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</tbody>
</table>
2015-2016 Pipeline Grads Dismissed by Specialty

- Anesthesiology
  - White, non-Hispanic: 0.4%
  - Hispanic: 13%
  - Black, non-Hispanic: 2.0%
  - Asian or Pacific Islander: 2.0%
  - White, Non-Hispanic: 4.1%
  - Unknown: 0.7%
- Family medicine
  - White, non-Hispanic: 0.3%
  - Hispanic: 22%
  - Black, non-Hispanic: 1.4%
  - Asian or Pacific Islander: 2.0%
  - White, Non-Hispanic: 37%
  - Unknown: 0.7%
- Internal medicine
  - White, non-Hispanic: 0.5%
  - Hispanic: 24%
  - Black, non-Hispanic: 1.4%
  - Asian or Pacific Islander: 2.0%
  - White, Non-Hispanic: 38%
  - Unknown: 0.7%
- Obstetrics and gynecology
  - White, non-Hispanic: 0.3%
  - Hispanic: 35%
  - Black, non-Hispanic: 1.0%
  - Asian or Pacific Islander: 2.0%
  - White, Non-Hispanic: 42%
  - Unknown: 0.2%
- Pediatrics
  - White, non-Hispanic: 0.6%
  - Hispanic: 19%
  - Black, non-Hispanic: 2.0%
  - Asian or Pacific Islander: 3.3%
  - White, Non-Hispanic: 22%
  - Unknown: 0.9%
- Psychiatry
  - White, non-Hispanic: 0.2%
  - Hispanic: 19%
  - Black, non-Hispanic: 2.0%
  - Asian or Pacific Islander: 3.3%
  - White, Non-Hispanic: 22%
  - Unknown: 0.9%
- Surgery
  - White, non-Hispanic: 12.3%
Inclusion in the clinical learning environment: Building the conditions for diverse human flourishing

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\textsuperscript{a}Pediatrics, Centre for Medical Education, and Office of Social Accountability and Community Engagement, Faculty of Medicine, McGill University, Montreal, Canada; \textsuperscript{b}Department of Field Activities, Accreditation Council for Graduate Medical Education, Chicago, IL

\textbf{ABSTRACT}

\textbf{Aim}: While diversity, equity, and inclusion are much proclaimed aspirational goals in education programs, the clinical learning environment (CLE) frequently falls short of meaningful incorporation of these concepts in processes, policies, and local culture. In this paper, we explore how inclusion, diversity, and equity can and should be defined and operationalized within medical education.

\textbf{Methods}: Three cases, organized around Hafferty’s curricular framework (formal, informal, and hidden), we illustrate lapses and potential best practices in inclusion in the CLE.

\textbf{Results}: The essential “best-practice” of programs inclusive of diverse individuals is the design of policies, processes, and behavioral norms co-creatively with all community members. Potential pitfalls to greater inclusion include nostalgic reference to “the past”, a neutrality that is operationalized without the rudder of explicit values and not recognizing that ethical obligations between teachers, learners, and programs are at the heart of the discussion of how inclusive learning and work environments are built.

\textbf{Conclusion}: Inclusive CLEs provide space for co-creation, understand the need to ensure the voices of the vulnerable (i.e. learners) are heard and valued and through this promote the flourishing of diverse human capital, in keeping with a model that views diversity as a key attribute or organizational excellence.
VI.B.6. Programs, in partnership with their Sponsoring Institutions, must provide a professional, equitable, respectful, and civil environment that is free from discrimination, sexual and other forms of harassment, mistreatment, abuse, or coercion of students, residents, faculty, and staff. (Core)
The Cost of Incivility

Christine Porath @Porat... 8/26/19
A1. Customers punish organizations harshly for incivility, even if they don’t witness it. #workhuman

Christine Porath @Porat... 8/26/19
A1. Incivility impairs performance, creativity & thinking—even for witnesses. People miss information right in front of them. Those simply around incivility are more likely to have dysfunctional or aggressive thoughts, although they may be unaware of the connection. #workhuman

Christine Porath @Porat... 8/26/19
A1. The human and business costs of incivility are much greater than you think. People experiencing incivility may struggle to get off the side and back into the game. #workhuman
Revamping existing data/ adding new items to inform program requirement adherence

ACGME Complaints and Concerns Resource and the ACGME Ombudsperson field issues raised by trainees:

- We need to catalogue the nature of these reports
- We need to ascribe R/E/G to the reports to look for inclusiveness issues

New questions for the resident and faculty surveys will include items that sample elements that will help us to assess compliance with VI.B.6.
How do you assess for compliance with CPR VI.B.6 and how do you enforce it?

Office of Resident Services houses the concerns and complaints function

Heretofore, ACGME has not served as an advocate for residents over programs because we are accrediting programs as to their compliance with the common program requirements

However, now that a single complaint can trigger a noncompliance event that is in violation of the requirement that the learning environment is free from discrimination, sexual and other forms of abuse or coercion of students, residents, faculty and staff, the old approaches are insufficient
ACGME toolkit is limited

Accreditation decisions after a site visit include:
- Continued accreditation
- Continued accreditation with warning
- Probationary accreditation
- Withdrawal of accreditation

There is now a need to develop finer tools to effect behavioral change of an institution or program with a problematic learning environment.
Changes relating to how programs will be evaluated based on board examination pass rate were made by the Board based on logic that was consistent with the idea that a learner practices without distinction whether or not the exam was passed on the first attempt or not.

Further, there is little evidence that links board examination score to success in practice across a number of parameters.

However, there is evidence that correlates MCAT with USMLE Step 1 performance, and that links USMLE Step 1 performance with board examination performance. Overemphasis on USMLE Step 1 performance in medical school has unintended consequences for medical education and resident selection.
The validity argument about using USMLE Step 1 and 2 scores for postgraduate residency selection decisions is neither structured, coherent, nor evidence based.

...scores are not associated with measures of clinical skill acquisition among advanced medical students, residents, and subspecialty fellows.

We do not believe that USMLE Step 1 scores should continue to be the major determining factor in the selection of graduating medical students for interview for graduate medical education positions.

These scores (USMLE STEP1) do not measure many clinical aptitudes and skills, qualities of professionalism, or competencies specific to the planned training program.

Although using numbers as a filter is a convenient way to screen large numbers of applications, USMLE Step 1 scores do not come close to reflecting the totality of attributes critically relevant to a candidate’s potential performance during residency training.
Holistic Approaches to Residency Selection

Gives greater attention to other important qualities, such as clinical reasoning, patient care, leadership, professionalism, and ability to function as a member of a health care team

We will need more standardized modes of assessment and reporting that are readily sortable to do this

Other components of a holistic review of candidates should be nationally normed as well; these might include research experience and accomplishments, community engagement, leadership roles, unique personal attributes, and diversity

Are there better ways to measure physician quality that link to medical education?

New work beginning with medical schools and ACGME will combine medical school parameters with milestones data from resident performance to begin to identify patterns that may be more correlative with actual practice.

Continued work examining physician performance and linking to training parameters might inform future decisions. As augmented intelligence permits associations to be discovered, prediction of performance may be more accurate.
Parental Income Correlates with MCAT Performance

• Parental Income predicts MCAT
• MCAT predicts USMLE
• USMLE Step 1 predicts ITE and Board passage
• ACGME formerly evaluated programs on first-time board pass rate as opposed to eventual pass rate
• No correlation exists at present to link USMLE Step 1 performance and success as a clinician, so new interpretation of program quality de-emphasizes the need to select candidates based on achievement of a score that is seldom achieved by minority test-takers who arise from less wealthy families

Figure 3. Influence of Parental Income on Average Medical College Admission Test (MCAT) Scores for Underrepresented Minority (URM) and All Other (Non-URM) Applicants for Admission in 2001

Error bars are not shown, because of the large sample sizes, the SEs of the mean are too small to register on the figure.

Cohen JJ. JAMA. 2003; 298(9):1143-9
Program Requirement Changes to Section V: Board Certification

Program director should encourage all eligible program graduates to take the certifying examination offered by the applicable American Board of Medical Specialties (ABMS) member board or American Osteopathic Association (AOA) certifying board

V.C.3.a)-d) Board pass rate (addresses both written and oral exams):

The program’s aggregate pass rate of those taking the examination for the first time must be higher than the bottom fifth percentile of programs in that specialty
Program Requirement Changes to Section V: Board Certification

V.C.3.e) Any program whose graduates over the time period specified in the requirement have achieved an 80 percent pass rate will have met this requirement, no matter the percentile rank of the program for pass rate in that specialty.

Rolling seven year certification rate
V.C.3.f) Programs must report board certification status annually for the cohort of board-eligible residents that graduated seven years earlier.
Highland Diversification Initiative

No USMLE filter
Increased weight of gestalt score
Diversity Committee
Attending and resident buy-in
Diversity applicant week


Figure 2. Race/ethnicity of highland emergency medicine residents before and after the Highland diversification Initiative. A/J/AN/ PI, American Indian, Alaska Native, and Pacific Islander.
Implementation of Planning Committee Recommendations

Recommendation 1  a,b

*Creation of the D&I effort at ACGME*

Office of Diversity and Inclusion established and CDIO hired (Feb 28)

Recommendation 1c

Advisory committee to the ODI is being planned. Anticipate seating committee by fall 2019

Recommendation 2  *Data*

ACGME/AAMC working on data sharing agreement presently to obtain faculty identity information (Summer 2019)

Collection of each identified partner’s schema for categorizing R/E/G and other identity data underway (Summer 2019)

Plan initial data summit for fall 2019

Added questions to the 2019-20 resident and faculty surveys and will create new instructions for PD/DIO’s on documenting identity of residents, faculty and GME staff (Summer 2019)
Data Collection

New data are needed to answer questions that have never been asked before that assess diversity and inclusion with respect to race/ethnicity, gender, sexual identity, and ability.

Obtaining existing data (HR)

Creating new instruments (internally and in cooperation with nominating organizations)

Focus on maximizing response/minimizing threat

Internal:

R/E/G for: Field staff, ED/AED, CLER staff, and all ACGME employees

R/E/G for: All volunteer committees

Milestones

Review Committees

Board of Directors

Working with ACGME HR on the employee engagement survey to assess environment differences for various groups
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Data Collection

We have approximately 80% of resident data on R/E and nearly 100% by gender through program director report on ADS

Missing data is important

Uncertain method of assessment

We have no data on faculty and GME staff (CCC, GMECs, PD, DIO, coordinators, CEOs, CAO, etc.)

We don’t know what happens to our graduates and their impact on health care
External Partners in Data Alignment

Each organization collects data for some segment along the arc of training or of the practice of physicians

Each collects it in its own way and uses different criteria which makes tracking along the continuum of training and practice difficult

We plan to hold a summit of organizations around data classification and data sharing with respect to identity to assist in answering significant questions about diversity and inclusion in healthcare

Common standards of collection and classification

Common strategies to collapse and organize classifications that yield the most meaning
Recommendation 3 Systematic Recruitment and Admissions

Making appearances describing the changes to the Common Program Requirements (Sections IC, V, and VI) with RCs, programs and organizations (Ongoing effort)

Use specialty mix data on R/E/G, to begin work on holistic admission for GME. Have identified potential individuals with this expertise (Fall 2020)

Plan for recognition of programs that have shown excellence building the physician pipeline and DEI initiatives generally (Winter 2021)

Identifying existing pipeline programs to make available for programs on ACGME D&I website (Ongoing; Summer 2019)

Contact specialty organizations to consider creating recognition programs to improve diversity within specialties (Winter 2020)
Recommendation 4 *Withdrawal/Dismissal*

We have reviewed and extended analysis of the withdrawal and dismissal rate for GME. In Winter 2018, Dr. Nasca met with selected programs to discuss these matters at their institutions and we will continue these conversations (Ongoing)

Complete deeper dive into the elements assessing the free text information associated with the w/d and dismissal cases nor recommended additional collection of data (Fall 2019)

Initiating research involvement with external colleagues who are interested in working on w/d and dismissal issues in GME in specialty specific areas. (Summer 2019)
Implementation of Planning Committee Recommendations

Recommendation 5 *Inclusive Clinical Learning Environment*

Initiated the process of identifying sources of scholarship in reduction of implicit bias, microaggression and ally training in health care (Summer 2019)

Begin consideration of the intersection of well-being and discrimination, and their impact on performance of minority residents and fellows and possible contribution to w/d and dismissal (Winter 2020)

Engage CLER leadership on how to assess inclusiveness of the clinical learning environment in their reviews. (Fall 2019)

Working with survey task force to add questions on resident, fellow and faculty mistreatment. (Summer 2019)

Work on a mechanism to recognize implementation of best practices to eliminate microaggressions, discrimination, and harassment in GME to date (Winter 2020)
Implementation of Planning Committee Recommendations

Recommendation 6 *Seeking fairness for the individual*

Abutted a fundamental problem in the means by which the ACGME might serve to assist in establishing fairness in due process situations with individual residents in their programs and sponsoring institutions. This will be an important element of the work of the Advisory Committee (Winter 2020)

Engage Dr. Holmboe regarding work to assess implicit bias and its impact on milestones assessment (Fall 2019)

Recommendation 7 *Communications*

Working to establish a full communications plan with Ms. Amidon to include website and social media presence (Ongoing; Summer 2019)

Multiple opportunities to influence groups to improve diversity and inclusion efforts in GME underway (Ongoing)

Planning a Diversity and Inclusion track for the 2020 Annual Education Conference (Summer 2019)
Initial Strategic Planning
ACGME Office of Diversity and Inclusion

Contact Us

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