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

March 11, 2019

ACGME Names First Chief Diversity and Inclusion Officer

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.

ORIGINAL CONTRIBUTION

Student Body Racial and Ethnic Composition and Diversity-Related Outcomes in US Medical Schools

Somnath Saha, MD, MPH
Gretchen Guiton, PhD
Paul F. Wimmers, PhD
LuAnn Wilkerson, EdD

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 53.9%, respectively; $P < .001$; adjusted odds ratio [OR], 1.33; 95% confidence interval [CI], 1.13-1.57). This association was strongest in schools in which students perceived a positive climate for interracial interaction. White students in the highest URM 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 URM proportions and diversity-related outcomes. Student body URM proportions were not associated with white or nonwhite students' plans to practice in underserved communities, although URM students were substantially more likely than white or nonwhite/non-URM students to plan to serve the underserved (48.7% vs 18.8% vs 16.2%, respectively; $P < .001$).

MOST MEDICAL SCHOOLS IN the United States explicitly seek to engender diversity within their student bodies.[1] 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.[2,3] 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.[4] In recent years, however, these policies have come under increasing scrutiny as

JAMA. 2008;300(10):1135-1145

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

Can Cultural Competency Reduce Racial And Ethnic Health Disparities? A Review And Conceptual Model

Cindy Brach
Irene Fraserirector
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

Table 1. Unadjusted Association Between Disadvantaged Population and Receipt of Care From White vs Black, Hispanic, and Asian Physicians, Medical Expenditure Panel Survey, 2010

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

[a] Odds of patients in a demographic group reporting a black physician relative to non-Hispanic white patients reporting a black physician.

[b] Odds of patients in a demographic group reporting a Hispanic physician relative to non-Hispanic white patients reporting a Hispanic physician.

[c] Odds of patients in a demographic group reporting an Asian physician relative to non-Hispanic white patients reporting an Asian physician.

Marrast LM, et al. *JAMA Intern Med.* 2014;174(2):289-291.

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§

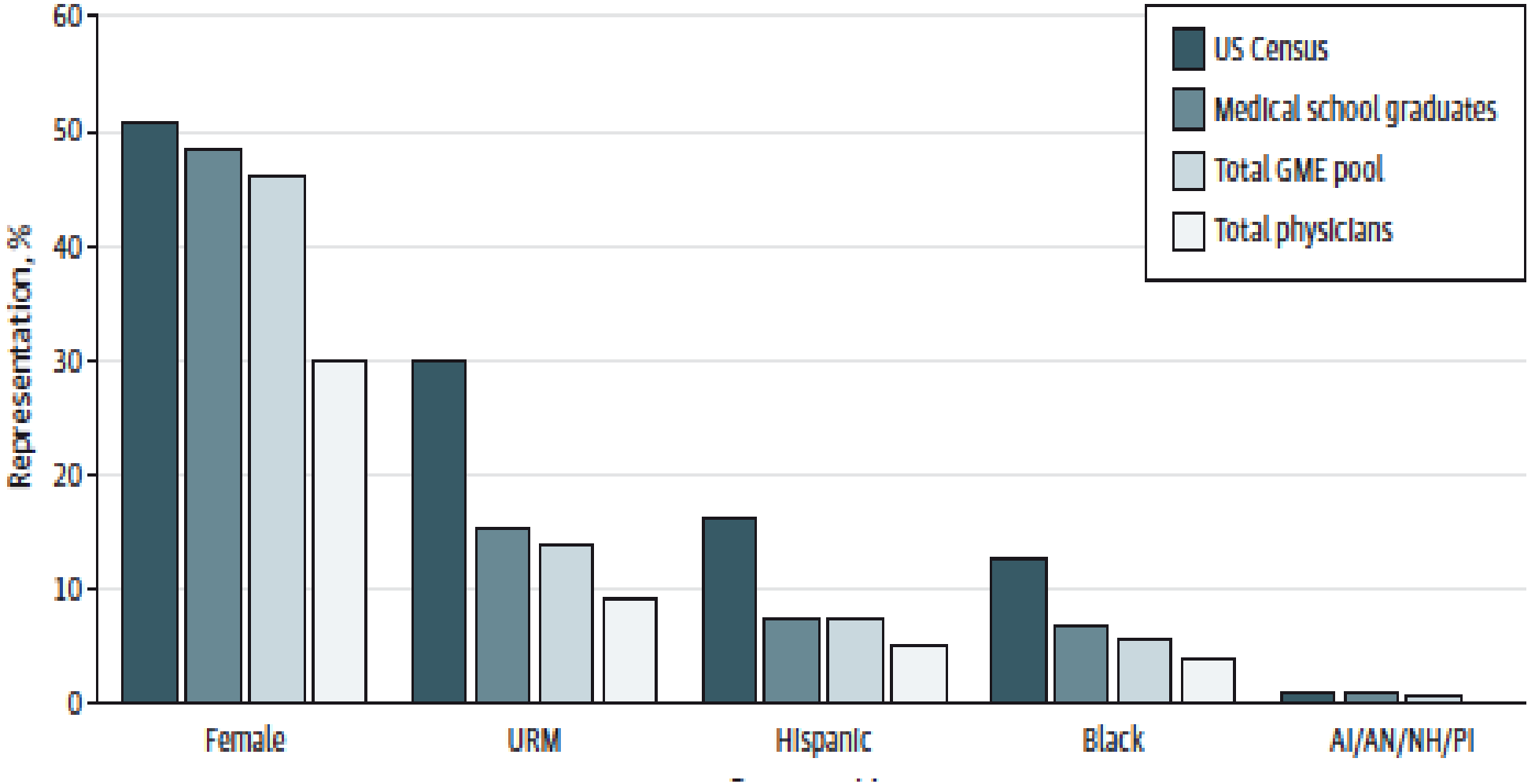
September 2018

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 diseases, 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 preventives — 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 similar number of preventives in the ex ante stage, but are much more likely to select every preventive 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 mistrust 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 or measures of doctor quality and effort. Our findings suggest black doctors could help reduce cardiovascular mortality by 16 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

Figure 1. Distribution in the 2010 US Population, 2012 Medical School Graduates, 2012 Practicing Physicians, and the 2012 Graduate Medical Education (GME) Trainee Pool



Deville C, Hwang W, Burgos R, Chapman CH, Both S, Thomas CR, Jr. Diversity in Graduate Medical Education in the United States by Race, Ethnicity, and Sex, 2012. *JAMA Intern Med.* Published online August 24, 2015. doi:10.1001/jamainternmed.2015.4324.

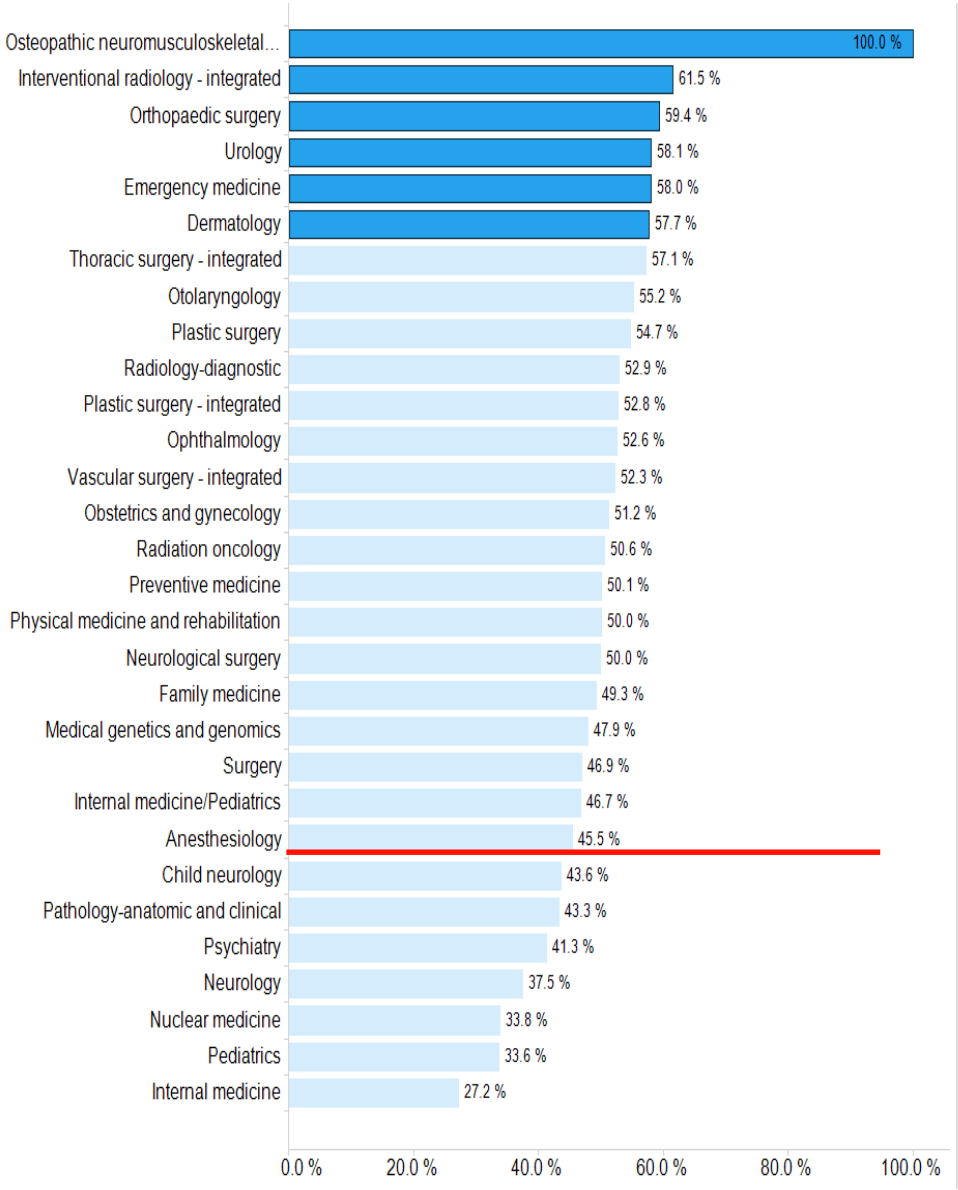
ACGME Graduate Demographics

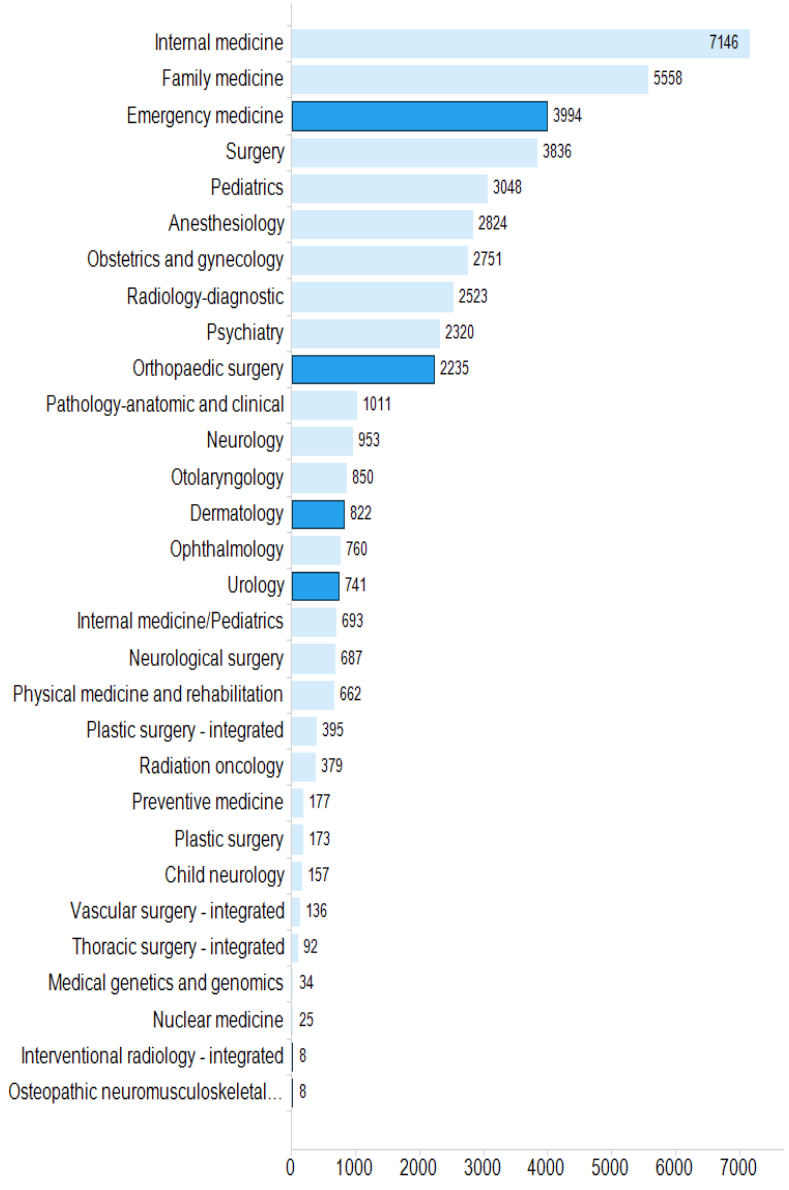
2016-2017 Academic Year

Race/Ethnicity	Pipeline (PGY-1) Programs		Continuing GME / Subspecialty Programs		Total	
White, non-Hispanic	13,105	45.66%	6,544	47.63%	19,649	46.30%
Asian or Pacific Islander	5,369	18.71%	3,219	23.43%	8,588	20.24%
Hispanic	1,459	5.08%	781	5.68%	2,240	5.28%
Black, non-Hispanic	1,356	4.72%	625	4.55%	1,981	4.67%
Native American/Alaskan	78	0.27%	25	0.18%	103	0.24%
Other	1,446	5.04%	1,029	7.49%	2,475	5.83%
Unknown/Missing	5,890	20.52%	1,515	11.03%	7,405	17.45%
Grand Total	28,703	100.00%	13,738	100.00%	42,441	100.00%

White, Non-Hispanic by Specialty

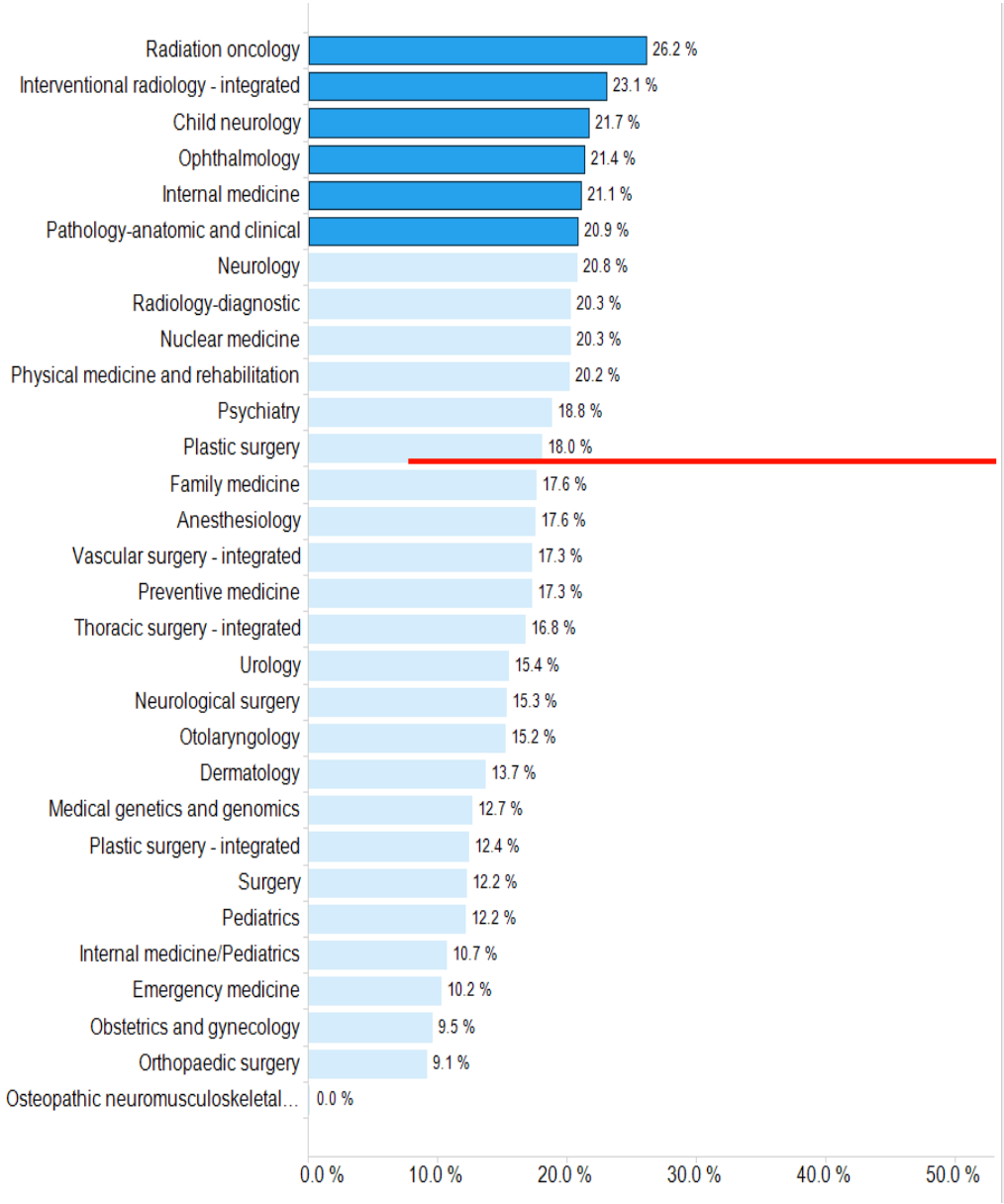
2016-2017 Academic Year

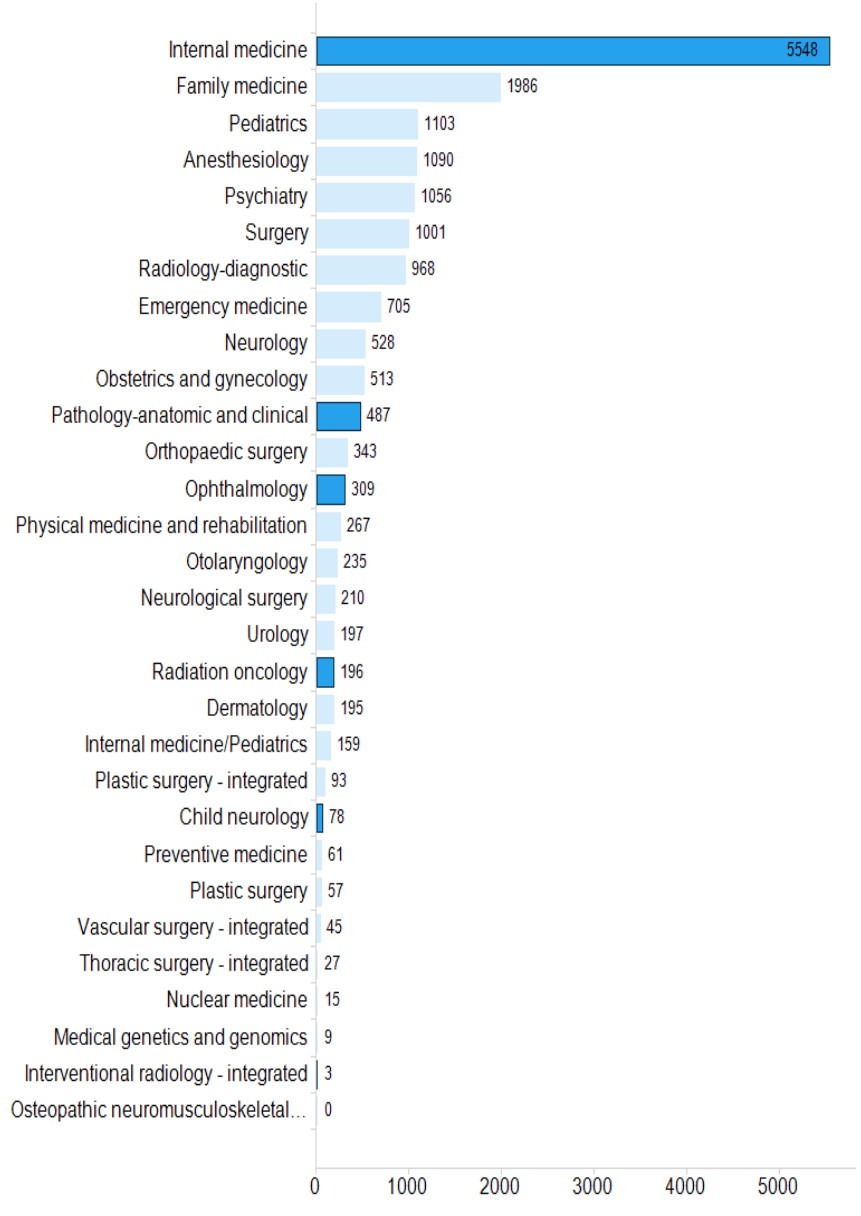




Asian and Pacific Islander by Specialty

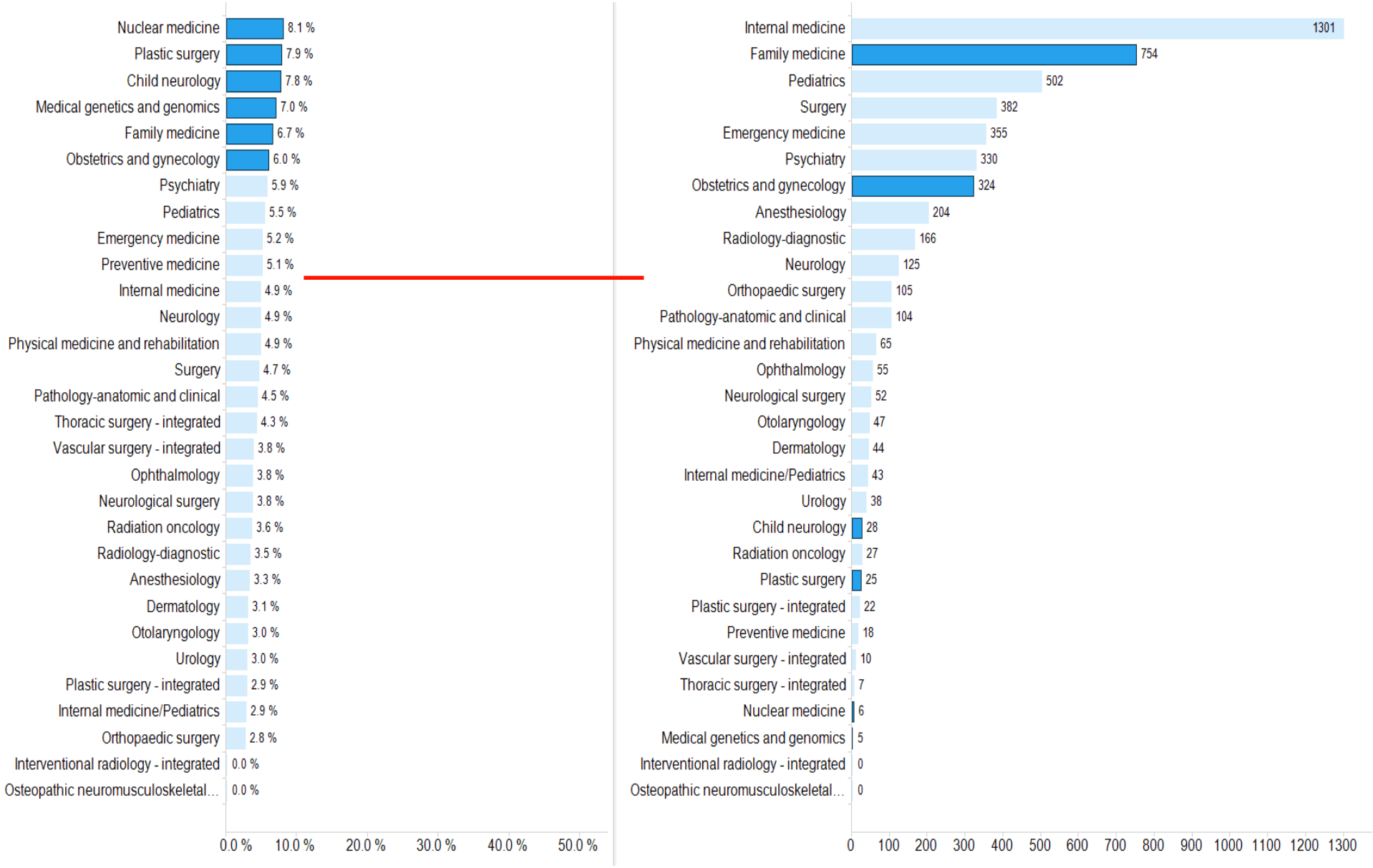
2016-2017 Academic Year





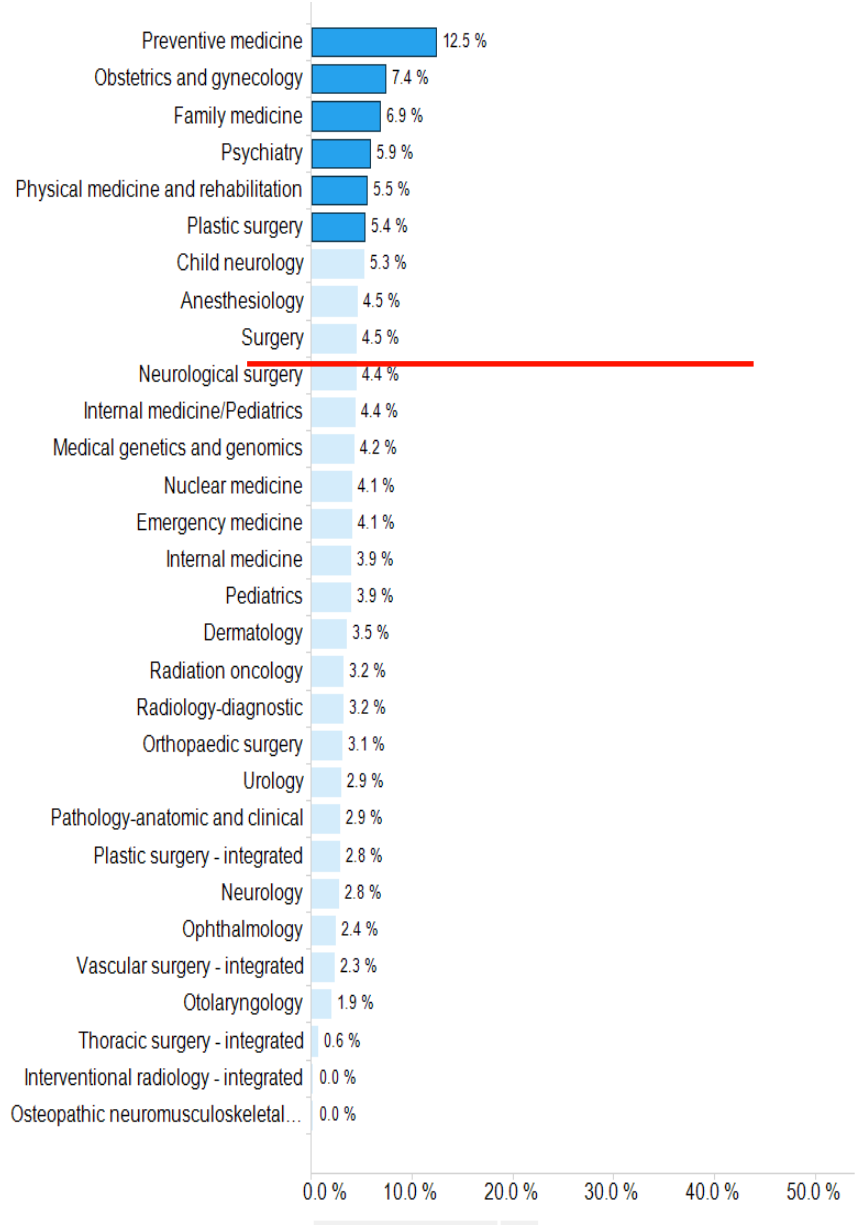
Hispanic by Specialty

2016-2017 Academic Year



Black, Non-Hispanic by Specialty

2016-2017 Academic Year



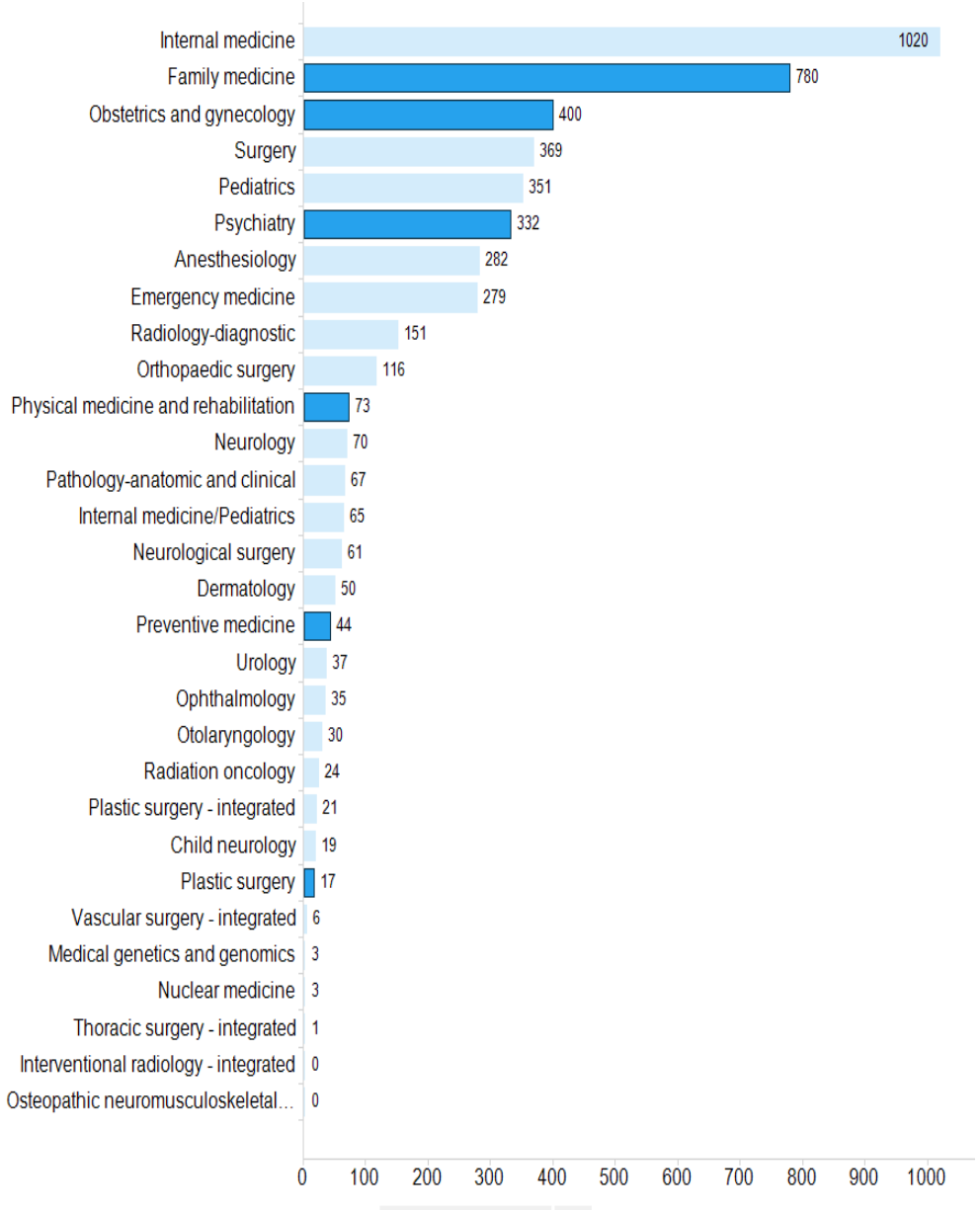
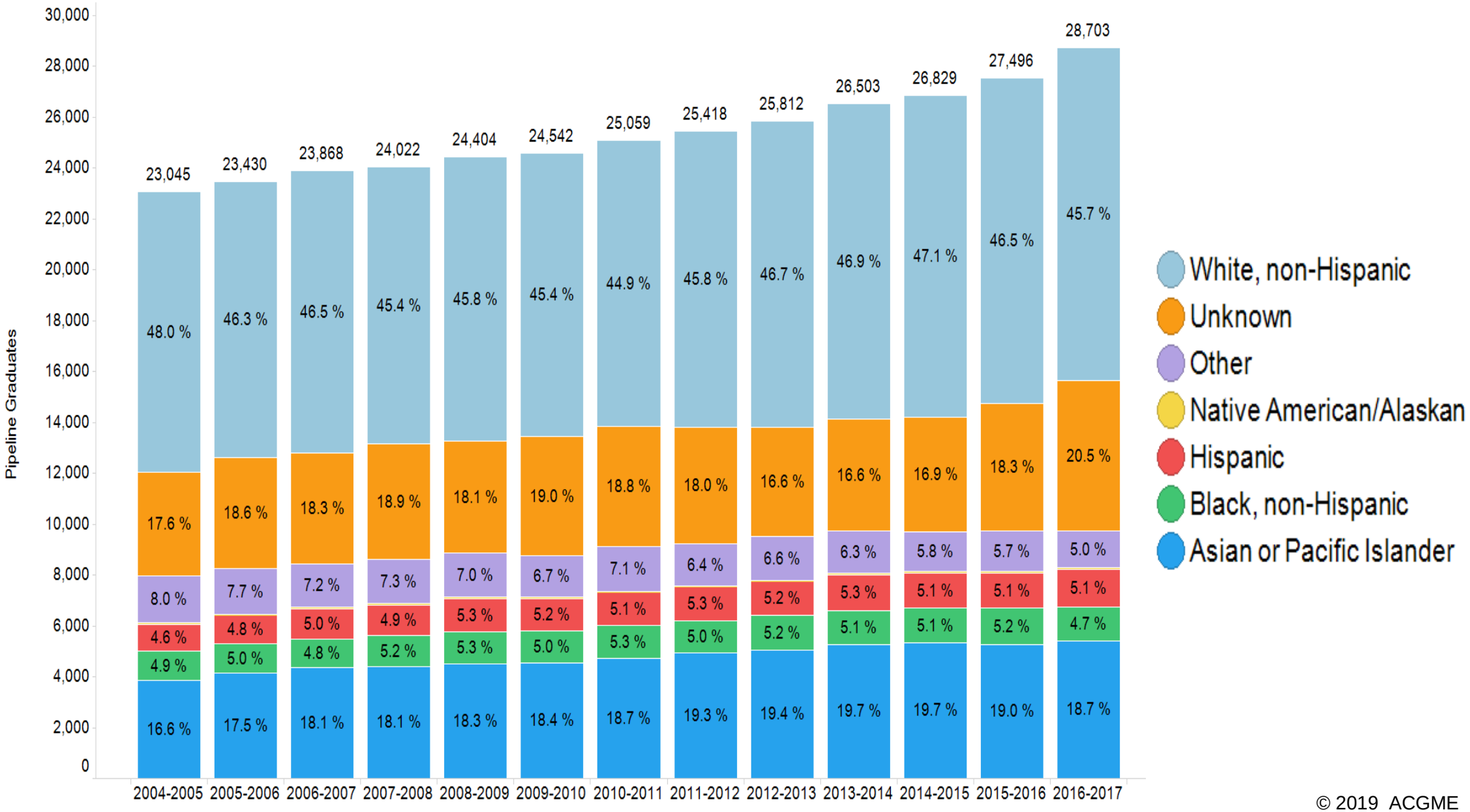


Table 8. Race and Ethnic Origin of Resident Physicians in ACGME-Accredited and in Combined Specialty Graduate Medical Education (GME) Programs on Duty December 31, 2017, by Specialty

	No. of Resident Physicians[a,b]								
Specialty/Subspecialty	Black	American Indian/ Alaskan Native	White	Asian	Native Hawaiian/ Pacific Islander	Multi-racial	Other/ Unknown	Hispanic Origin	Total
Internal medicine	1522	17	11 214	9615	31	641	3188	2029	26 228
Adult congenital heart disease	0	0	11	2	0	0	1	3	14
Advanced heart failure and transplant cardiology	3	0	34	33	0	1	6	7	77
Cardiovascular disease	137	1	1242	1062	2	88	199	176	2731
Clinical cardiac electrophysiology	4	0	102	55	0	4	23	21	188
Clinical informatics	1	0	16	12	0	2	2	2	33
Critical care medicine	9	0	113	91	0	8	7	15	228
Endocrinology, diabetes, and metabolism	34	2	265	285	0	17	63	79	666
Gastroenterology	82	1	695	620	0	41	86	101	1525
Geriatric medicine	13	0	85	83	1	4	28	17	214
Hematology	0	0	4	10	0	1	1	0	16
Hematology and medical oncology	64	0	762	729	0	47	72	90	1674
Infectious disease	48	1	391	217	1	22	51	83	731
Interventional cardiology	12	0	124	119	0	9	24	12	288
Nephrology	68	0	256	399	1	30	80	62	834
Medical oncology	0	0	16	21	0	1	0	0	38
Pulmonary disease	3	0	19	37	0	0	11	6	70
Pulmonary disease and critical care medicine	70	1	917	593	0	38	107	107	1726
Rheumatology	23	0	226	190	0	10	28	34	477
Transplant hepatology	2	0	17	14	0	0	4	1	37

Brotherton S & Etzel S. *JAMA.* 2018; 320(10):1063

ACGME Pipeline Graduates



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

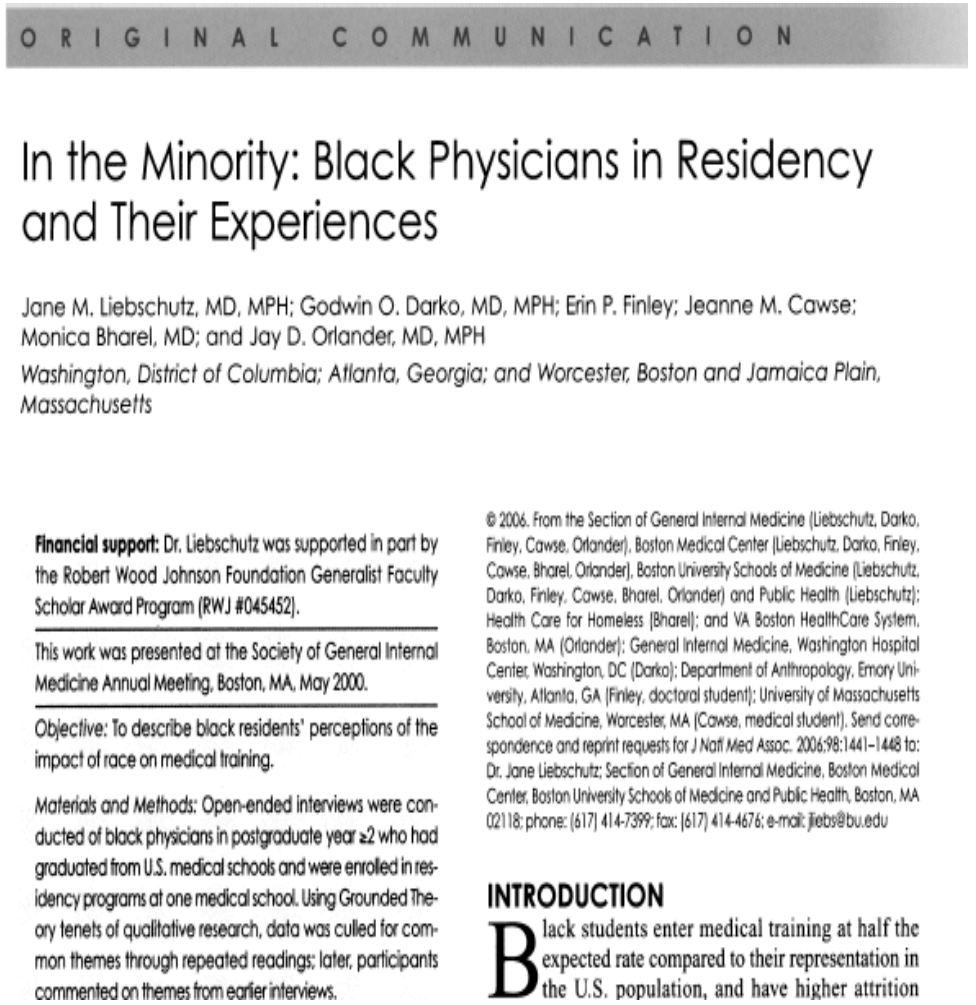
Retention descriptions in ADS Annual Update must include descriptions of how the clinical learning environment addresses inclusion of diverse candidates

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



ORIGINAL COMMUNICATION

In the Minority: Black Physicians in Residency and Their Experiences

Jane M. Liebschutz, MD, MPH; Godwin O. Darko, MD, MPH; Erin P. Finley; Jeanne M. Cawse; Monica Bharel, MD; and Jay D. Orlander, MD, MPH

Washington, District of Columbia; Atlanta, Georgia; and Worcester, Boston and Jamaica Plain, Massachusetts

Financial support: Dr. Liebschutz was supported in part by the Robert Wood Johnson Foundation Generalist Faculty Scholar Award Program (RWJ #045452).

This work was presented at the Society of General Internal Medicine Annual Meeting, Boston, MA, May 2000.

Objective: To describe black residents' perceptions of the impact of race on medical training.

Materials and Methods: Open-ended interviews were conducted of black physicians in postgraduate year ≥2 who had graduated from U.S. medical schools and were enrolled in residency programs at one medical school. Using Grounded Theory tenets of qualitative research, data was culled for common themes through repeated readings; later, participants commented on themes from earlier interviews.

 From the Section of General Internal Medicine (Liebschutz, Darko, Finley, Cawse, Orlander), Boston Medical Center (Liebschutz, Darko, Finley, Cawse, Bharel, Orlander), Boston University Schools of Medicine (Liebschutz, Darko, Finley, Cawse, Bharel, Orlander) and Public Health (Liebschutz); Health Care for Homeless (Bharel); and VA Boston HealthCare System, Boston, MA (Orlander); General Internal Medicine, Washington Hospital Center, Washington, DC (Darko); Department of Anthropology, Emory University, Atlanta, GA (Finley, doctoral student); University of Massachusetts School of Medicine, Worcester, MA (Cawse, medical student). Send correspondence and reprint requests for *J Natl Med Assoc.* 2006;98:1441–1448 to: Dr. Jane Liebschutz; Section of General Internal Medicine, Boston Medical Center, Boston University Schools of Medicine and Public Health, Boston, MA 02118; phone: (617) 414-7399; fax: (617) 414-4676; e-mail: jliebs@bu.edu

INTRODUCTION

Black students enter medical training at half the expected rate compared to their representation in the U.S. population, and have higher attrition

J Nat Med Assoc (2006) 98 (9): 1441

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"

JAMA Network Open

Original Investigation | Medical Education

Minority Resident Physicians' Views on the Role of Race/Ethnicity in Their Training Experiences in the Workplace

Abstract

IMPORTANCE Black, Hispanic, and Native American physicians remain underrepresented in medicine despite national efforts to increase diversity in the health care workforce. Understanding the unique workplace experiences of minority physicians is essential to inform strategies to create a diverse and inclusive workforce. While prior research has explored the influence of race/ethnicity on the experiences of minority faculty and medical students, there is a paucity of literature investigating how race/ethnicity affects the training experiences of resident physicians in graduate medical education.

OBJECTIVE To characterize how Black, Hispanic, and Native American resident physicians experience race/ethnicity in the workplace.

DESIGN, SETTING, AND PARTICIPANTS Semistructured, in-depth qualitative interviews of Black, Hispanic, and Native American residents were performed in this qualitative study. Interviews took place at the 2017 Annual Medical Education Conference (April 12-13, 2017) in Atlanta, Georgia), sponsored by the Student National Medical Association. Interviews were conducted with 27 residents from 21 residency programs representing a diverse range of medical specialties and geographic locations.

MAIN OUTCOMES AND MEASURES The workplace experiences of Black, Hispanic, and Native American resident physicians in graduate medical education.

RESULTS Among 27 participants, race/ethnicities were 19 (70.3%) Black, 3 (11%) Hispanic, 1 (4%) Native American, and 4 (15%) mixed race/ethnicity; 15 (55.6%) were female. Participants described the following 3 major themes in their training experiences in the workplace: a daily barrage of microaggressions and bias, minority residents tasked as race/ethnicity ambassadors, and challenges negotiating professional and personal identity while seen as "other."

CONCLUSIONS AND RELEVANCE Graduate medical education is an emotionally and physically demanding period for all physicians. Black, Hispanic, and Native American residents experience additional burdens secondary to race/ethnicity. Addressing these unique challenges related to race/ethnicity is crucial to creating a diverse and inclusive work environment.

Key Points

Question How do minority resident physicians view the role of race/ethnicity in their training experiences?

Findings This qualitative study of 27 minority resident physicians found that participants described 3 major themes: a daily barrage of microaggressions and bias, minority residents tasked as race/ethnicity ambassadors, and challenges negotiating professional and personal identity while seen as "other."

Meaning Results of this study suggest that minority residents face extra workplace burdens during a period already characterized by substantial stress, warranting further attention from educators, institutions, and accreditation bodies.

+ Invited Commentary

Author Affiliations and article information are listed at the end of this article.

Osseo-Asare A et al. JAMA Network Open. 2018;1(5):e182723

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)

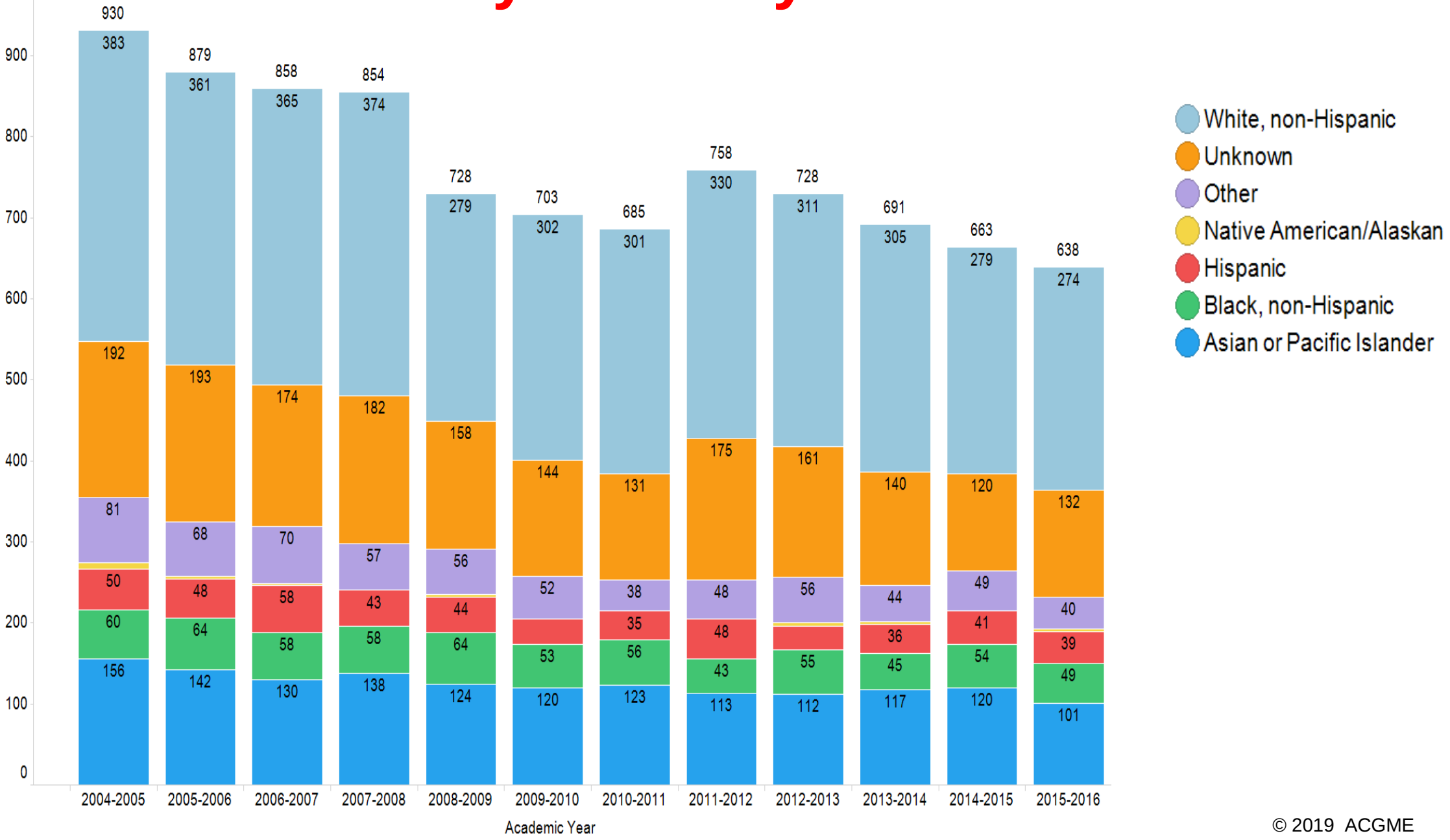
Minority students were more likely to report that their race/ethnicity had adversely affected their medical school experience (11% vs 2%; P<.001) and cited racial discrimination, racial prejudice, feelings of isolation, and different cultural expectations as causes

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)

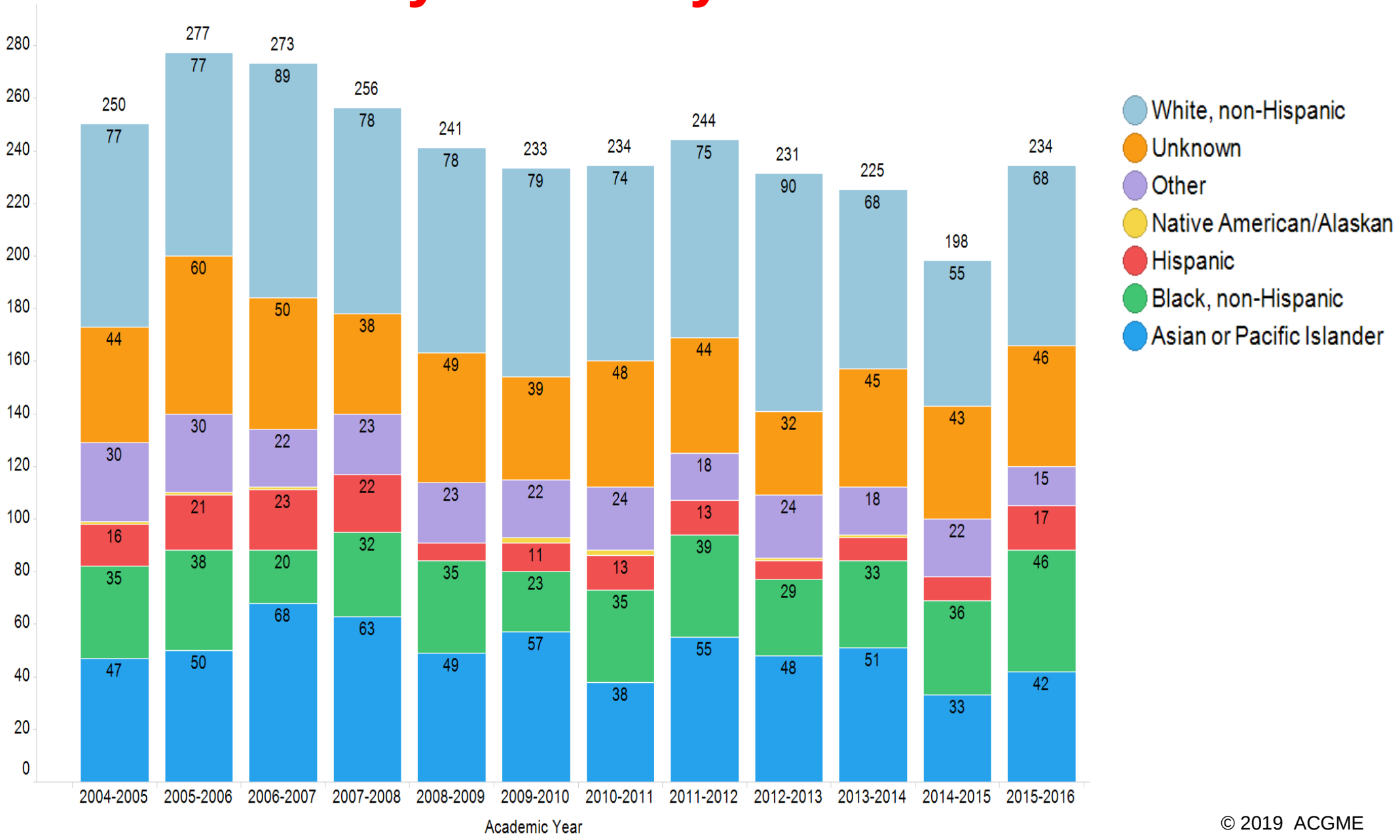
Adverse experiences related to race appear to relate strongly to burnout among minority students and may be related to the increased attrition rates of minority medical students

Dyrbye LN et al. *Arch Intern Med.* 2007;167(19):2103-2109.

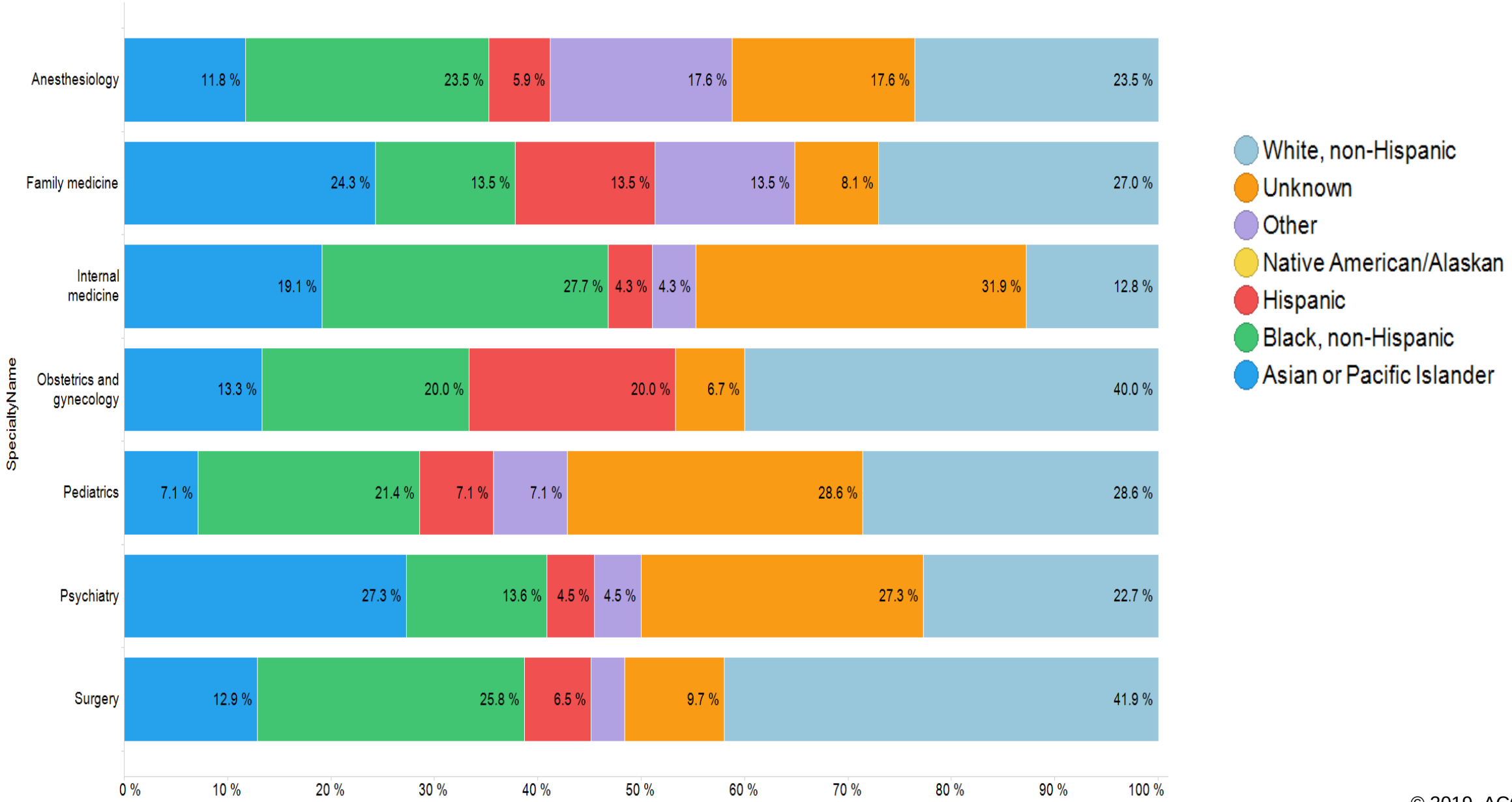
Pipeline Withdrawn by Ethnicity



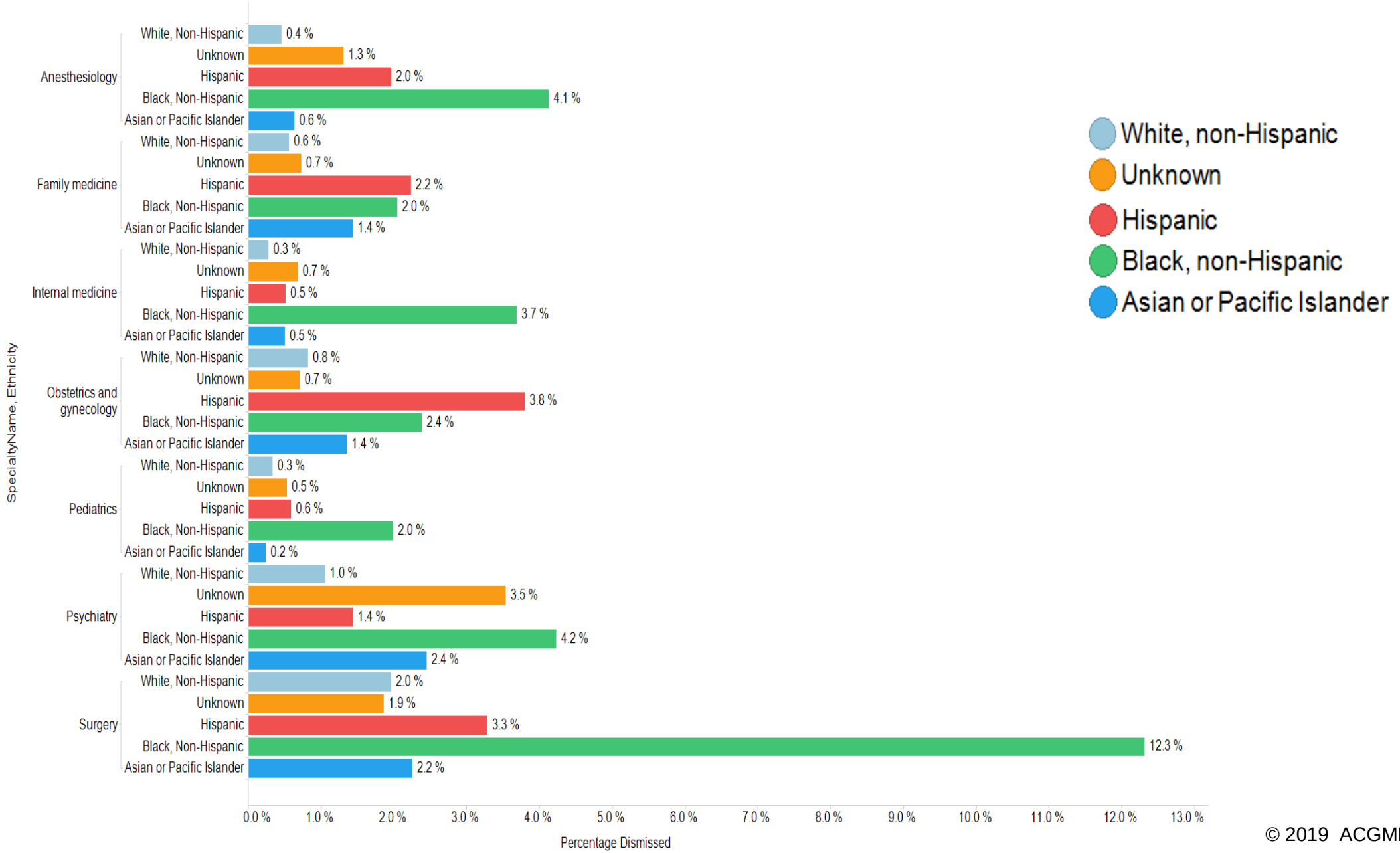
Pipeline Dismissed by Ethnicity



2015-2016 Pipeline Dismissed by Specialty



2015-2016 Pipeline Grads Dismissed by Specialty



MEDICAL TEACHER
https://doi.org/10.1080/0142159X.2019.1566600

Inclusion in the clinical learning environment: Building the conditions for diverse human flourishing

Saleem Razack[a] and Ingrid Philibert[b]

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ABSTRACT

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.

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.

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.

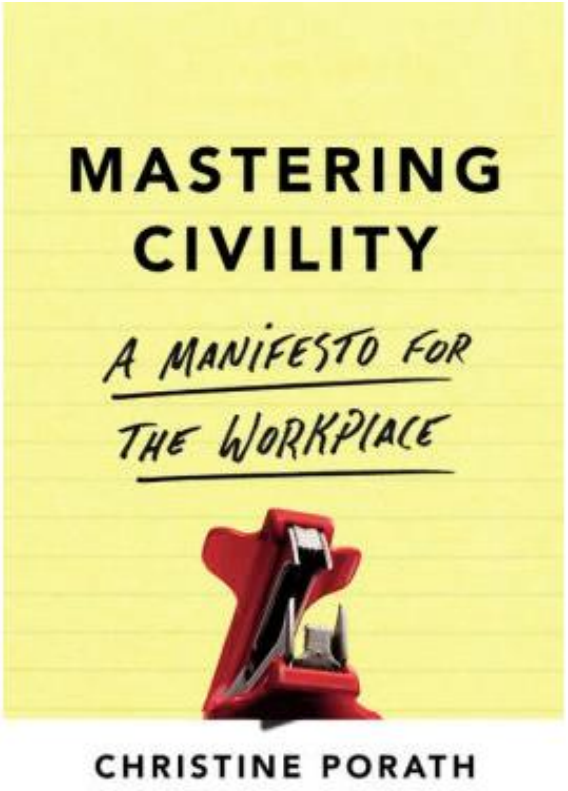
Conclusion: Inclusive CLE's provide space for co-creation, understand the need to ensure the voices of the vulnerable (i.e. learners) are heard and valued and through this promote the flourishing of diverse human capital, in keeping with a model that views diversity as a key attribute or organizational excellence.

Razack S & Philibert I. (2019) *Medical Teacher Published online February 22, 2019. doi:10.1080/0142159X.2019.1566600*

New Program Requirement VI.B.6.

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

3

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

6 12

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. #workh

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 to CPR Section V

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.

Does USMLE Performance Predict Physician Quality?

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

WC McGaghi, ER Cohen, and DB. Wayne (2011) Acad Med. 86:48–52

ACADEMIC MEDICINE | AAMC
Journal of the Association of American Medical Colleges

Assessment and Testing

Are United States Medical Licensing Exam Step 1 and 2 Scores Valid Measures for Postgraduate Medical Residency Selection Decisions?

William C. McGaghie, PhD, Elaine R. Cohen, and Diane B. Wayne, MD

Abstract

Purpose
United States Medical Licensing Examination (USMLE) scores are frequently used by residency program directors when evaluating applicants. The objectives of this report are to study the chain of reasoning and evidence that underlies the use of USMLE Step 1 and 2 scores for postgraduate medical resident selection decisions and to evaluate the validity argument about the utility of USMLE scores for this purpose.

Method
This is a research synthesis using the critical review approach. The study first describes the chain of reasoning that underlies a validity argument about using test scores for a specific purpose. It continues by summarizing correlations of USMLE Step 1 and 2 scores and reliable measures of clinical skill acquisition drawn from nine studies involving 393 medical learners from 2005 to 2010. The integrity of the validity argument about using USMLE Step 1 and 2 scores for postgraduate residency selection decisions is tested.

Results
The research synthesis shows that USMLE Step 1 and 2 scores are not correlated with reliable measures of medical students', residents', and fellows' clinical skill acquisition.

Conclusions
The validity argument about using USMLE Step 1 and 2 scores for postgraduate residency selection decisions is neither structured, coherent, nor evidence based. The USMLE score validity argument breaks down on grounds of extrapolation and decision/interpretation because the scores are not associated with measures of clinical skill acquisition among advanced medical students, residents, and subspecialty fellows. Continued use of USMLE Step 1 and 2 scores for postgraduate medical residency selection decisions is discouraged.

A Plea to Reassess the Role of United States Medical Licensing Examination Step 1 Scores in Residency Selection

Charles G. Prober, MD, Joseph C. Kolars, MD, Lewis R. First, MD, and Donald E. Melnick, MD (2015) *Academic Medicine* 90(10): 1-3

"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

Charles G. Prober, MD, Joseph C. Kolars, MD, Lewis R. First, MD, and Donald E. Melnick, MD (2015) *Academic Medicine* 90(10): 1-3

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

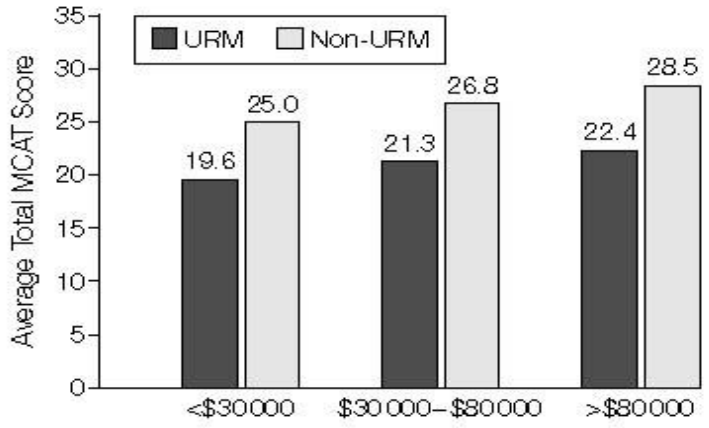
New work beginning with medical schools and ACGME will combine medical school parameters with milestones data from resident performance to begin to identify patterns that may be more correlative with actual practice

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

GENERAL MEDICINE/CONCEPTS

The Diversity Snowball Effect: The Quest to Increase Diversity in Emergency Medicine: A Case Study of Highland's Emergency Medicine Residency Program

Jocelyn Freeman Garrick, MD, MS*; Berenice Perez, MD; Tiffany C. Anaebere, MD; Petrina Craine, MD; Claire Lyons, MD; Tammy Lee, MPH

*Corresponding Author. E-mail: jgarrick@alamedahealthsystem.org.

Blacks, Hispanics/Latinos, American Indians, Pacific Islanders, Alaska Natives, and Native Hawaiians make up 33% of the US population. These same groups are underrepresented in medicine. In 2013, the physician workforce was 4.1% black, 4.4% Hispanic/Latino, 0.4% American Indian or Alaska Native, 11.7% Asian, and 48.9% white. Only 9.9% of emergency physicians identify as underrepresented minority (4.5% black, 4.8% Hispanic/Latino, and 0.6% American Indian/Alaska Native). Efforts to increase the number of underrepresented minority physicians are important because previous studies show improved outcomes when the patient and physician share the same racial/ethnic background. Starting in 2006, the faculty at the Highland EM Residency Program in Oakland, CA, began a diversification initiative to increase the number of underrepresented minority residents. The goal was to closely mirror the US population and match 30% underrepresented minorities with each incoming class. After the initiative, there was a 2-fold increase in the number of underrepresented minority residents (from 12% to 27%). This article is a review of the strategies used to diversify the Highland EM Residency Program. Most components can be applied across emergency medicine programs to increase the number of underrepresented minority residents and potentially improve health outcomes for diverse populations. [Ann Emerg Med. 2019;73:639-647.]

Please see page 640 for the Editor's Capsule Summary of this article.

0196 0644/$ see front matter

https://doi.org/10.1016/j.annemergmed.2019.01.039

INTRODUCTION

In 2017, the US Census reported the racial/ethnic breakdown of the population as 60.7% white, 18.1% Hispanic/Latino, 13.4% black, 5.8% Asian, 1.3% ethnic makeup of the United States may improve health disparities in vulnerable populations.[8-10]

Annals of Emerg Med (2019). 73(8): 639-47

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

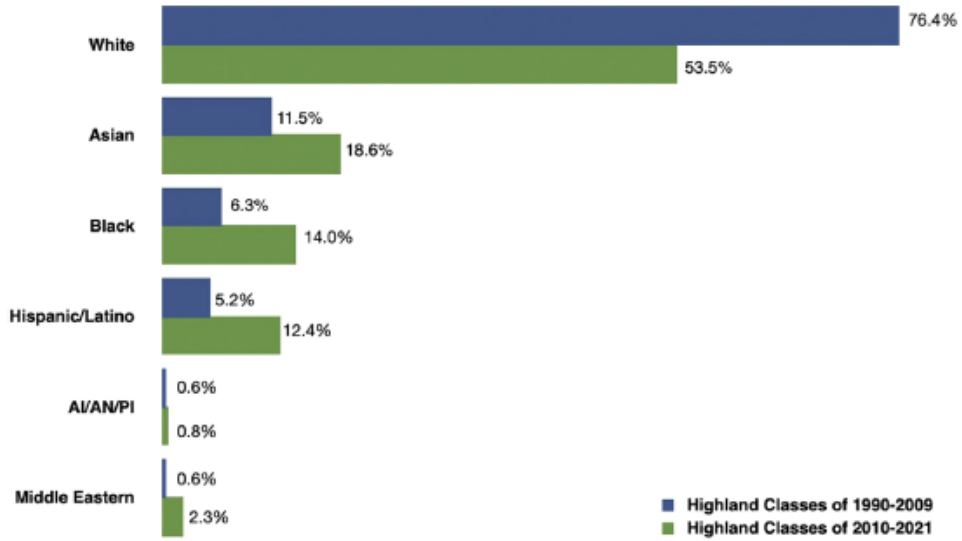


Figure 2. Race/ethnicity of highland emergency medicine residents before and after the Highland diversification initiative. *AI/AN/PI*, American Indian, Alaska Native, and Pacific Islander.

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

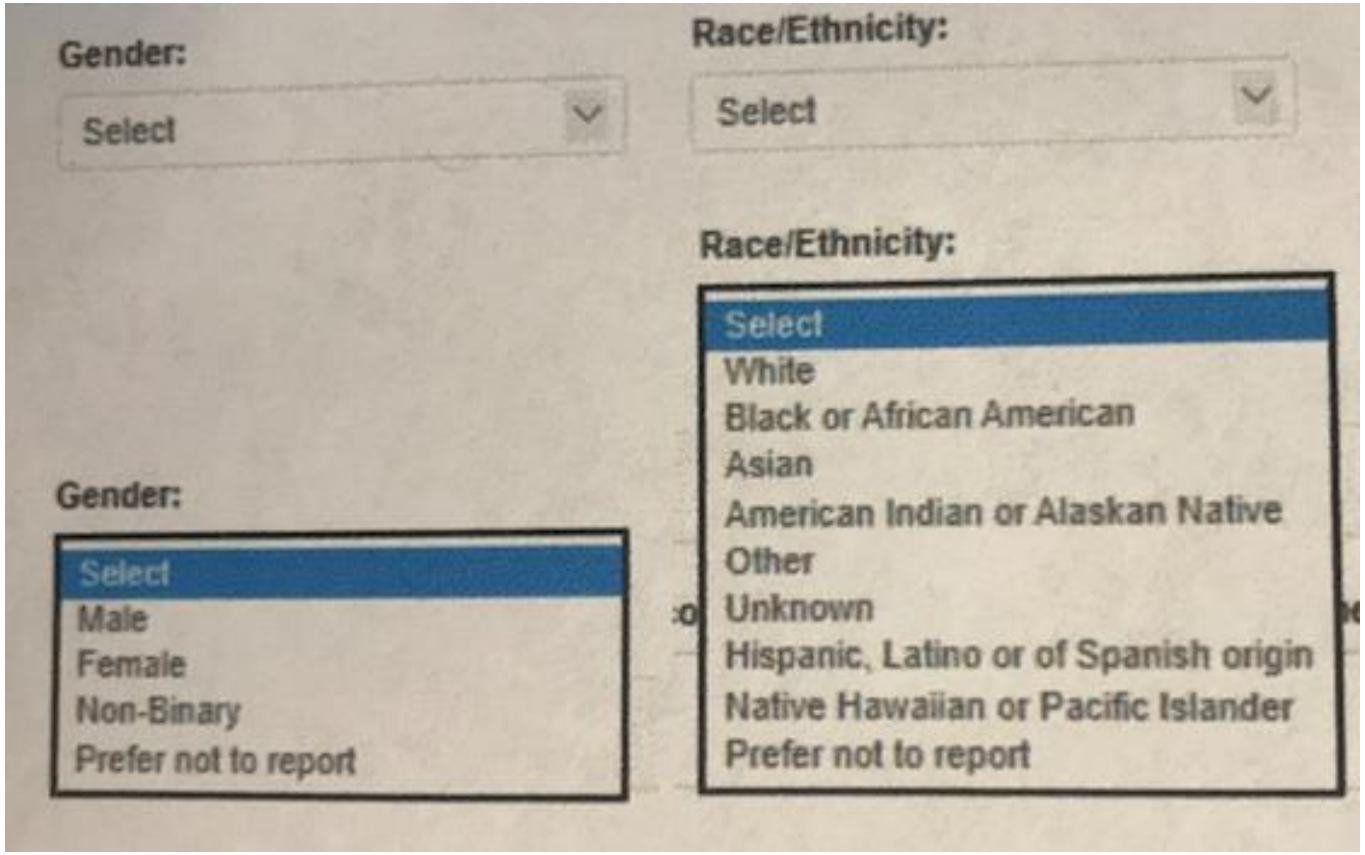
Categories: AAMC

IDENTITY_DETAIL_CD	IDENTITY_DESC
A00	Asian (Category)
A01	Other Asian
A02	Bangladeshi
A03	Cambodian
A04	Chinese
A05	Filipino
A06	Indian
A08	Indonesian
A09	Japanese
A10	Korean
A11	Laotian
A13	Pakistani
A14	Taiwanese
A15	Vietnamese

IDENTITY_DETAIL_CD	IDENTITY_DESC
B00	Black or African American (Category)
B01	African
B02	African American
B03	Afro-Caribbean
B04	Other Black or African American
H00	Hispanic, Latino, or of Spanish Origin (Category)
H01	Argentinean
H02	Colombian
H03	Cuban
H04	Dominican
H05	Mexican, Mexican American, Chicano/Chicana
H06	Other Hispanic, Latino, or of Spanish Origin
H07	Peruvian
H08	Puerto Rican

IDENTITY_DETAIL_CD	IDENTITY_DESC
I00	American Indian or Alaska Native
I01	Tribal Affiliation
P00	Native Hawaiian or Other Pacific Islander (Category)
P01	Guamanian
P03	Native Hawaiian
P04	Other Pacific Islander
P06	Samoan
U00	Unknown
W00	White
X00	Other
Z00	Decline to Respond

Categories: ACGME/AMA



AMA Groupings
Asian
Black
Hispanic
Native American/Alaskan
Unknown
White
Other
Null/blank

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:

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

Implementation of Planning Committee Recommendations

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)

Implementation of Planning Committee Recommendations

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)

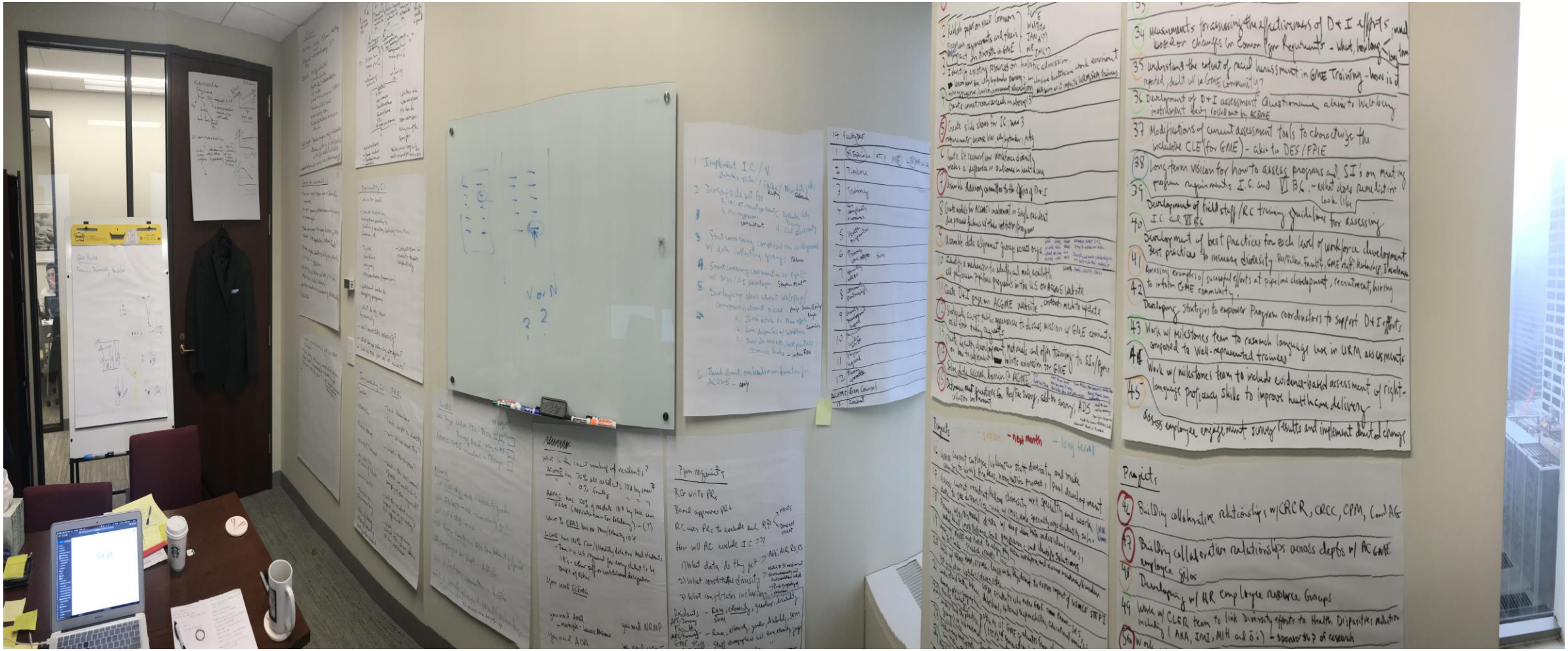
Recommendation 7 *Communications*

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

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