Diversity in Graduate Medical Education

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What does diversity mean?

- **Diversity**
  - Euphemism: Defense against attack of a former term for marginalized groups (e.g., Minority) that was used to address disparities.
  - Literal Meaning: Recognition that allyship through common cause is more effective than each group's independent struggle (Piggybacking, strength in numbers).
  - Antithesis: Everyone has some distinctive aspect and recognition of it gives them meaning and reason to be represented and valued (Identity).

- **Antithesis**
  - Denial that unequal treatment may be a remedy for inequitable (Anti-affirmative action).

- **Colorblindness**

- **Undermines the mission to confront inequitable history that has led to current conditions**
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 and education.

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

• Before 2003: URM (Blacks, Mexican-Americans, Native Americans (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.

• March 19, 2004, the AAMC Executive Committee adopted a clarification to its definition of "underrepresented in medicine" (URiM)

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

• Shift in focus from a national perspective to a regional or local perspective on underrepresentation

• Shift from a fixed aggregation of four groups to a continually evolving underlying reality of demographics of society and the profession

• Data collection and reporting on a broader range of racial and ethnic self-descriptions
Diversity in Context

The context of diversity

The term “diversity” which came about in conjunction with the passage of the U.S. Civil Rights Act of 1964, has been evolving to include an ever-growing list of identities—race, gender, and sexual orientation to physical appearance, believed criteria, thought, values, socioeconomic status, and rural/urban geographic location, among others. This is a welcome expansion of representation, but this added context has a downside: it threatens to blur the targets and obscure actions when achieving diversity is the goal. An important issue in particular seems to be the context of addressing equity for underrepresented racial and ethnic groups. Most weeks, the U.S. National Academy will release five research themes on black, Asian, and women in science, engineering, and medicine—themes that threaten the future of blacks broadly in science. Bending curves to address the emerging diversity at all levels and career levels will helpfully bring racial equity to prominence in these fields and in doing so, expand the benefits of science, engineering, and medicine to society.

There are unintended negative consequences of the expanded definition of diversity. The so many groups, contexts, and measures of diversity are increasingly measured in a piecemeal and disjointed way. Where progress is claimed through any lens that shows success. And, in so many cases, diversity is often described through the lens of gender, leaving other groups as especially important, or unimportant, and it is hard to capture the diverse views of how to move forward in the strategic and present fashions of diversity in science, engineering, and medicine. In other words, the greater context of inclusion and equity can get lost, as long as diversity remains unconnected. The last point is particularly relevant to blacks in the United States who have experienced slavery, legally enforced segregation, and discrimination, and more recently resistance for the advancement of blacks and people of color. It is true in science, engineering, and medicine.

These may be factors in the crucial levels seen across the academic ladder. Blacks in science, engineering, and medicine, for example, the ranking of blacks in entering medical school between 2016 and 2018 in the United States was only 6%, a percentage of 0.1% that represented only 0.1% of all students entering medical school. This occurs during a historic interest in the number of medical schools which represented only 0.7% of all students entering medical school. Thus, while this is happening at the nation’s level, the U.S. National Academy of Medicine’s most recent data, in 2016, 9.7% of all blacks in a class that was recently increased by over 20% in one year. Thus, there is a crucial time in all areas in the medical educational and career systems for this particular group.

In response, the diverse trend of blacks in science and medicine, and a number of science and medicine, the National Academy in 2019 that devoted specifically on the growing numbers of black women in medicine. The idea became a blueprint for actions that address not only blacks in medicine, but also the greater diversity of women in medicine, and moves to create equal opportunity and reinstate overall. Embracing the expanding definition of diversity is easy, but using the word with focus...for achieving diversity will take great attention.

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Source: AAMC Applicant Matriculant Data file as of March 20, 2019
## Total number of active residents 2019-20

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>Core Programs</th>
<th>Overall specialty and subspecialty</th>
</tr>
</thead>
<tbody>
<tr>
<td>White non-Hispanic</td>
<td>56,077 (47.7%)</td>
<td>68,835 (47.5%)</td>
</tr>
<tr>
<td>Asian/ Pacific Islander</td>
<td>22,927 (19.5%)</td>
<td>29,684 (20.5%)</td>
</tr>
<tr>
<td>Hispanic</td>
<td>7,291 (6.2%)</td>
<td>8,891 (6.2%)</td>
</tr>
<tr>
<td>Black Non-Hispanic</td>
<td>6,153 (5.2%)</td>
<td>7,376 (5.1%)</td>
</tr>
<tr>
<td>Native American/Alaska Native</td>
<td>356 (0.3%)</td>
<td>428 (0.3%)</td>
</tr>
<tr>
<td>Other</td>
<td>7,255 (6.2%)</td>
<td>9,615 (6.8%)</td>
</tr>
<tr>
<td>Unknown</td>
<td>17,437 (14.8%)</td>
<td>20,356 (14.0%)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>117,496</strong></td>
<td><strong>144,988</strong></td>
</tr>
</tbody>
</table>
All active anes residents by race/ethnicity/gender #
All active anes residents by race/ethnicity/gender # (inset)
All active anesthesiology residents and fellows by race/ethnicity/gender #
Evidence of Racial and Ethnic Disparities in Healthcare

584 pages detailing the extent of racial and ethnic differences in health outcomes that are not otherwise attributable to known factors such as access to health care

Disparities consistently found across a wide range of disease areas and clinical services

Disparities are found even when clinical factors, such as stage of disease presentation, co-morbidities, age, and severity of disease were adjusted

Disparities are found across a range of clinical settings, including public and private hospitals, teaching and non-teaching hospitals, etc.

Disparities in care are associated with higher mortality among minorities (e.g., Bach et al., 1999; Peterson et al., 1997; Bennett et al., 1995)

Why does diversity matter?

We live in racially segregated communities

Disease burden and health and healthcare inequities are strongly concentrated in residential areas of historically marginalized individuals

People tend to seek medical care within their community

Historically marginalized practitioners tend to practice in underserved communities and serve residents of their same race/ethnicity (race-concordance)

There are high odds that a Black, Latinx or Asian physician will disproportionately see a patient of their same race or ethnicity

The percentage of historically marginalized physicians trained in the US has not changed in 15 years
Benefits of racially concordant care

Addresses the unfortunate reality of how we trust in American society

Intention to adhere to medical advice is heightened

Patient satisfaction is better among historically marginalized individuals who receive racially concordant care

Improved clinical outcomes in some categories has been shown

Improves access to care for individuals who would rather forego care than to receive it in an environment that dehumanizes them, discriminates against them and fails to communicate effectively with them
ACGME foundational principles in DEI

- Society must view health care disparities as a deficiency in healthcare quality
- Health equity is a means to achieve elimination of health care disparities
- Increasing workforce diversity is a means to achieve health equity
- Inclusion is a tool to ensure that diversity is successful
Health disparities can be eliminated after health equity is achieved

Provision of fair and just care to each person for what they need to be as healthy as possible

A system, by design, that does not disadvantage, marginalize or disenfranchise any user

Absence of remediable differences in health between groups
Hazard of depending on racially concordant care to eliminate health disparities

Racial and ethnic health inequities occur because of other factors, more social than medical.

The social determinants of health contribute to excess morbidity and mortality that does not have a solely medical solution: Lack of access to healthy foods and food practices; inundation with ultraprocessed foods; community and interpersonal violence; lack of access to greenspace for play and exercise; toxic environmental conditions; housing insecurity; poverty/wealth gap; allostatic load; adverse childhood events; inadequate transportation; neighborhood disinvestment; over-policing; residential segregation; and, structural racism.\(^1\)

The political determinants of health recognize how inequitable policies, politics, regulations and laws have impaired access to care and contribute to health inequities.\(^2\)

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Hazard of depending on racially concordant care to eliminate health disparities

We have not graduated enough Black, Latinx and Indigenous physicians over the past 40 years to satisfy the demand for concordant care.

All physicians must embrace cultural humility to improve the care they give to patients from historically marginalized groups.
ACGME action Steps

- ACGME formed an Office for Diversity Equity and Inclusion (DEI)
- Modified common program requirements to address DEI
- Developed new tools to assess programs and institutions for compliance
- Changed its mission to address the formative piece that programs typically lack in experience and expertise in DEI
- Changed its vision to explicitly add diversity and inclusion as key elements
- Developed learning communities to continuously inform and improve DEI practices: ACGME Equity Matters
ACGME EQUITY MATTERS

A Continuous Learning and Process Improvement Initiative in DEI for the GME Community
What is Equity Matters?

DEI Resources\* + Learning Communities = Equity Matters in GME
Equity Matters Goal - Resource Provision for GME

- Inquire, Engage, Extract
- Analyze, Assess, Customize, Innovate
- Guide and Assist
## Equity Matters Learning Communities - Purpose

<table>
<thead>
<tr>
<th>Inquire, engage, extract</th>
<th>Analyze, customize and innovate</th>
<th>Guide and assist</th>
</tr>
</thead>
<tbody>
<tr>
<td>Engage with experts and compile existing practices from the GME community to provide a resource that enhances understanding of current efforts in DEI and anti-racism. Establish safe and brave spaces for those driving change.</td>
<td>Generate problem lists, assess current educational and program development tools that address the problems, analyze gaps, then customize current tools or, where needed, innovate new ones to enact favorable change in diversity and clinical learning environments</td>
<td>Guide the enactment and assessment of these new tools to cause effective change and disseminate through peer-advisory use of members from Learning Communities</td>
</tr>
</tbody>
</table>
Equity Matters - Continuous Learning and Process Improvement Phases

- Acknowledge
- Acceptance
- Assessment & Adaptation
- Action
4 Learning Communities – 2021-2022

DEI Leadership Certificate
• 90 Individuals
• Organizational, Department, Program, and Resident Leader Participants

Council of Medical Specialty Societies
• 28 Specialty Societies
• 54 CEO/Presidents and DEI Leader Participants

Organization of Program Directors Associations
• 11 Associations
• 22 GME and DEI Leader Participants

Blue Cross Blue Shield IL/IPD
• 7 Institutions
• 70 CEO, CFO, CMO, DEI, GME Leader, and Resident Participants
Workforce Diversity matters to the elimination of health disparities

• Eliminating health care disparities is consistent with the mission of the ACGME to improve health care and population health by assessing and enhancing the quality of resident physicians' education through advancements in accreditation and education

• ACGME envisions a health care system where the quadruple aim has been realized, aspiring to advance a transformed system of GME with global reach that is immersed in evidence-based, data-driven, clinical learning and care environments defined by excellence in clinical care, safety, cost effectiveness, professionalism, and diversity and inclusion

• Educating physicians who are more likely to serve underserved patients and locate in minority communities increases health care access and improves trust, communication and outcomes for those most at risk for health disparities
Increasing racial/ethnic diversity in the physician workforce supports concordance

Isn’t forcing people to work where they don’t want to work

Isn’t limiting patient access to the best physicians

Isn’t forcing patients to only see doctors of their own race/ethnicity

Proximity is an important factor, but not the only factor

Physicians’ willingness to work in disadvantaged communities and to accept Medicare/Medicaid

Patient choice plays a role
Care provided by a physician who shares the racial identity of the patient

Why do individuals seek out physicians of their same race/ethnicity/religion?

- Comfort/familiarity
- Language concordance/communication
- Safety- psychological, physical
- Trust, respect
- Shared world-view
- Proximal location

Why do physicians disproportionately care for patients of their same race/ethnicity/religion?

- Race-conscious professionalism
  - Sense of doing a societal good; Recognition of unique role; job satisfaction
  - Identifies with the population served
  - Sense of belongingness
- Exclusion from markets
  - Discrimination/Racism
  - Elitism
ACGME Actions

Common Program Requirements

- **Section IC** enjoin programs in partnership with their SIs to engage in practices to increase workforce diversity and provide for inclusivity.

- **Section VIB.6** enjoin programs to provide a civil, equitable, professional learning environment.

- **Section II.A.4.a).(10)** protects residents from retaliation and intimidation.

- **Section V** shifts emphasis to ultimate success on board certification from the sole use of first-time exam performance.

Clinical Learning Environment Review

**HQ Pathway 5**: Resident, fellow, and faculty member education on eliminating health care disparities.

**HQ Pathway 6**: Resident, fellow, and faculty member engagement in clinical site initiatives to eliminate health care disparities.
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)

Changes went into effect 1 July 2019
Physician Pipeline—“Pathway” Problem

There are not enough URMIs 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?
Opportunities for Partnership

Science Technology Engineering and Math → STEM and Medicine STEMM

Many community programs focus on early learners but don’t feel comfortable connecting with hospitals and academic medical centers in their communities—reach out to them

Half of the programs ACGME accredits are not directly associated with a medical school — If these programs actively engage with STEMM programs, we can greatly enhance community partnerships

AMCs have resources and can provide mentors, shadowing opportunities, and research experiences

AMCs have also constructed barriers and can remove them to enhance access
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 pathway of candidates into medicine at various levels 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: **Regularize Individualized Learning Plans**

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
What happens when you increase diversity in an environment unaccustomed to it?

Matriculation of residents from underrepresented groups requires social adaptation of the learning environment:

- Mitigate cultural underexposure or indifference
- Cease stereotypical projections
- Reduce environmental elements that trigger imposter syndrome
- Effectively and transparently address uncivil behavior

Diversity education, implicit bias training and mandatory demonstration of competence often engender cynicism, resistance and resentment within the learning environment.

Must protect those charged with increasing diversity from being targeted by racism deniers or those antagonistic to change in our communities.
Naming racism in order to dismantle it

- Institutionalized/Structural
- Personally-mediated
- Internalized

Examine structures, policies, practices, norms, and values to answer the questions:
- How are these inequities being maintained?
- How could race be operating here?

https://www.youtube.com/watch?v=GNhcY6fTyBM

The Gardner’s Tale
Woven into society’s fabric
Demonstrates how past mistreatment drives current inequities
Focused much more on outcomes than on bad actors
Measured by outcomes like disparities

May appear as subtle, unconscious, unintended structures or normative values that are based upon privileges afforded primarily to the dominant culture – White privilege: Unasked for and unearned
Remedy requires a change in social structures


Common Program Requirements Section V: First-time Pass Rate

ACGME seeks to improve the quality of resident education, and a measure of this has been the first-time specialty certification exam pass rate.

Each specialty residency review committee had been able to set its own floor as to what constituted a successful first-time pass rate.

ACGME has now made the first-time pass rate the same for all specialties.

ACGME is now concerned with collection of longitudinal board certification data to examine ultimate pass rate compared to first-time pass rate with respect to quality of performance in practice.

Historically marginalized students have lower median scores on standardized examinations for MCAT and USMLE Steps 1 and 2 than whites.
Modified program requirements regarding first-time board pass rates

Intended to reduce overreliance on USMLE Step 1 performance
Reduces the unintended consequences of the emphasis now placed on Step 1
Allows medical schools to stress their distinctive strengths as opposed to having a national curriculum
May improve ability to diversify specialties that have overemphasized the importance of USMLE Step 1 performance and that currently have little diversity

Logistic regression showed white examinees compared with nonwhite examinees (black individuals, Asian individuals, and individuals of other races) (OR, 1.8; 95%CI, 1.03-3.0) were more likely to pass the qualifying examination on the first try.

White, non-Hispanic examinees compared with Hispanic examinees (OR, 2.4; 95%CI, 1.2-4.7) were more likely to pass the certifying examination on the first try.
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.
Do we overemphasize standardized examination performance?

94-99% of physicians ultimately pass their board certifying examinations.

Considerable evidence correlates MCAT with USMLE Step 1 score, and USMLE Step 1 score with first-time specialty examination performance.

First-time passage has not been shown to correlate with stronger clinical performance.

No correlation between high quality practice outcomes for physicians trained in programs that selected trainees with higher standardized medical licensure scores. Using standardized test scores to determine who is the “best” clinician was not supported in this study.

Complication rates for graduates in practice best correlated with the complication rate of the residency program in which they trained. The effect persisted for 17 years post-residency.

Judging medical training programs by subsequent patient outcomes places the evaluation of medical training much closer to its purpose than do evaluations based on admission selectivity, board scores, or rankings by news magazines or leaders in the field.

Since holistic admission relies less on standardized test performance history, expectations that standardized testing ability will improve without intervention to address the skills deficit is harmful:

- Provide individualized education supplementation
- Remove or reduce significance of standardized testing requirements from assessment and promotion in training
A Plea to Reassess the Role of United States Medical Licensing Examination Step 1 Scores in Residency Selection

“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.
USMLE program announces upcoming policy changes

Posted: February 12, 2020

Today, the Federation of State Medical Boards (FSMB) and the National Board of Medical Examiners® (NBME®), co-sponsors of the United States Medical Licensing Examination® (USMLE®), announced upcoming policy changes to the USMLE program.

- Changing Step 1 score reporting from a three-digit numeric score to reporting only pass/fail;
- Reducing the allowable number of exam attempts on each Step or Step Component from six to four; and
- Requiring all examinees to successfully pass Step 1 as a prerequisite for taking Step 2 Clinical Skills

These new policies will continue to enable the USMLE program to provide high-quality assessments for the primary user of exam results (state medical boards) while also addressing other considerations, such as exam security and unintended consequences of secondary score uses. The secondary uses of Step 1 scores for residency screening, in particular, have been the focus of extensive discussion over the past year at the FSMB and NBME, within the USMLE program, and with multiple stakeholders within the broader medical education and regulatory communities.

"These new policies strengthen the integrity of the USMLE and address concerns about Step 1 scores impacting student well-being and medical education," said Humayun Chaudhry, DO, MACP, President and CEO of the FSMB. "Although the primary purpose of the exam is to assess the knowledge and skills essential to safe patient care, it is important that we improve the transition from undergraduate to graduate medical education."

"The USMLE program governance carefully considered input from multiple sources in coming to these decisions. Recognizing the complexity of the environment and the desire for improvement, continuation of the status quo was not the best way forward," reported Peter Katsurakis, MD, MBA, President and CEO of NBME. "Both program governance and staff believe these changes represent improvements to the USMLE program and create the environment for improved student experiences in their education and their transition to residency."

These policy changes are currently planned to be phased in over the next 11-24 months. For specific information on each policy, consult the links above to the detailed statements accompanying each policy change. A podcast supplementing the information contained in this announcement is below.
After controlling for US Medical Licensing Examination Step 1 scores, research productivity, community service, leadership activity, and Gold Humanism membership, the study found that black (adjusted odds ratio [aOR], 0.16; 95%CI, 0.07-0.37) and Asian (aOR, 0.52; 95%CI, 0.42-0.65) medical students remained less likely to be AΩA members than white medical students.

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 in training.

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 directly 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

Cohen JJ. The Consequences of Premature Abandonment of Affirmative Action in Medical School Admissions. JAMA. 2003; 298(9):1143-9
The Diversity Snowball Effect: The Quest to Increase Diversity in Emergency Medicine: A Case Study of Highland's Emergency Medicine Residency Program

Jacelyn Freeman Gwiritch, MD, MEd; Beaver Pena, MD, Tiffany C. Amare, MD, Patricia Craine, MD; Claire Lyons, MD, Tammy Lee, MPH

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Diversity Committee
Attending and resident buy-in Diversity applicant week

Increased weight of gestalt score

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

0369 0444/© see front matter
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https://doi.org/10.1016/j.annemergmed.2019.01.033


Figure 2. Race/ethnicity of highland emergency medicine residents before and after the Highland diversification initiative. A/AN/Pi, American Indian, Aléshia Native, and Pacific Islander.

BLacks, Hispanic/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, 3.7% Asian, and 48.5% white. Only 8.9% of emergency physicians identify as underrepresented minority (URM) black, 4.5% 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 2013, the faculty at the Highland ER Residency Program in Galesburg, IL 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 were 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 ER 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(6):43-47]
“Not everything that can be counted counts, and not everything that counts can be counted”

William Bruce Cameron (1963) “Informal Sociology: A Casual Introduction to Sociological Thinking”
Inclusive Clinical Learning Environment

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)
Obtained AAMC GQ data from 2016 and 2017 from 27,504 graduates

Compared with white students, Asian, URM, and multiracial students reported higher rates of mistreatment (24.0%, 31.9%, 38.0%, and 32.9%) and discrimination based on race/ethnicity (3.8%, 15.7%, 23.3%, and 11.8%, respectively)

URM female medical students reported the highest prevalence of racial/ethnic discrimination
How common is, abuse and discrimination?

7409 residents (99.3% of the eligible residents) from all 262 surgical residency programs surveyed 31.9% reported discrimination based gender, 16.6% reported racial discrimination, 30.3% reported verbal or physical abuse (or both), and 10.3% reported sexual harassment.

65.1% of the women reported gender discrimination and 19.9% reported sexual harassment.

Patients and families were most frequent sources of gender discrimination (43.6% of residents) and racial discrimination (47.4%), whereas attending surgeons were the most frequent sources of sexual harassment (27.2%) and abuse (51.9%).

Hu and Ellis et al. NEJM (2019) DOI: 10.1056/NEJMsa1903759
National Evaluation of Racial/Ethnic Discrimination in US Surgical Residency Programs

6956 residents in 301 programs sampled, 1346 (23.7%) reported discrimination (race/ethnicity/religion)

Discrimination rates were higher in blacks (171 of 242 [70.7%]), Asians (442 of 963 [45.9%]), Latinx (122 of 482 [25.3%]), and other nonwhites (175 of 526 [33.3%]) compared with whites (435 of 3455 [12.6%]).

For Blacks:
- Different standards of evaluation (92 of 240 [38.3%])
- Denied opportunities (39 of 242 [16.1%])
- Slurs and hurtful comments (60 of 242 [24.8%])
- Mistaken nonphysician 62.4%, someone else 55.8%

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 and the Learning Environment

Students from racial and ethnic minorities experience more microaggressions that they attribute to their race.

Studies suggest that the higher prevalence of depression symptoms among this subgroup of students is likely driven by factors within the learning environment rather than individual traits.

Medical schools need to do more to improve the learning environment for nonwhite students.

A Prognostic Index to Identify the Risk of Developing Depression Symptoms Among U.S. Medical Students Derived From a National, Four-Year Longitudinal Study

Lizette N. Dyrbye, MD, MPH, Natalie M. Wittet, MD, Rachel R. Hackman, PhD, MPH, Mark Yeazel, MD, MPH, Jason Hedin, PhD, John P. Devito, PhD, Sara E. Burek, PhD, Brooke Cunningham, MD, PhD, Sean M. Phelan, PhD, MPH, D. Shanafelt, MD, and Michelle van Ryn, PhD, MPH

Abstract

Purpose
To determine baseline individual and school-related factors associated with increased risk of developing depression symptoms by year four (Y4) of medical school, and to develop a prognostic index that stratifies risk of developing depression symptoms (Depression-Pi) among medical students.

Method
The authors analyzed data from 3,743 students (79% of 4,732) attending 49 U.S. medical schools who completed baseline (2010) and Y4 (2014) surveys. Surveys included validated scales measuring depression, stress, coping, and social support. The authors collected demographics and school characteristics and conducted multivariate analysis to identify baseline factors independently associated with Y4 depression symptoms. They used these factors to create a prognostic index for developing depression.

They randomly divided the data into discovery (n = 2,405) and replication (n = 1,288) datasets and calculated c statistics (c).

Results
The authors identified eight independent prognostic factors for experiencing depression symptoms during training within the discovery dataset: age, race, ethnicity, tuition, and baseline depression symptoms, stress, coping behaviors, and social support.

Conclusions
Demographics, tuition, and baseline depression symptoms, stress, coping behaviors, and social support are independently associated with risk of developing depression during training among U.S. medical students. By stratifying students into four risk groups, the Depression-Pi may allow for a tiered primary prevention approach.
Ability to focus wanes
Engagement with work suffers
Feelings of apathy and hopelessness
Increased irritability, emotional exhaustion
Lack of productivity and poor performance

Burnout impairs job performance
Pipeline Withdrawn by Ethnicity (%)
Pipeline Dismissed by Ethnicity (%)
5.1% of all surgery residents are Black

5.9% of all pediatrics residents are Black

3.1% of all ortho residents are Black
2015-2016 Pipeline Grads Dismissed by Specialty

- Anesthesiology
  - White, non-Hispanic: 0.4%
  - Unknown: 1.3%
  - Hispanic: 2.0%
  - Black, non-Hispanic: 4.1%

- Family medicine
  - White, non-Hispanic: 0.6%
  - Unknown: 0.7%
  - Hispanic: 2.2%
  - Black, non-Hispanic: 6.7%

- Internal medicine
  - White, non-Hispanic: 0.8%
  - Unknown: 0.7%
  - Hispanic: 3.7%
  - Black, non-Hispanic: 2.2%

- Obstetrics and gynecology
  - White, non-Hispanic: 0.4%
  - Unknown: 1.4%
  - Hispanic: 2.4%
  - Black, non-Hispanic: 12.3%

- Orthopaedic surgery
  - White, non-Hispanic: 12.5%
  - Unknown: 2.0%
  - Hispanic: 12.3%
  - Black, non-Hispanic: 12.3%

- Pediatrics
  - White, non-Hispanic: 0.2%
  - Unknown: 1.0%
  - Hispanic: 3.5%

- Psychiatry
  - White, non-Hispanic: 1.4%
  - Unknown: 2.4%
  - Hispanic: 4.2%

- Surgery
  - White, non-Hispanic: 2.0%
  - Unknown: 3.3%
  - Hispanic: 6.1%
Female surgical residents face discrimination that can mean burnout, suicidal thoughts, study finds

by Bethany Ao, Updated: December 16, 2019

When Beine Wong was a urology resident at Stanford Hospitals and Clinics, she found herself sidelined in favor of her fellow resident—a white man—as at least one occasion when it came to major surgeries, like kidney or bladder removals.

“I remember a specific incident when my attending asked for someone with ‘more muscle,’ ” said Wong, a urologist in private practice in Chester County. “It was very disappointing.”

Second-year med student Christopher Veal had just learned he failed a remediation course, necessitated because he had failed — by just one point — his final musculoskeletal exam.

Those failures were bad enough. Then, as a University of Vermont (UVM) dean was giving him this bad news, Veal heard the words he had dreaded. Two former classmates grimly told him: Whenever the dean asked this question, it was a signal he should consider quitting.

“Are you sure you really want to become a doctor?”

In an invited commentary published Feb. 9 in Academic Medicine, Veal, now in his fourth year at UVM’s Lerner College of Medicine, described how crushed and terrified he felt. He hid in a stairwell, got down on his knees and cried. He most certainly did want to become a doctor.
Experiences of LGBTQ Residents in US General Surgery Training Programs

2019 survey of surgical residents attached to the ABSITE exam.
6381 residents (85.6% response rate) of whom 305 (4.8%) described themselves as LGBTQ

LGBTQ residents were as satisfied as their non-LGBTQ peers with their decision to become a surgeon, they were nearly twice as likely to consider leaving their program.

52.9% experienced discrimination (vs. 42.3% non-LGBTQ, p<0.001)
47.5% sexual harassment (vs. 29.3%, p<0.001)
74.8% bullying (vs. 66.9% non-LGBT, p=0.005)

Attending surgeons were most common source

Surgical educators should be aware of the unique stressors faced by their LGBTQ trainees, but half of trainees don’t disclose

Table 2. Frequency of Mistreatment, Duty-Hour Violations, Burnout, and Suicidal Thoughts among U.S. Surgical Residents.\textsuperscript{2}

<table>
<thead>
<tr>
<th>Variable</th>
<th>Overall (N = 7409)</th>
<th>Men (N = 4438)</th>
<th>Women (N = 2935)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>number (percent)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gender discrimination</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A few times per year</td>
<td>2366 (31.9)</td>
<td>442 (10.0)</td>
<td>1912 (65.1)</td>
</tr>
<tr>
<td>A few times per month or more frequently</td>
<td>913 (12.3)</td>
<td>117 (2.6)</td>
<td>789 (26.9)</td>
</tr>
<tr>
<td>Racial discrimination</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A few times per year</td>
<td>1227 (16.6)</td>
<td>671 (15.1)</td>
<td>547 (18.6)</td>
</tr>
<tr>
<td>A few times per month or more frequently</td>
<td>859 (11.6)</td>
<td>477 (10.7)</td>
<td>379 (12.9)</td>
</tr>
<tr>
<td>Discrimination based on pregnancy or childcare status</td>
<td>368 (5.0)</td>
<td>194 (4.4)</td>
<td>168 (5.7)</td>
</tr>
<tr>
<td></td>
<td>532 (7.2)</td>
<td>144 (3.2)</td>
<td>383 (13.0)</td>
</tr>
<tr>
<td>A few times per year</td>
<td>361 (4.9)</td>
<td>84 (1.9)</td>
<td>275 (9.4)</td>
</tr>
<tr>
<td>A few times per month or more frequently</td>
<td>171 (2.3)</td>
<td>60 (1.4)</td>
<td>108 (3.7)</td>
</tr>
<tr>
<td>Any discrimination on the basis of gender, race, or pregnancy or childcare status</td>
<td>2848 (38.4)</td>
<td>884 (19.9)</td>
<td>1950 (66.4)</td>
</tr>
<tr>
<td>A few times per year</td>
<td>1773 (23.9)</td>
<td>645 (14.5)</td>
<td>1122 (38.2)</td>
</tr>
<tr>
<td>A few times per month or more frequently</td>
<td>1075 (14.5)</td>
<td>239 (5.4)</td>
<td>828 (28.2)</td>
</tr>
</tbody>
</table>

Only 5.1% (810) of all surgery residents are Black, 8.8% (810) are Latinx, 18.8% (1737) are Asian.
<table>
<thead>
<tr>
<th>Variable</th>
<th>Overall (N = 7409)</th>
<th>Men (N = 4438)</th>
<th>Women (N = 2935)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Any mistreatment exposure</strong></td>
<td>3694 (49.9)</td>
<td>1605 (36.1)</td>
<td>2073 (70.6)</td>
</tr>
<tr>
<td>A few times per year</td>
<td>2289 (30.9)</td>
<td>1120 (25.2)</td>
<td>1162 (39.6)</td>
</tr>
<tr>
<td>A few times per month or more frequently</td>
<td>1405 (19.0)</td>
<td>485 (10.9)</td>
<td>911 (31.0)</td>
</tr>
<tr>
<td><strong>Duty-hour violations of the 80-hr rule in the previous 6 mo — no. of mo</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0</td>
<td>4518 (61.0)</td>
<td>2952 (66.5)</td>
<td>1548 (52.7)</td>
</tr>
<tr>
<td>1–2</td>
<td>1869 (25.2)</td>
<td>954 (21.5)</td>
<td>906 (30.9)</td>
</tr>
<tr>
<td>≥3</td>
<td>1022 (13.8)</td>
<td>532 (12.0)</td>
<td>481 (16.4)</td>
</tr>
<tr>
<td><strong>Outcome measures</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Burnout</strong></td>
<td>2849 (38.5)</td>
<td>1591 (35.9)</td>
<td>1245 (42.4)</td>
</tr>
<tr>
<td><strong>Suicidal thoughts</strong></td>
<td>333 (4.5)§</td>
<td>173 (3.9)</td>
<td>156 (5.3)</td>
</tr>
</tbody>
</table>

Hu and Ellis et al. NEJM (2019) DOI: 10.1056/NEJMsa1903759
Addressing Harmful Bias and Eliminating Discrimination in Health Professions Learning Environments

• Build an institutional culture of fairness, respect and anti-racism by making diversity equity and inclusion top priorities
• Develop, assess, and improve systems to mitigate harmful biases and to eliminate racism and all other forms of discrimination
• Integrate equity into health professions curricula, explicitly aiming to mitigate the harmful effects of bias, exclusion, discrimination, racism, and all other forms of oppression
• Increased the numbers of health professions students, trainees, faculty, an institutional administrators and leaders from historically marginalized and excluded populations

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Thank you
Closing the gap won’t be easy

To achieve meaningful change, people must be willing to take uncomfortable steps. It’s human nature to want to stick with what’s safe and familiar.

I [will] urge people to do uncomfortable things because that’s the only way we make progress. Justice has never happened, equality has never been won, breakthroughs in science or in human relations have never been achieved by people who only do things that are comfortable and convenient. We cannot increase the justice quotient or the health quotient if we insist on only doing things that are easy.

- Bryan Stevenson at AAMC 2019