ACGME's Approach to Diversity, Equity, and inclusion in GME

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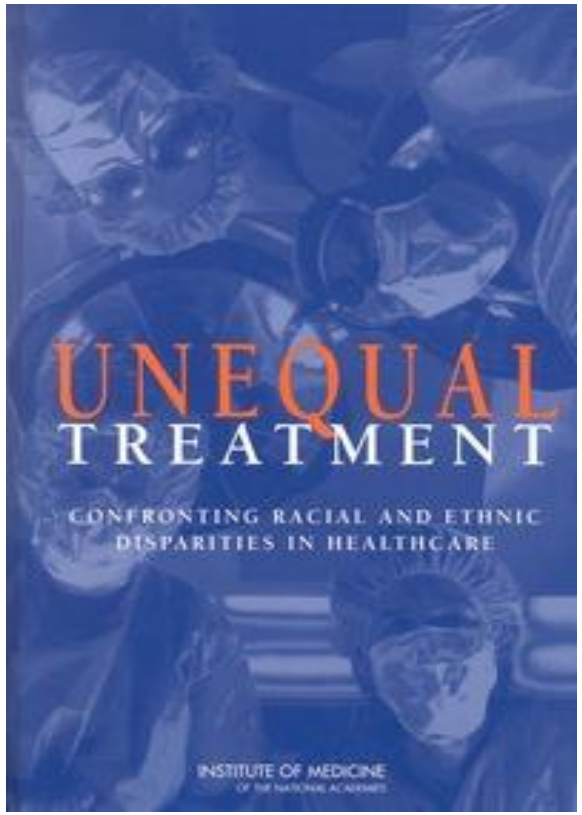
Evidence of racial and ethnic disparities in healthcare



Nat Academy Press 2002
http://www.nap.edu/catalog/10260.html

- 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)

ACGME foundational principles in DEI

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

Why does diversity matter?

- We tend to live in racially segregated communities in the United States
- 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 their historically marginalized residents
- 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

Relevance of race/ethnicity to service

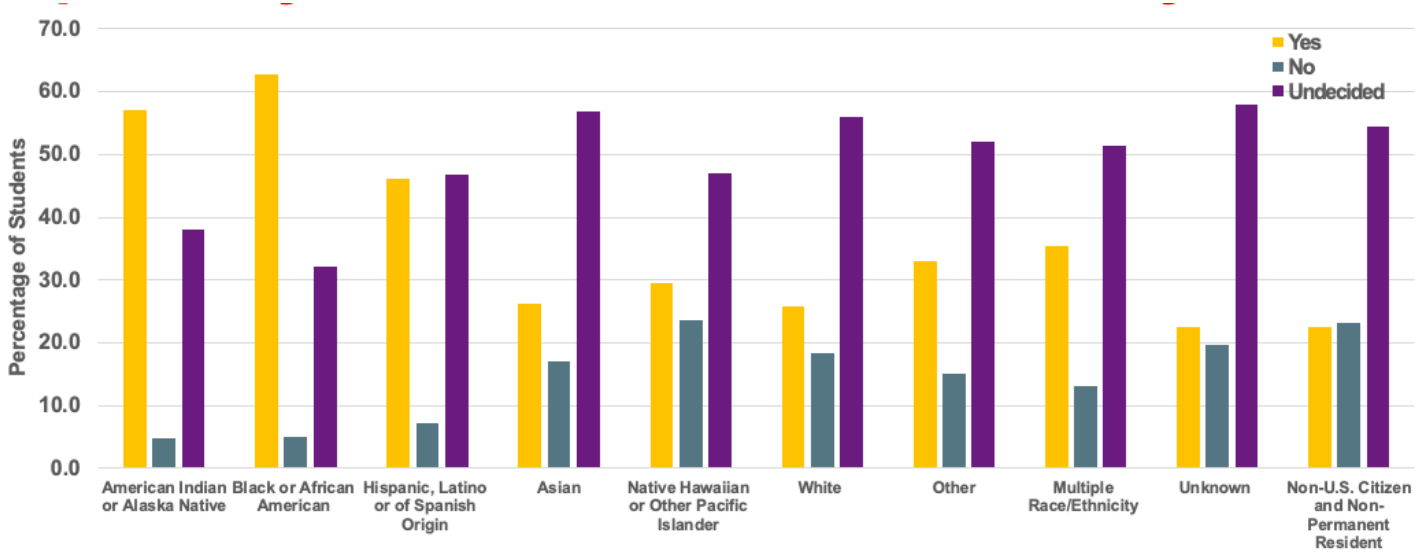
Students from UIM groups tend to want to serve underserved patients and work in disadvantaged communities disproportionately. This is borne out by multiple workforce studies that show relative odds of racial concordance in care.

SES alone is not an adequate surrogate for race/ethnicity to predict practice patterns because UIM students from the highest SES categories serve the underserved at greater rates than do white students from the lowest SES groups.[1,2]

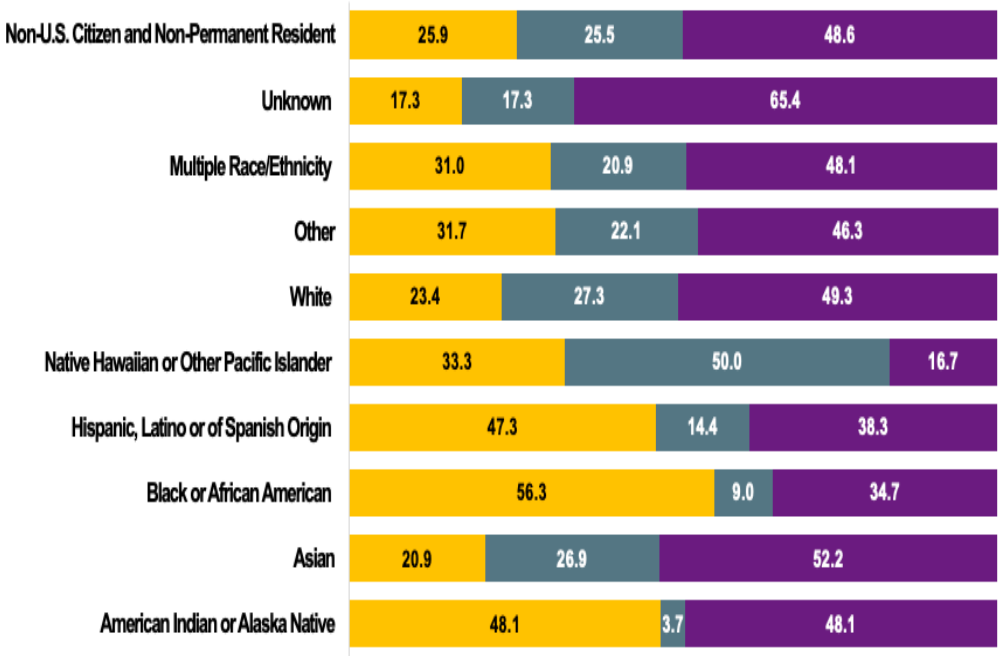
[1]Saha S, Shipman SA. Race-neutral versus race-conscious workforce policy to improve access to care. Health Aff (Millwood). 2008;27(1):234-245.
[2]Xu, Gang, et al. "The relationship between the race/ethnicity of generalist physicians and their care for underserved populations." American Journal of Public Health 87.5 (1997): 817-822.

Can you predict who is more likely to serve underserved and marginalized communities?

AAMC Matriculating Student Questionnaire



AAMC Graduating Student Questionnaire



AAMC: Data Warehouse, MSQ_R, GQ_R, and IND_IDENT_R tables as of December 30, 2020. MSQ_R last updated 1/9/2020. GQ_R last updated 8/26/2020. IND_IDENT_R last updated 12/3/2020.

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.

Impact of racial concordance is greater in primary care

Cross-sectional analysis of a nationally representative sample of 150,391 visits by black and white Medicare beneficiaries to 87,893 physicians

Most visits by black patients were with a small group of physicians (80% of visits were accounted for by 22% of physicians) whereas these same physicians (19,492) only saw 22% of white patients; 68,311 physicians saw 78% of white patients, but only 20% of black patients.

Physicians treating black patients report greater difficulties in obtaining access for their patients to subspecialists, diagnostic imaging, and nonemergency hospital admission.

A Black physician was 39.9 times more likely to see a Black patient than was a white physician.

Bach, PB et al. N Engl J Med 2004;351:575-84.

The NEW ENGLAND JOURNAL of MEDICINE

SPECIAL ARTICLE

Primary Care Physicians Who Treat Blacks and Whites

Peter B. Bach, M.D., M.A.P.P., Hoangmai H. Pham, M.D., M.P.H., Deborah Schrag, M.D., M.P.H., Ramsey C. Tate, B.S., and J. Lee Hargraves, Ph.D.

ABSTRACT

BACKGROUND

In the United States, black patients generally receive lower-quality health care than white patients. Black patients may receive their care from a subgroup of physicians whose qualifications or resources are inferior to those of the physicians who treat white patients.

METHODS

We performed a cross-sectional analysis of 150,391 visits by black Medicare beneficiaries and white Medicare beneficiaries 65 years of age or older for medical "evaluation and management" who were seen by 4355 primary care physicians who participated in a biannual telephone survey, the 2000–2001 Community Tracking Study Physician Survey.

RESULTS

Most visits by black patients were with a small group of physicians (80 percent of visits were accounted for by 22 percent of physicians) who provided only a small percentage of care to white patients. In a comparison of visits by white patients and black patients, we found that the physicians whom the black patients visited were less likely to be board certified (77.4 percent) than were the physicians visited by the white patients (86.1 percent, P=0.02) and also more likely to report that they were unable to provide high-quality care to all their patients (27.8 percent vs. 19.3 percent, P=0.005). The physicians treating black patients also reported facing greater difficulties in obtaining access for their patients to high-quality subspecialists, high-quality diagnostic imaging, and nonemergency admission to the hospital.

Indigenous physicians' role in treating chronic pain in indigenous people

Given that pain is culturally experienced and communicated, cultural differences between providers and patients may interfere with understanding patients' pain symptoms.

Indigenous providers tended to rate the patient with higher Indigenous ethnic salience more congruently with the self-reported pain ratings, perhaps due to perceived similarities and lowered unconscious bias

The Healing Relationship in Indigenous Patients' Pain Care: Influences of Racial Concordance and Patient Ethnic Salience on Healthcare Providers' Pain Assessment

REVISED REFERENCES, 04/13/2016

Abstract

Indigenous persons suffer from among the highest rates of chronic pain in the United States. Using a relationship-centered medical decision-making framework, this study sought to examine the influence of Indigenous racial concordance and patient ethnic salience on providers' assessment of pain. From May to October 2010, pre-identified healthcare providers working exclusively with Indigenous patients in the United States were randomly assigned an online clinical case vignette presenting an Indigenous patient reporting chronic lower back pain. A 2 × 2 analysis of variance, between-subjects design, was conducted with the predictor variables racial concordance and patient ethnic salience on the outcome measure of providers' ratings of patient's pain on a visual analogue scale. We found a significant interactional effect between racial concordance and patient ethnic salience on providers' pain assessment ratings. Indigenous providers tended to rate the patient with higher Indigenous ethnic salience more congruently with the self-reported pain ratings, perhaps due to perceived similarities and lowered unconscious bias. This is the first known study to examine racial concordance of the healthcare provider and ethnic salience of the patient in pain care. This study informs healthcare provider practice and consideration of patients' racial/cultural attributes and possible influence on assessment bias, which may be particularly relevant among Indigenous patients. More research is needed to identify specific interventions to improve cultural awareness and sensitivity for Indigenous persons who suffer from pain.

Keywords

Indigenous health, pain, pain disparities, patient–provider relationship, racial concordance, patient ethnic salience, American Indian health, pain assessment, medical decision-making

Authors

Michelle Johnson-Jennings, PhD, (Choctaw Nation tribal member)—founding director of the Research for Indigenous Community Health (RICH) Center, Associate to the Dean for Indigenous Health, assistant professor, and License Eligible clinical health psychologist at the University of Minnesota—served as first author in developing the research design, implementing the project, and writing the manuscript.

Wassim Tarraf, PhD, assistant professor, Wayne State University, served as statistical

Johnson-Jennings, Michelle, Wassim Tarraf, and Hector M. González. "The healing relationship in Indigenous patients' pain care: Influences of racial concordance and patient ethnic salience on healthcare providers' pain assessment." *International Journal of Indigenous Health* 10.2 (2015): 33-50.

Does diversity matter for health?

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

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

CV disease impact was significant, leading to a projected 19% reduction in the black-white male gap in cardiovascular morbidity and 9% in CV mortality

Diabetes, cholesterol screening and invasive testing were up 20%; return visits were up 20%

Flu shots were significantly more likely in concordant pairings

Does Diversity Matter for Health?
Experimental Evidence from Oakland*

Marcella Alsan† Owen Garrick‡ Grant Graziani§

June 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 mistrust the medical system and for those who experienced greater hassle costs associated with their visit. 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 differential quality of doctors or discrimination. 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.

JEL Classification Codes: I12, I14, C93
Keywords: Homophily, social distance, mistrust, behavioral misperceptions, health gradients

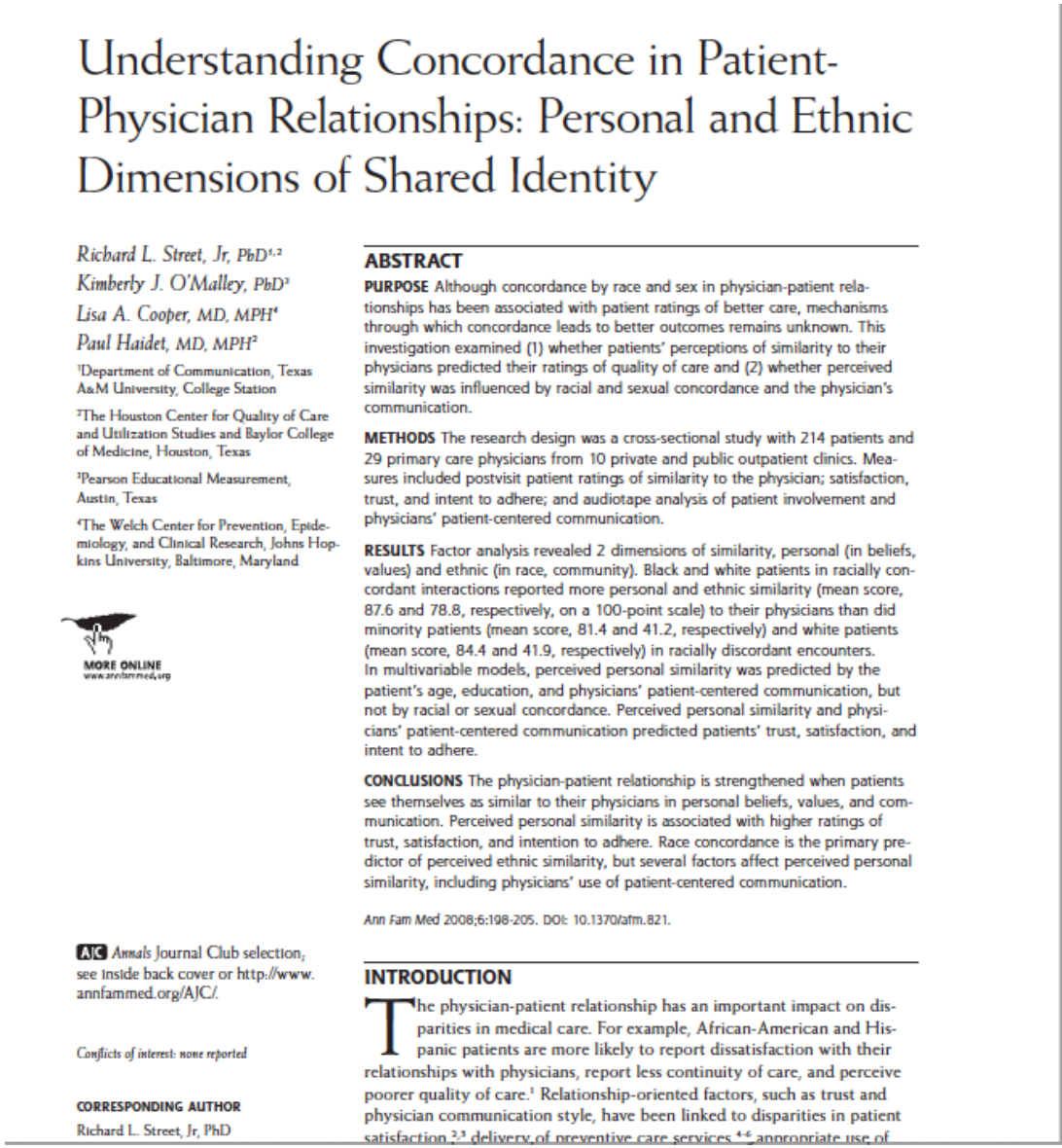
*We thank Pascaline Dupas and the J-PAL Board and Reviewers who provided important feedback that improved the design and implementation of the experiment. We thank Jeremy Bulow, Kate Casey, Arun Chandrasekhar, Raj Chetty, Karen Eggleston, Erica Field, Michael Greenstone, Seema Jayachandran, Damon Jones, Melanie Morten, Maria Polyakova, Al Roth, Kosali Simon, Ebonya Washington and Crystal Yang for their helpful comments. Javarcia Ivory, Matin Mirramezani, Edna Idna, Anlu Xing and especially Morgan Foy provided excellent research assistance. We thank the study doctors and field staff team for their participation and dedication. We thank the administration at Stanford and J-PAL particularly Lesley Chang, Rhonda McClinton-Brown, Dr. Mark Cullen, Dr. Douglas K. Owens, Ann Dohn, Ashima Goel, Atty. Ann James, Atty. Tina Dobleman, Nancy Lonhart, Jason Bauman and

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

Patients see themselves in their physicians

Physician-patient relationship is strengthened when patients see themselves as similar to their physicians in personal beliefs, values, and communication.

Perceived personal similarity is associated with higher ratings of trust, satisfaction, and intention to adhere. Race concordance is the primary predictor of perceived ethnic similarity



Understanding Concordance in Patient-Physician Relationships: Personal and Ethnic Dimensions of Shared Identity

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Kimberly J. O'Malley, PhD[3]
Lisa A. Cooper, MD, MPH[4]
Paul Haidet, MD, MPH[2]

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[2]The Houston Center for Quality of Care and Utilization Studies and Baylor College of Medicine, Houston, Texas

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[4]The Welch Center for Prevention, Epidemiology, and Clinical Research, Johns Hopkins University, Baltimore, Maryland

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ABSTRACT

PURPOSE Although concordance by race and sex in physician-patient relationships has been associated with patient ratings of better care, mechanisms through which concordance leads to better outcomes remains unknown. This investigation examined (1) whether patients' perceptions of similarity to their physicians predicted their ratings of quality of care and (2) whether perceived similarity was influenced by racial and sexual concordance and the physician's communication.

METHODS The research design was a cross-sectional study with 214 patients and 29 primary care physicians from 10 private and public outpatient clinics. Measures included postvisit patient ratings of similarity to the physician; satisfaction, trust, and intent to adhere; and audiotape analysis of patient involvement and physicians' patient-centered communication.

RESULTS Factor analysis revealed 2 dimensions of similarity, personal (in beliefs, values) and ethnic (in race, community). Black and white patients in racially concordant interactions reported more personal and ethnic similarity (mean score, 87.6 and 78.8, respectively, on a 100-point scale) to their physicians than did minority patients (mean score, 81.4 and 41.2, respectively) and white patients (mean score, 84.4 and 41.9, respectively) in racially discordant encounters. In multivariable models, perceived personal similarity was predicted by the patient's age, education, and physicians' patient-centered communication, but not by racial or sexual concordance. Perceived personal similarity and physicians' patient-centered communication predicted patients' trust, satisfaction, and intent to adhere.

CONCLUSIONS The physician-patient relationship is strengthened when patients see themselves as similar to their physicians in personal beliefs, values, and communication. Perceived personal similarity is associated with higher ratings of trust, satisfaction, and intention to adhere. Race concordance is the primary predictor of perceived ethnic similarity, but several factors affect perceived personal similarity, including physicians' use of patient-centered communication.

Ann Fam Med 2008;6:198-205. DOI: 10.1370/afm.821.

AJC *Annals* Journal Club selection, see inside back cover or http://www.annfammed.org/AJC/.

Conflicts of interest: none reported

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Richard L. Street, Jr, PhD

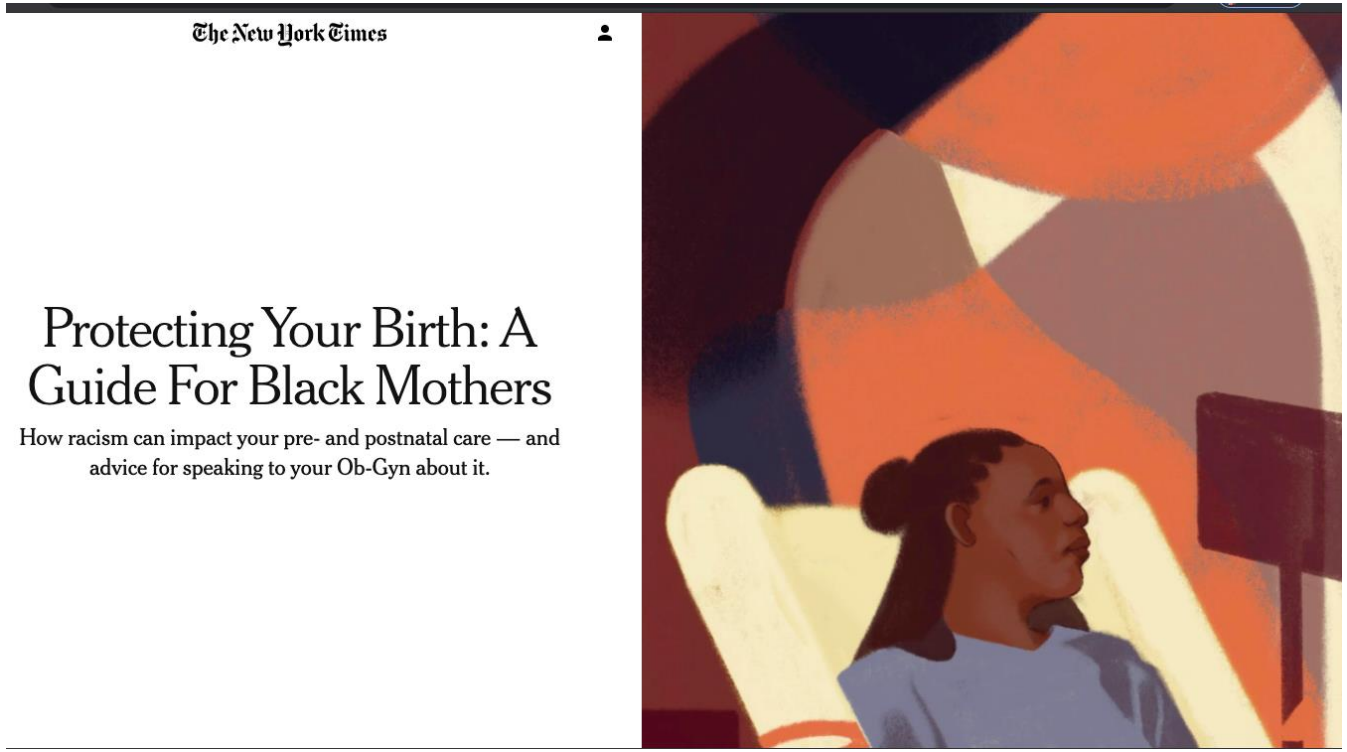
INTRODUCTION

The physician-patient relationship has an important impact on disparities in medical care. For example, African-American and Hispanic patients are more likely to report dissatisfaction with their relationships with physicians, report less continuity of care, and perceive poorer quality of care.[1] Relationship-oriented factors, such as trust and physician communication style, have been linked to disparities in patient satisfaction,[2,3] delivery of preventive care services,[4-6] appropriate use of

Street, R.L., O'Malley, K.J., Cooper, L.A. and Haidet, P., 2008. Understanding concordance in patient-physician relationships: personal and ethnic dimensions of shared identity. *The Annals of Family Medicine*, *6*(3), pp.198-205.

Patients are requesting concordant care

- Step 1: Acknowledge Race and Racism In The Room
- Step 2: Create a Care Plan Anticipating That Racism May Impact Pregnancy
- Step 3: Identify How Racism May Impact Labor
- Step 4: Identify How Racism May Impact Postpartum



https://www.nytimes.com/article/black-mothers-birth.html?smid=url-share

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

Race-conscious professionalism

Describes the process black professionals confront when attempting to navigate the competing demands of professionalism, racial obligations, and personal integrity

Hispanic and black physicians tend to not leave minority communities once they settle in such areas, and when they move, they tend to move to areas similar to those that they are from.

ACADEMIC MEDICINE

Perspective

Race-Conscious Professionalism and African American Representation in Academic Medicine

Brian W. Powers, Augustus A. White, MD, PhD, Nancy E. Oriol, MD, and Sachin H. Jain, MD, MBA

Abstract

African Americans remain substantially less likely than other physicians to hold academic appointments. The roots of these disparities stem from different extrinsic and intrinsic forces that guide career development. Efforts to ameliorate African American underrepresentation in academic medicine have traditionally focused on modifying structural and extrinsic barriers through undergraduate and graduate outreach, diversity and inclusion initiatives at medical schools, and faculty development programs. Although essential, these initiatives fail to confront the unique intrinsic forces that shape career development. America's ignoble history of violence, racism, and exclusion exposes African American physicians to distinct personal pressures and motivations that shape professional development and career goals. This article explores these intrinsic pressures with a focus on their historical roots; reviews evidence of their effect on physician development; and considers the implications of these trends for improving African American representation in academic medicine. The paradigm of "race-conscious professionalism" is used to understand the dual obligation encountered by many minority physicians not only to pursue excellence in their field but also to leverage their professional stature to improve the well-being of their communities. Intrinsic motivations introduced by race-conscious professionalism complicate efforts to increase the representation of minorities in academic medicine. For many African American physicians, a desire to have their work focused on the community will be at odds with traditional paths to professional advancement. Specific policy options are discussed that would leverage race-conscious professionalism as a draw to a career in academic medicine, rather than a force that diverts commitment elsewhere.

Notwithstanding important progress, substantial challenges remain in ameliorating racial inequalities in health and health care in the United States. One enduring challenge is the underrepresentation of minority populations, especially African Americans, among the faculty at academic medical centers (AMCs). At each stage of career development, African Americans remain less likely than other physicians to hold academic appointments. Despite constituting 13% of the American population as of 2014, African Americans accounted for only 7.4% of assistant professors, 3.8% of associate professors

In this Perspective, we explore the intrinsic pressures that contribute to African American underrepresentation at AMCs with a focus on their historical roots; review evidence of their effect on physician career development; and consider the implications for AMCs seeking to improve African American representation among their faculties. We conclude by providing specific policy options.

Extrinsic Versus Intrinsic Forces In Shaping Career Development as Factors Contributing to Underrepresentation

medicine have traditionally been focused on modifying these extrinsic forces through tactics such as undergraduate and graduate outreach, diversity and inclusion initiatives at medical schools, and faculty development programs.

Although these are essential programs, we believe the prevailing focus on extrinsic factors has obscured the role intrinsic forces play on the decision to pursue and sustain a career in academic medicine. America's ignoble history of violence, racism, and exclusion exposes African American physicians to distinct personal pressures and motivations that

Wilkins D. Identities and roles: Race, recognition, and professional responsibility. MD Law Rev. 1998. 57:1502–1595.

Brown T et al. Does the under- or overrepresentation of minority physicians across geographical areas affect the location decisions of minority physicians? Health Serv Res 2009 44(4):1290-308

Powers, BW et al. Academic Medicine 2016. 91(7):913-5

Brian W. Powers, Nancy E. Oriol, Sachin H. Jain Journal of Health Care for the Poor and Underserved, Volume 26, Number 1, February 2015, pp. 73-81

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:
- The political determinants of health recognize how inequitable policies, politics, regulations, and laws have impaired access to care and contribute to health inequities[1]

Lack of access to healthy foods and food practices

Inundation with ultra-processed foods

Community and interpersonal violence

Lack of access to greenspace for play and exercise

Toxic environmental conditions

Housing insecurity, Inadequate transportation and education

Poverty/wealth gap

Allostatic load and exposure to Adverse Childhood Events

Inadequate transportation

Neighborhood disinvestment

Over-policing

Residential segregation

Structural racism[2]

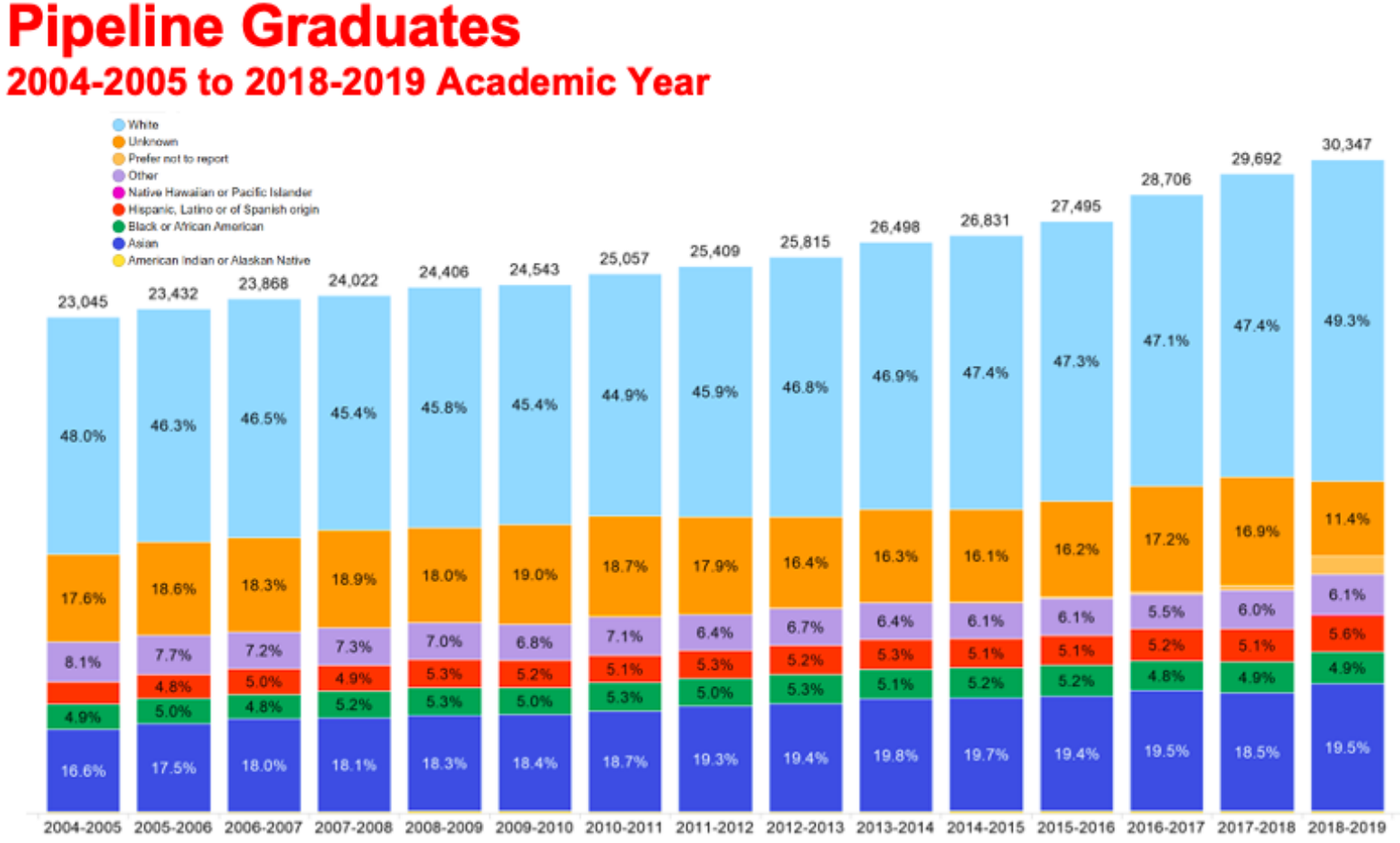
[1]Dawes, D.E., 2020. *The political determinants of health*. Johns Hopkins University Press.

[2]Pronk, N.P., Kleinman, D.V. and Richmond, T.S., 2021. Healthy People 2030: Moving toward equitable health and well-being in the United States. *EClinicalMedicine*, *33*.

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[1] to improve the care they give to patients from historically marginalized groups



ACGME Data Resource Book Academic Years 2004-2019

[1]Tervalon M, Murray-Garcia J. Cultural humility versus cultural competence: a critical distinction in defining physician training outcomes in multicultural education. J Health Care Poor Underserved. 1998;9:117–25.

Burden of expectation

Privilege for some and obligation for others

Assumptions associated with typical gender norms; ethnicity biases; medical students' socialization and professional development (most notably with regard to career expectations)

Explicit, implicit, and even hidden institutional-level barriers and hurdles for URM students

Central character in this case-study attended medical school "thanks to an institutional scholarship and federal financial aid, and societal expectations that can be associated with this kind of support for students, specifically those who are members of underrepresented in medicine groups.

AMA Journal of Ethics®
March 2017, Volume 19, Number 3: 238-244

ETHICS CASE

Why It's Unjust to Expect Location-Specific, Language-Specific, or Population-Specific Service from Students with Underrepresented Minority or Low-Income Backgrounds

Commentary by Barret Michalec, PhD, Maria Athina (Tina) Martimianakis, PhD, Jon C. Tilburt, MD, MPH, and Frederic W. Hafferty, PhD

Abstract

In this case we meet Amanda, a medical student of Native and Latin American ethnicity who receives financial aid. Her friends are surprised by her interest in an elite residency program. They suggest, rather, that with her language skills, ethnic background, and interest in social justice, she has a responsibility to work with underserved patient populations. In our commentary, we consider issues raised by the case and explore Amanda's friends' underlying expectations and assumptions that perpetuate the very inequities that the resolution of the case purports to address. We also identify the role of privilege and address the "burden of expectation" that appears to be associated with underrepresented minority (URM) medical students and normative assumptions about their career paths.

Case

Amanda is a second-year medical student at a private Midwestern medical school, which she is able to attend thanks to an institutional scholarship and federal financial aid. She has been seriously engaged with campaigns on campus for health equity and social justice in the community and in the country at large. Amanda grew up in a family with mixed Native American and Latin American roots and was a first-generation college graduate in her family; thus, issues of access to education and health care are very important to her.

Amanda grew up speaking Spanish fluently and studied medical Chinese in her first year of medical school. She has used her language skills in a medical student-run clinic that provides free basic clinical services to those with limited English proficiency (LEP), which includes Spanish and Chinese speakers. As a second-year medical student, she has begun thinking about clinical years and plans for a successful residency match. During her recent visit with her family over Christmas, her parents and maternal grandmother

Michalec, Barret, et al. "Why It's Unjust to Expect Location-Specific, Language-Specific, or Population-Specific Service from Students with Underrepresented Minority or Low-Income Backgrounds." *AMA journal of ethics* 19.3 (2017): 238-244.

Conflict perspective

Expectations reflect and express implicit biases —subconscious stereotypes—that are cultivated through socialization processes (including those associated with medical professional development) that guide beliefs, perceptions, and even interactions

It is a powerful means of social control because people are implicitly and explicitly taught norms, values, and perspectives that reflect the hegemony of those in positions of power and authority

Through socialization processes and mechanisms nested within and associated with the institution of medicine specifically, trainees internalize the values, beliefs, and practices of their profession—for better or for worse—and perpetuate them through their own actions, beliefs, and assumptions

Michalec, Barret, et al. "Why It's Unjust to Expect Location-Specific, Language-Specific, or Population-Specific Service from Students with Underrepresented Minority or Low-Income Backgrounds." *AMA journal of ethics* 19.3 (2017): 238-244.

Privilege

Shroud of privilege—social advantages (often race or ethnicity and gender-based) that protect certain people and provide a more clearly paved path to upward social mobility in comparison to others who encounter explicit and implicit hurdles and pitfalls (e.g., institutionalized sexism and racism).

Privilege is reflected in their apparent assumption that they do not have responsibility to work with underserved patient populations and that they somehow see themselves as more free than Amanda to explore their own professional interests

Michalec, Barret, et al. "Why It's Unjust to Expect Location-Specific, Language-Specific, or Population-Specific Service from Students with Underrepresented Minority or Low-Income Backgrounds." *AMA journal of ethics* 19.3 (2017): 238-244.

What responsibility do we all have to serve the underserved?

Medicine, foundationally, is a service profession and that all medical professionals have a fiduciary responsibility to serve diverse patient populations. In contrast to her friends, the central character is attributed a burden of service because of her ethnic identity, language skills, and having previously worked to alleviate health inequities.

Skills stemming in part from her ethnicity make her more naturally suited for work in URM communities and chain her to an expectation of altruistic medical “servitude”

The text does not say that they expect Amanda to join them in service to minority, immigrant, and LEP patients) are protected from this mantle of responsibility because of their privilege.

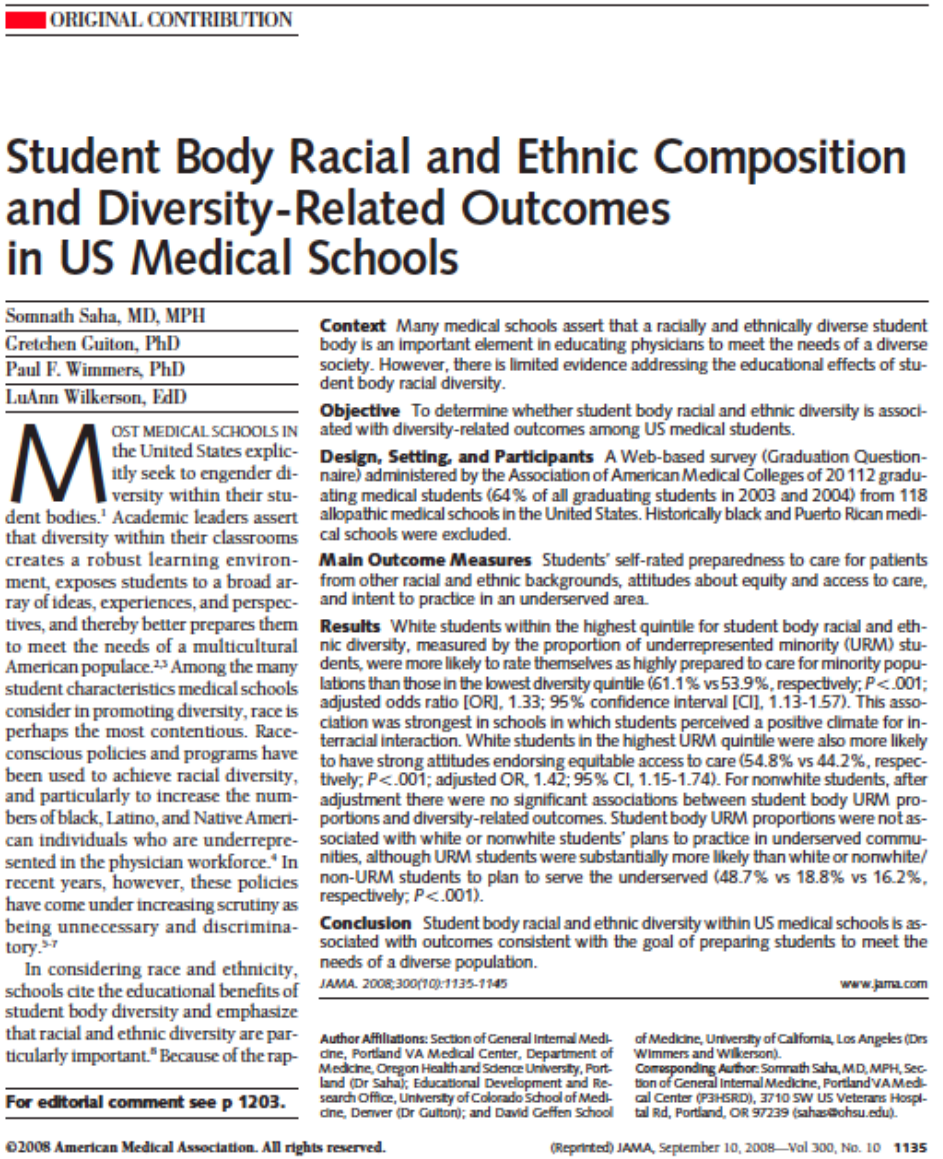
Michalec, Barret, et al. "Why It’s Unjust to Expect Location-Specific, Language-Specific, or Population-Specific Service from Students with Underrepresented Minority or Low-Income Backgrounds." *AMA journal of ethics* 19.3 (2017): 238-244.

Both/And strategy to accelerate change

Take advantage of race conscious professionalism and the propensity of UIM physicians to care for minoritized patients and underserved communities

AND

Work to inculcate cultural humility in what we teach and role model for all physicians in training, recognizing the role that diversity plays in this aspect of peer education and experience as well.



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; $P<.001$).

Conclusion Student body racial and ethnic diversity within US medical schools is associated with outcomes consistent with the goal of preparing students to meet the needs of a diverse population.

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

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 being unnecessary and discriminatory.[5-7]

In considering race and ethnicity, schools cite the educational benefits of student body diversity and emphasize that racial and ethnic diversity are particularly important.[8] Because of the rap-

For editorial comment see p 1203.

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Saha, S., Guiton, G., Wimmers, P.F. and Wilkerson, L., 2008. Student body racial and ethnic composition and diversity-related outcomes in US medical schools. *Jama*, *300*(10), pp.1135-1145.

ACGME action steps

Changed its mission to address the formative piece that programs typically lack experience and expertise in DEI

Changed its vision to explicitly add diversity and inclusion as key elements

Modified common program requirements to address DEI

Developed new tools to assess programs and institutions for compliance as support the work of the review committees

Developed learning communities to continuously improve DEI practices – ACGME Equity Matters™

Extracting data on DEI practices from the Annual Program Update and expanding them for use for the entire GME community - ACGME Equity Matters Resource Collection (Q1 2023)

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

https://acgme.org/About-Us/Overview/Mission-Vision-and-Values Adopted by ACGME Board of Directors September 2020

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ACGME EQUITYMATTERS™

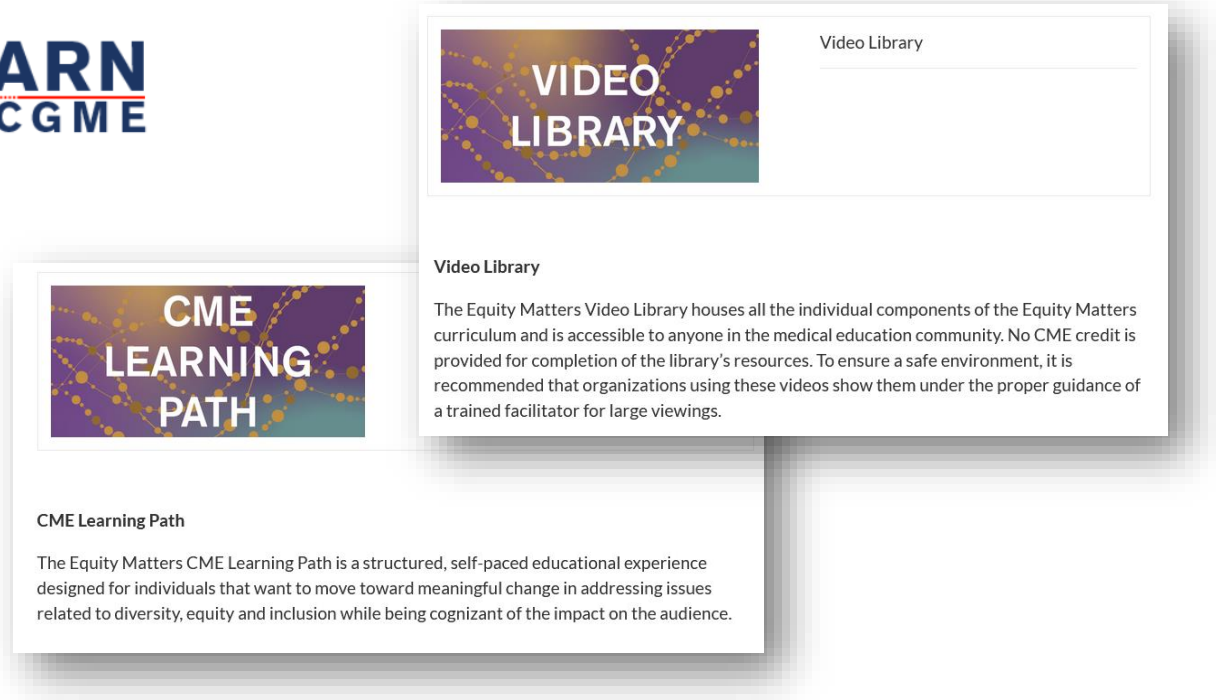
A Continuous Learning and Process Improvement Initiative in DEI for the GME Community

Fundamentals of DEI and antiracism learning modules

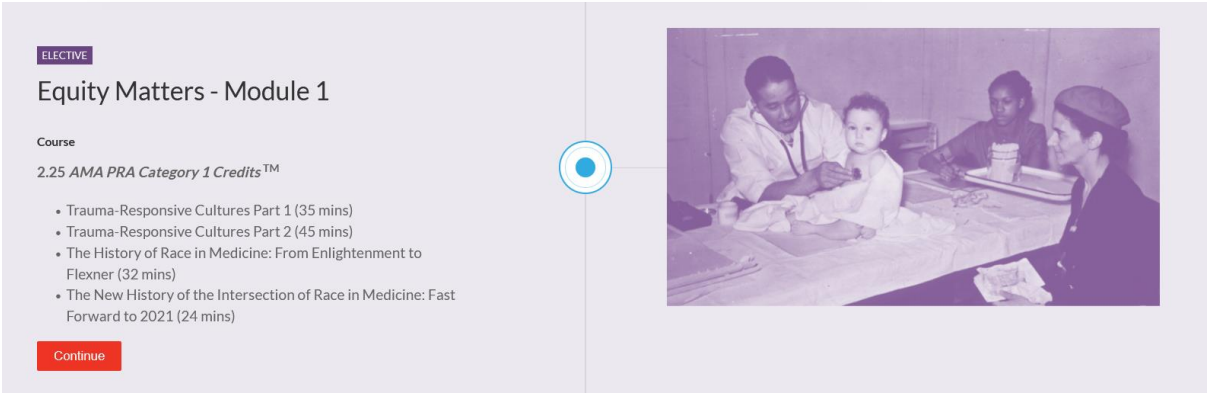
1. Trauma-Responsive Cultures Part 1 & 2
2. The History of Race in Medicine: From the Enlightenment to Flexner
3. The New History of the Intersection of Race in Medicine: Fast Forward to 2021
4. Building Safe and Courageous Spaces in GME
5. Steps Leaders Can Take to Increase Diversity, Enhance Inclusion, and Achieve Equity
6. Gender Equity: Culture and Climate
7. Naming Racism and Moving to Action Part 1 & 2
8. Women in Medicine
9. Gender Disparities
10. Exposing Inequities and Operationalizing Racial Justice
11. Patient Safety, Value, and Healthcare Equity: Measurement Matters
12. Using a Structured Approach to Recruit Diverse Residents, Fellows, and Faculty
13. Intersectionality: A Primer
14. The Intersection of Race and Gender Oppression as Root Causes of Health Inequities
15. The Black Experience in Medicine
16. Whiteness: Power and Privilege in the Context of US Racism Part 1 & 2
17. Asian, Pacific Islander, and API American Experience
18. Latino, Hispanic, or of Spanish Origin Part 1 & 2
19. American Indian and Alaskan Natives in Medicine Part 1 & 2
20. Geography: The Impact of Place
21. Sexual Minorities
22. Gender Minorities
23. Federal Regulations
24. First-Generation & Low-Income Trainees in Medicine
25. Creating an Inclusive Environment for Muslim and Sikh Trainees
26. Creating an Inclusive Environment for Orthodox Jewish Trainees
27. Disability Accommodation in Graduate Medical Education
28. Disability Inclusion in Graduate Medical Education
29. Health Disparities in Correctional Medicine and the Justice Involved Population
30. Non-Traditional-Age: Remaining inclusive of and supporting non-traditionally-aged learners
31. Immigration and IMGs: J-1 Physicians Add Valuable Diversity
32. Undocumented Students in Medical Education
33. Language: Linguistic Diversity and Health Equity in GME
34. Dominant Culture Norms in Medical Education
35. Becoming an Ally Part 1 & 2
36. Holistic Review Part 1-4
37. Anti-Racism
38. Pronouns
39. Military and VA perspectives in the learning environment

ACGME EQUITYMATTERS™

LEARN at ACGME



- 35+ DEI foundational video topic presentations packaged into 13 modules as part of a structured, self-paced educational experience.
- 18 AMA PRA Category 1 Credits™ currently available. Registration to Learn at ACGME required, no cost
- To access, register through the link below. Please allow up to 24 hours for confirmation.



https://dl.acgme.org/pages/equity-matters

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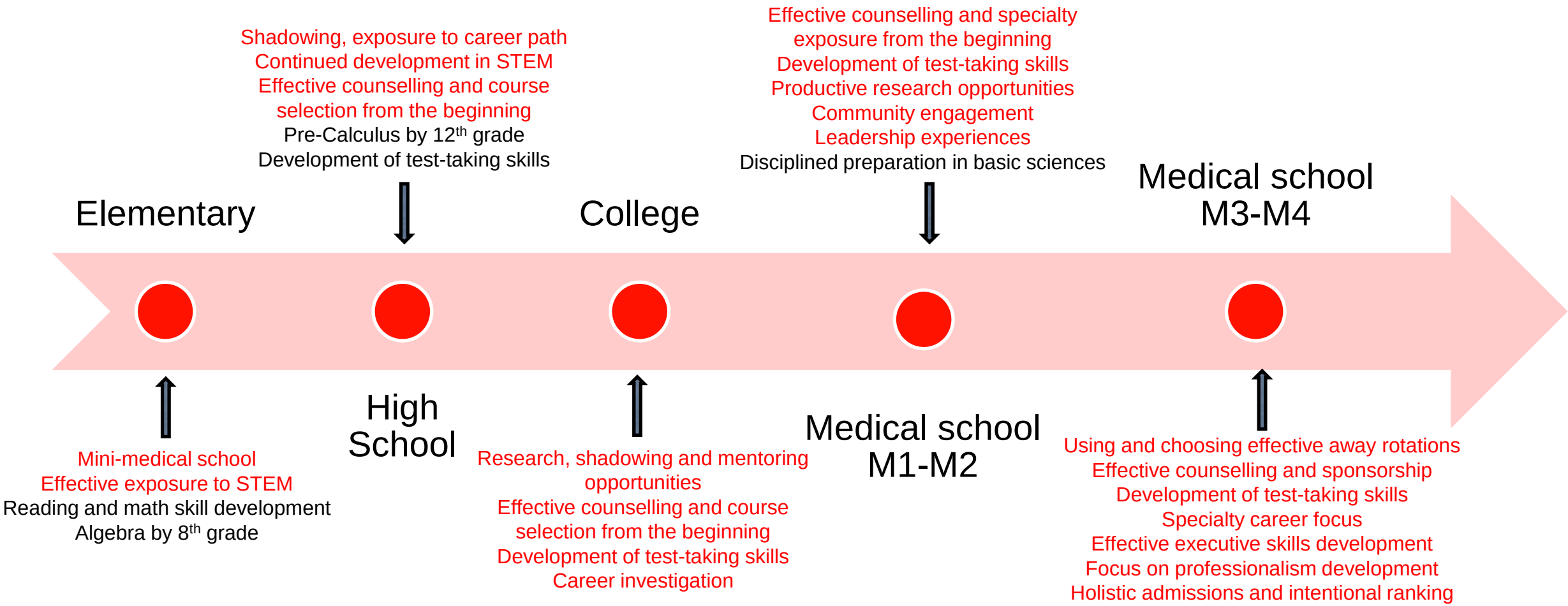
Common Program Requirement I.C.

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)

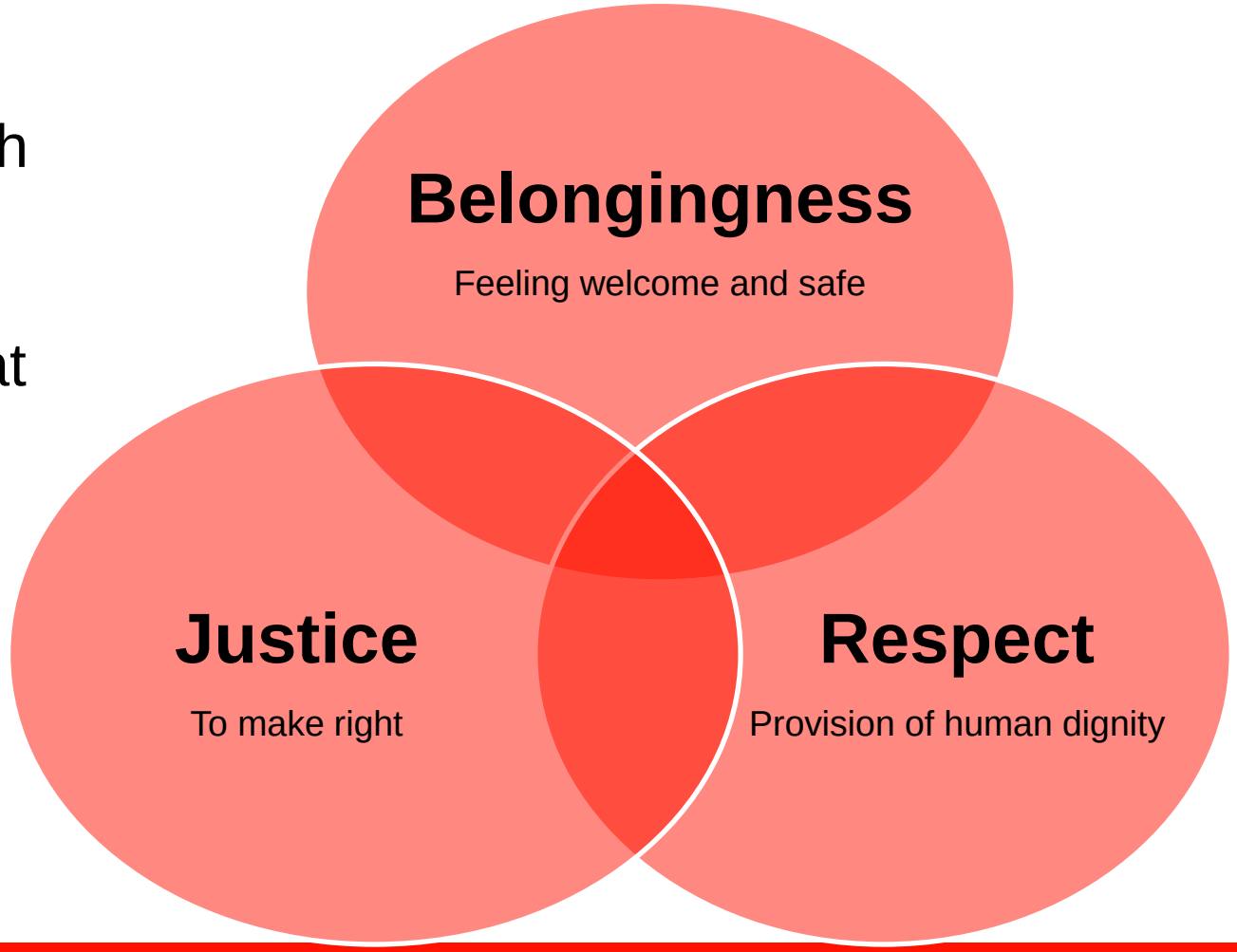
Production of clinicians is a long-term process with multiple points of intervention



"We don't control the entry of students into medicine, so there's nothing we can do to advance diversity"

Common 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)



Tokenism, exclusion, and privilege

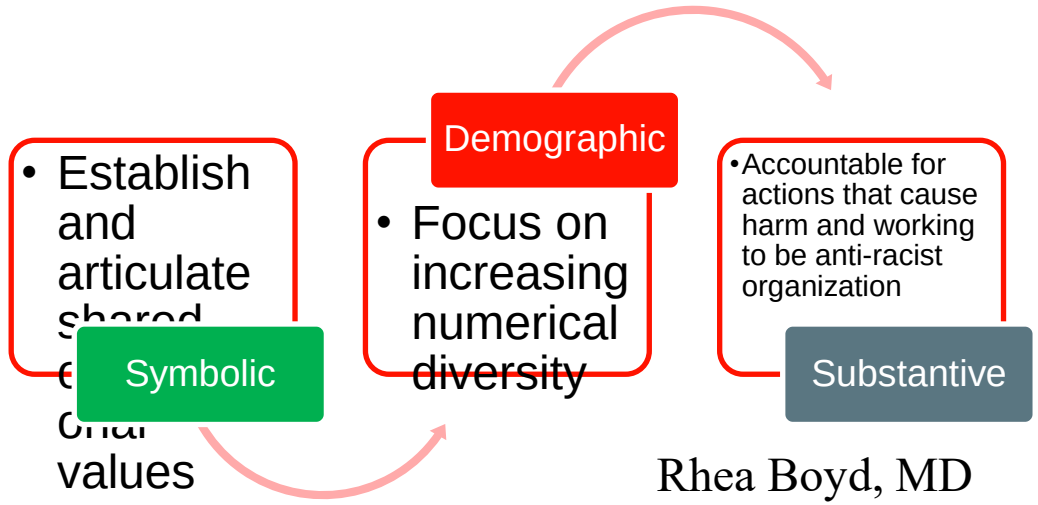
The practice of tokenism, which is defined as doing something (e.g., hiring minorities) only to prevent criticism and give the appearance that people are being treated fairly, is a hollow and, arguably, irresponsible act.

Inclusion- Having a seat at the table

Belongingness – Being able to bring your true self to the environment

Privilege – Being able to speak when you are at the table

Opposite of inclusion is incomplete, not necessarily exclusion – Arin Reeves



Performative statements, inauthentic efforts, and denial have a multiplicative effect to undermine inclusivity

Putting the Annual Program Update to use

- ACGME Equity Matters Collection
- Compilation and categorization of APU responses that comprehensively detail the strategies GME is using to increase diversity in recruitment and retention
  - Attempt to pair with literature evidence
  - Seeking the best examples of strategies that adapted, implemented and ported to other programs and specialties
- Extractions of practices obtained from the ACGME APU and solicited strategies provided in the applications of the Barbara Ross Lee, DO, Diversity, Equity and Inclusion Award to be made available to the entire GME community
- Innovations created by the Equity Matters learning communities

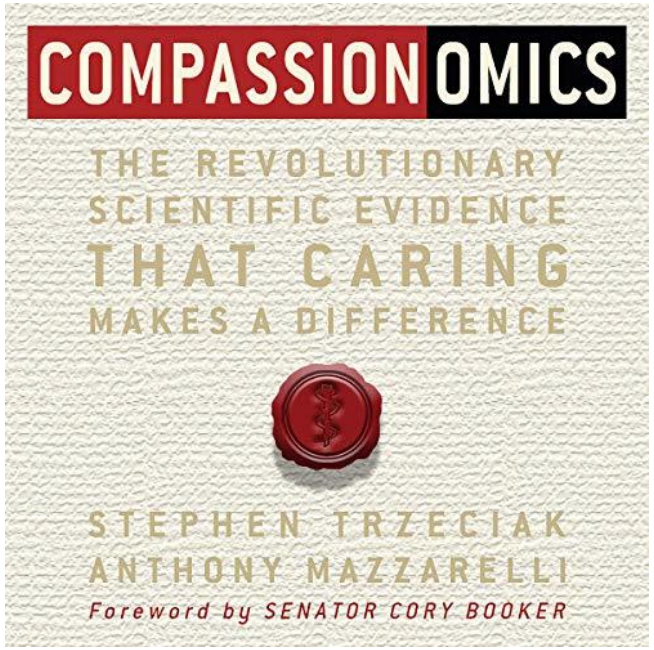
Holistic approach

Provision of resources according to need is an equity practice

Not all learners need the same supports and development of an individualized learning plan for each resident is an ACGME requirement (CPR V.A.1.d).(2))

Access to a learning specialist for some residents, additional opportunities to inculcate compassion into training may be needed for others

Promotion of inclusion and providing a sense of belongingness for your residents in the learning environment is also an equity practice



Trzeciak, Stephen and Anthony Mazzarelli. *Compassionomics: the revolutionary scientific evidence that caring makes a difference*. Chicago, IL: Huron Consulting Services, LLC, 2019.

ACGME Office of Diversity, Equity, and Inclusion

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Thank you