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

William McDade, MD, PhD
Chief Diversity, Equity and Inclusion Officer
Accreditation Council for Graduate Medical Education
Adjunct Professor of Anesthesiology
Rush Medical College
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)

Nat Academy Press 2002
http://www.nap.edu/catalog/10260.html
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.\(^1\,\text{,}^2\)

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

AAMC Matriculating Student Questionnaire

AAMC Graduating Student Questionnaire

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

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

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

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.

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.

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.

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

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

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.


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


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.

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


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.

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.

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.

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.

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.

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.
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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## 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 |
| 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 |
| 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 |
| 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 |
• 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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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

Elementary
- Shadowing, exposure to career path
- Continued development in STEM
- Effective counselling and course selection from the beginning
- Pre-Calculus by 12th grade
- Development of test-taking skills

High School
- Mini-medical school
- Effective exposure to STEM
- Reading and math skill development
- Algebra by 8th grade

College
- Research, shadowing and mentoring opportunities
- Effective counselling and course selection from the beginning
- Development of test-taking skills
- Career investigation

Medical school M1-M2
- Effective counselling and specialty exposure from the beginning
- Development of test-taking skills
- Productive research opportunities
- Community engagement
- Leadership experiences
- Disciplined preparation in basic sciences

Medical school M3-M4
- Using and choosing effective away rotations
- Effective counselling and sponsorship
- Development of test-taking skills
- Specialty career focus
- Effective executive skills development
- Focus on professionalism development
- Holistic admissions and intentional ranking

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

ACGME Office of Diversity, Equity, and Inclusion

Contact Us at diversity@acgme.org

Bill McDade, MD, PhD
wmcdade@acgme.org
312.755.7472

Denzel Avant, MS, MA
davant@acgme.org
872.275.2857

Rahardhika Utama, MA
rutama@acgme.org
312.755.7143

Morgan Passiment, MSJ
mpassiment@acgme.org
312.755.5012

Tiasia Davis
tdavis@acgme.org
312.755.7422

Muveddet Harris, MS
mharris@acgme.org
872.275.2860

Patrick Guthrie
pguthrie@acgme.org
312.755.7468

Allison Simpson, MA
asimpson@acgme.org
312.755.5040

Montrelle Clayton
mclayton@acgme.org
312.282.6800

Thank you