



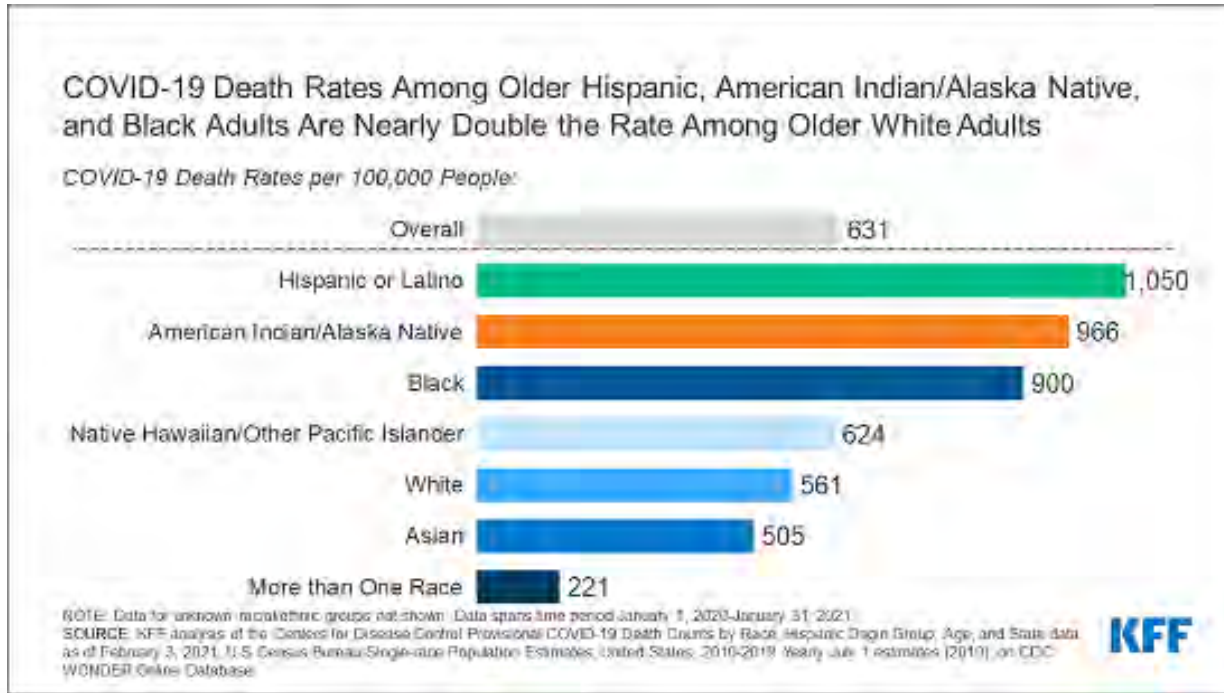
Diversity and Inclusion in Graduate Medical Education

William McDade, MD, PhD

Chief Diversity, Equity and Inclusion Officer

Accreditation Council for Graduate Medical Education

What Covid-19 taught us



Race Data for COVID-19 Patients Key to Assess Health Disparities

AMA and other leading physician groups are calling for access to race data in the context of COVID-19 testing, care access, and mortality data to identify health disparities.

COMMENTARY

It's No Surprise That COVID-19 Is Exposing Health Disparities

U.S. News
A WORLD REPORT

The coronavirus' impact on African Americans requires us to address an ongoing problem for U.S. communities.

The Washington Post
Democracy Dies in Darkness

The coronavirus is infecting and killing black Americans at an alarmingly high rate

By **Reis Thebault**, **Andrew Ba Tran** and **Vanessa Williams** April 7

THE CORONAVIRUS CRISIS

Opinion: U.S. Must Avoid Building Racial Bias Into COVID-19 Emergency Guidance

April 21, 2020 - 7:00 AM ET

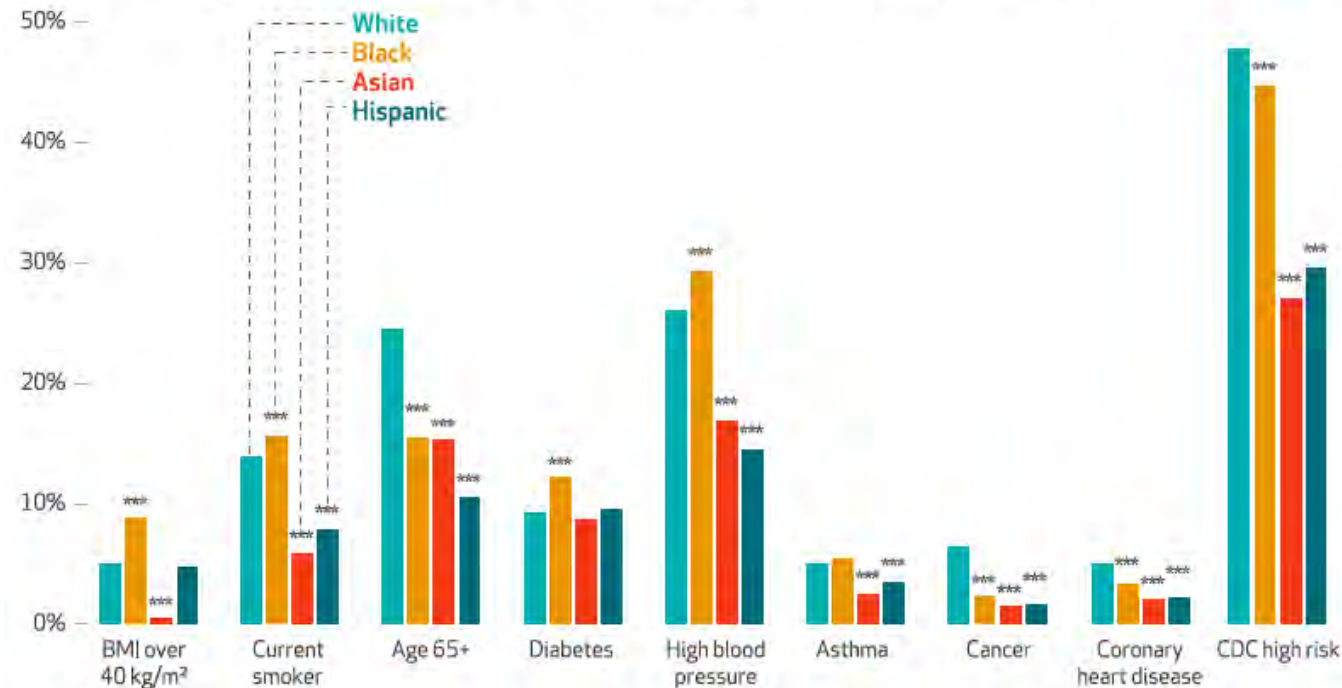
JOSSIE CARRERAS TARTAK

HAZAR KHIDIR

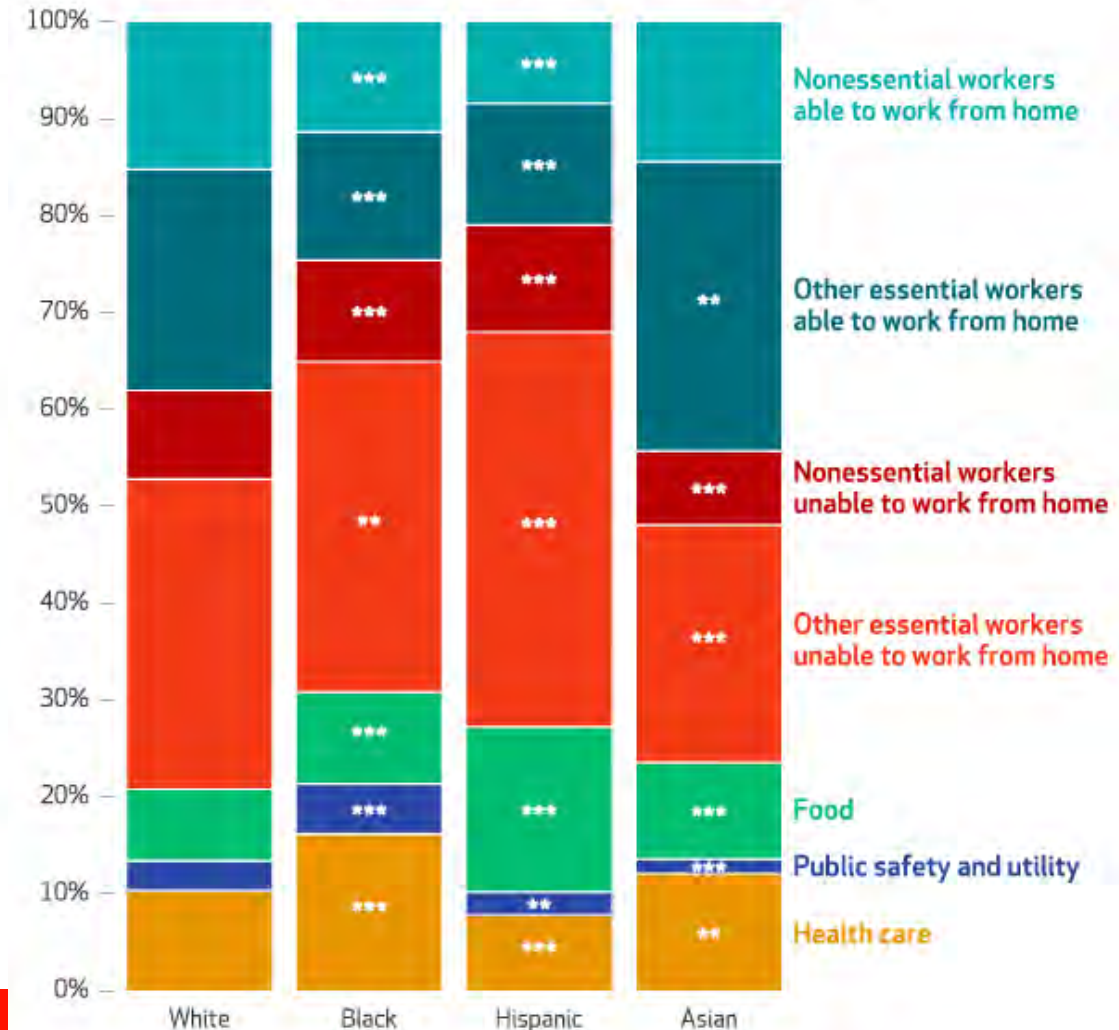


Covid-19's Disproportionate impact on minority individuals

Prevalence among US adults of selected risk factors and an overall Centers for Disease Control and Prevention (CDC) indicator for being at high risk for severe COVID-2019 illness, by race and ethnicity, 2014-17



Job characteristics among US workers, by race and ethnicity, 2014-17



TM Selden and TA Berdahl Health Affairs 39,NO. 9 (2020): 1624-1632



Why now?



What can medicine do in response?

So if George had come to see you, instead of writing, "This is a 56-year-old male with a history of no-shows and noncompliance with his medications," consider whether the note should begin with this acknowledgement in your mind, "This is a 56-year-old African American man, recently violated, burdened by violence, managing unimaginable stressors, yet despite all of those barriers to him being here, he presents for one fair shot at his health today."



A screenshot of the American College of Cardiology (ACC) website. The header includes the ACC logo, navigation links (Guidelines, JACC, ACC.21, Members, Join ACC), a search bar, and a 'Log in to MyACC' button. The main content area features a sidebar with links to 'Fellows in Training Section' and 'Resources'. The main article is titled 'Eight Minutes and 46 Seconds That Should Change the Way You Practice Medicine' by Gmerice Hammond, MD, MPH, dated June 16, 2020. The article text discusses the dehumanization of Black people and the murder of George Floyd. An inset image shows police officers with George Floyd. The source is cited as NBC NEWS/Dragnet, Wok, Security Camera Footage.

This article was authored by **Gmerice Hammond, MD, MPH**, cardiologist and health policy research Fellow in Training (FIT) at Barnes-Jewish Hospital, Washington University in St. Louis (Twitter: [@Gmericeh](#)).

ACGME pledges to demand justice

It is our collective duty to advocate for all our patients, and to care equally and equitably *for* all our patients, even as we care *about* our patients. We must use the support and appreciation the public has provided us due to the heroic altruistic work we have seen in health care across our nation in response to the COVID-19 pandemic. We must leverage that heightened social standing to speak out on behalf of everyone, promote equity and fairness, and demand justice in all its forms, especially in the provision of health care to all who require it.



The screenshot shows the ACGME website header with the logo and name. A navigation bar includes links for 'What We Do', 'Designated Institutional Officials', 'Program Directors and Coordinators', 'Residents and Fellows', and 'Meetings and Educational Activities'. The breadcrumb trail reads 'Home > Newsroom > A Message from Dr. Thomas J. Nasca'. The date 'June 3, 2020' is displayed, along with social media icons for Facebook, Twitter, LinkedIn, and Email. The article title is 'A Message from Dr. Thomas J. Nasca', with a sub-link 'Letters to the Community'. The text of the message begins with 'Dear Members of the Graduate Medical Education Community,' and continues with a statement of solidarity and commitment to justice. A red bar at the bottom of the page contains the text: 'The work of the ACGME has always been to bring people together to build better systems of education and training for the improvement of the health and well-being of the public. This includes a special responsibility to take-on the health care disparities that have been exacerbated by the COVID-19 pandemic. The ACGME is committed to addressing these disparities and ensuring that all patients receive the highest quality of care.'

Accreditation Council for
Graduate Medical Education

What We Do | Designated Institutional Officials | Program Directors and Coordinators | Residents and Fellows | Meetings and Educational Activities

Home > Newsroom > A Message from Dr. Thomas J. Nasca

June 3, 2020

[f](#) [t](#) [in](#) [e](#)

A Message from Dr. Thomas J. Nasca

[Letters to the Community](#)

Dear Members of the Graduate Medical Education Community,

I am compelled as a citizen to speak with you about the pain that we are experiencing. I acknowledge that I am not an African American man and cannot speak on their behalf. But I am a human being and a physician who must respond. The nation, the city of Chicago, our local communities, and our families have been shaken by the events of the past week. We collectively grieve over the senseless murder of George Floyd at the hand of four policemen, and rage against its roots in racism and the devaluation of human life. This malicious act has ignited reaction to this most deep-rooted injustice across our nation and comes in a time where we recognize inequity in health and survival from the pandemic upon us. We join arm-in-arm with the peaceful protestors to demand changes in our society and our systems in order to root out racism and injustice, and foster equity, mutual understanding, kindness, and justice. We understand the anger, pain, and frustration being demonstrated in the streets across our country, and we also recognize the fear and insecurity being felt by so many, including our colleagues, in the aftermath of the rioting of the past few days.

The work of the ACGME has always been to bring people together to build better systems of education and training for the improvement of the health and well-being of the public. This includes a special responsibility to take-on the health care disparities that have been exacerbated by the COVID-19 pandemic. The ACGME is committed to addressing these disparities and ensuring that all patients receive the highest quality of care.

ACGME's role

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

Provide an assurance function to the public through accreditation

Provide outreach and education to support the formative elements of change in the GME environment that leads to better health for the patients today and in the future



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

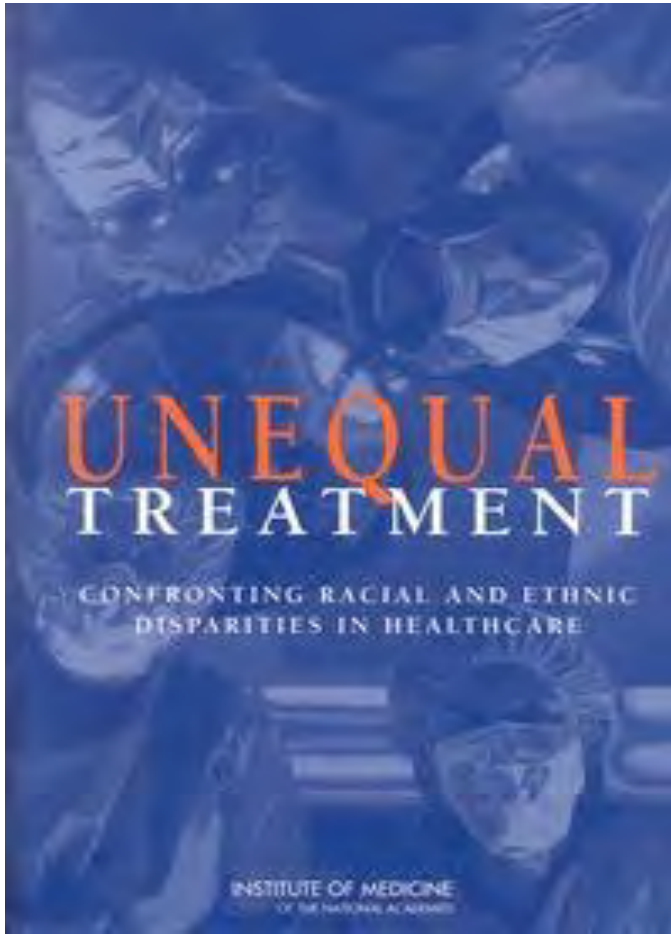


ACGME action Steps

- ACGME formed an Office for Diversity Equity and Inclusion (DEI)
- Modified common program requirements to address DEI
- 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 a key element
- Developed new tools to assess programs and institutions for compliance
- Developing learning communities to continuously improve DEI practices



Evidence of Racial and Ethnic Disparities in Healthcare



584 pages detailing the extent of racial and ethnic differences in healthcare that are not otherwise attributable to known factors such as access to 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 are taken into account

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 Acad Press 2002

Empathy gap

We have become comfortable with disparities because they are not our problem

We have become disconnected because we are not proximate to those who are suffering

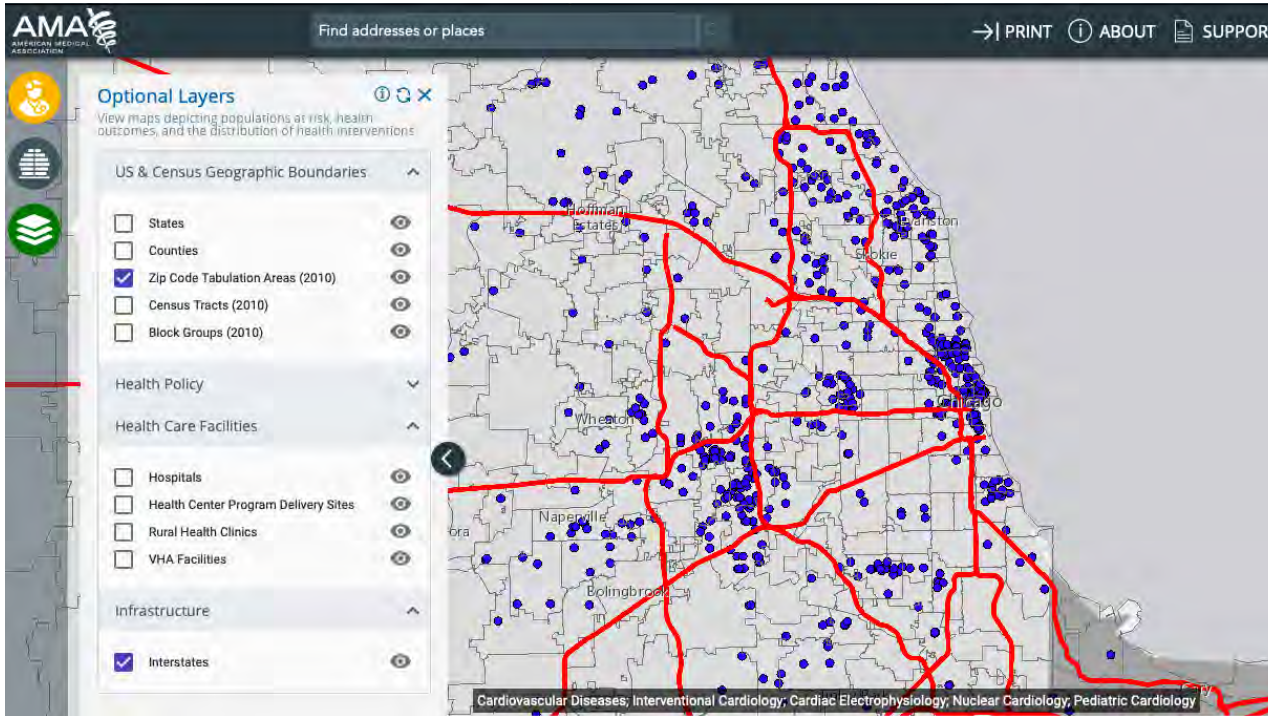
Vaclav Havel, Czech leader spoke of a willingness of the spirit to sometimes be in hopeless places and be a witness



Bryan Stevenson, founder/executive director of the Equal Justice Initiative at AAMC Learn Serve Lead 2019



Inverse association between where physicians practice and where disease burden is greatest



AMA Health Workforce Mapper

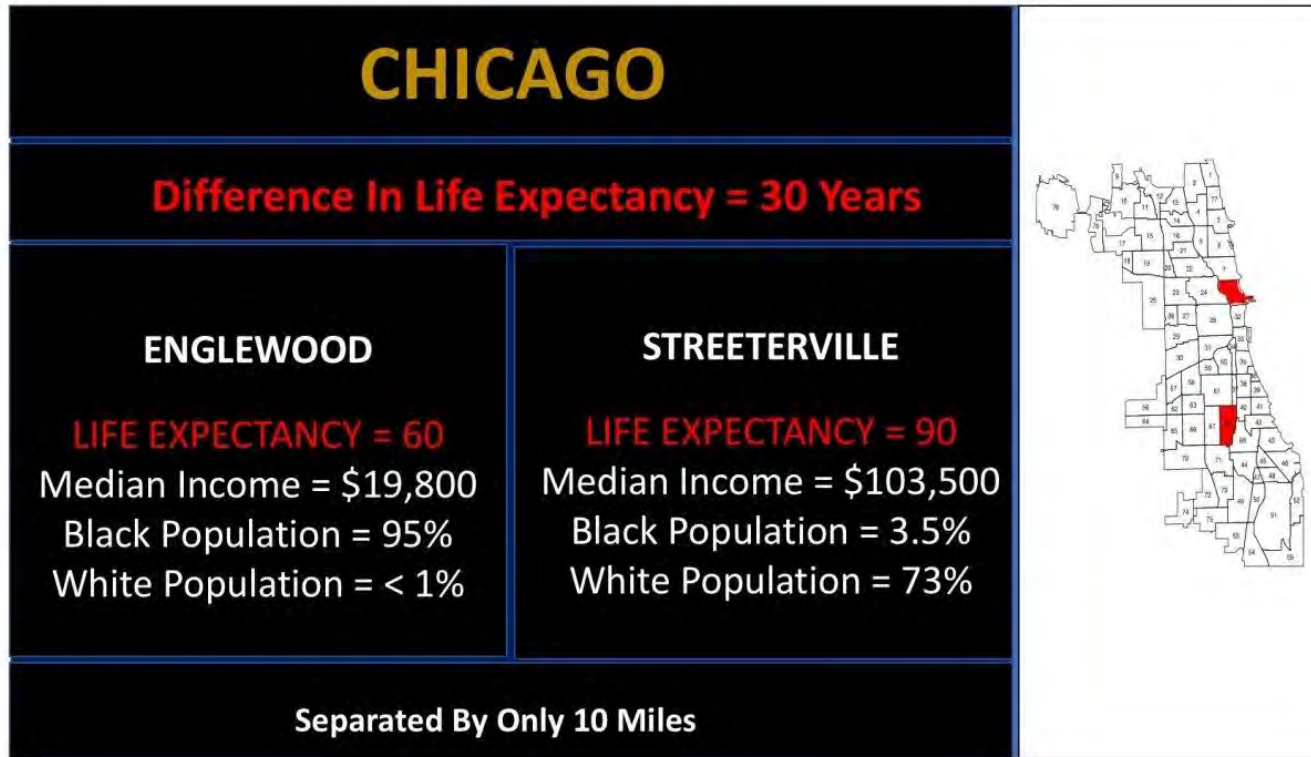
Life expectancy differs greatly based on zip code

Geographic co-location of physicians and disease may positively affect health outcomes

Physician distribution is not homogeneous nor related to disease burden



Inverse association between where physicians practice and where disease burden is greatest



Life expectancy differs greatly based on zip code

Geographic co-location of physicians and disease may positively affect health outcomes

Physician distribution is not homogeneous nor related to disease burden

NYT 5 Sept 2020

<https://www.nytimes.com/interactive/2020/09/05/opinion/inequality-life-expectancy.html>




Racial disparities in orthopedic care

Racial disparities in access to care exist in Medicare inpatients several cardiovascular, cancer and orthopedic procedures.

From 2012-2018, Black patients received 67,000 fewer orthopedic procedures than if the care had been equitably distributed.

In this same period, high-quality facilities performed 38,000 fewer orthopedic procedures for Black patients

For the nearly 2 million Medicare patients who received knee replacements, all non-white groups were less likely to be treated at a High Performing hospital than white patients when compared to the overall breakdown of who is getting these surgeries at all



The screenshot shows the US News & World Report website. The navigation bar includes 'USNews', 'HEALTH', and various sub-topics like 'Hospitals', 'Hospital Heroes', 'Doctors', 'Senior Care', 'Wellness', 'Diets', and 'Conditions'. The article title is 'Who Gets High Quality Hospital Care?' with a subtitle 'A look at racial disparities in access to surgical care.' The byline is 'By Anwesha Majumder and Ronan Corgel' dated 'July 28, 2020, at 12:00 a.m.' The article text states: 'A U.S. NEWS ANALYSIS OF seven years of Medicare records reveals broad and enduring racial disparities in who receives surgical care and in the quality of the hospitals where people of different races tend to get treated. These new findings build on many years of scientific research that has exposed racial disparities in access to health care. Among U.S. News' key findings:'. The findings are listed in a bulleted format: '• Racial disparities in access to care exist in Medicare inpatients age 65 and older across several cardiovascular, cancer and orthopedic procedures.' and '• These differences are particularly striking in cardiovascular and orthopedic care, where Black patients represented fewer than 5% of Medicare beneficiaries who received the examined treatments, approximately a third less often than would be expected given that Black patients represented 7.3% of all Medicare hospitalizations. This translated to Black patients receiving 20,400 fewer cardiovascular procedures and 67,000 fewer orthopedic procedures'. There is a small image on the right side of the article with the caption '(GETTY IMAGES)'.



Where you live matters

Odds of being a PCP shortage area were 67 percent higher for majority African American zip codes

As the degree of segregation increased, the odds of being a PCP shortage area increased for majority African American zip codes



Gaskin, D.J., Dinwiddie, G.Y., Chan, K.S. and McCleary, R.R., 2012. Residential segregation and the availability of primary care physicians. Health services research, 47(6), pp.2353-2376.

HSR

Health Services Research

© Health Research and Educational Trust

DOI: 10.1111/j.1475-6773.2012.01417.x

RESEARCH ARTICLE

Residential Segregation and the Availability of Primary Care Physicians

Darrell J. Gaskin, Gniesha Y. Dinwiddie, Kitty S. Chan, and Rachael R. McCleary

Objective. To examine the association between residential segregation and geographic access to primary care physicians (PCPs) in metropolitan statistical areas (MSAs).

Data Sources. We combined zip code level data on primary care physicians from the 2006 American Medical Association master file with demographic, socioeconomic, and segregation measures from the 2000 U.S. Census. Our sample consisted of 15,465 zip codes located completely or partially in an MSA.

Methods. We defined PCP shortage areas as those zip codes with no PCP or a population to PCP ratio of >3,500. Using logistic regressions, we estimated the association between a zip code's odds of being a PCP shortage area and its minority composition and degree of segregation in its MSA.

Principal Findings. We found that odds of being a PCP shortage area were 67 percent higher for majority African American zip codes but 27 percent lower for majority Hispanic zip codes. The association varied with the degree of segregation. As the degree of segregation increased, the odds of being a PCP shortage area increased for majority African American zip codes; however, the converse was true for majority Hispanic and Asian zip codes.

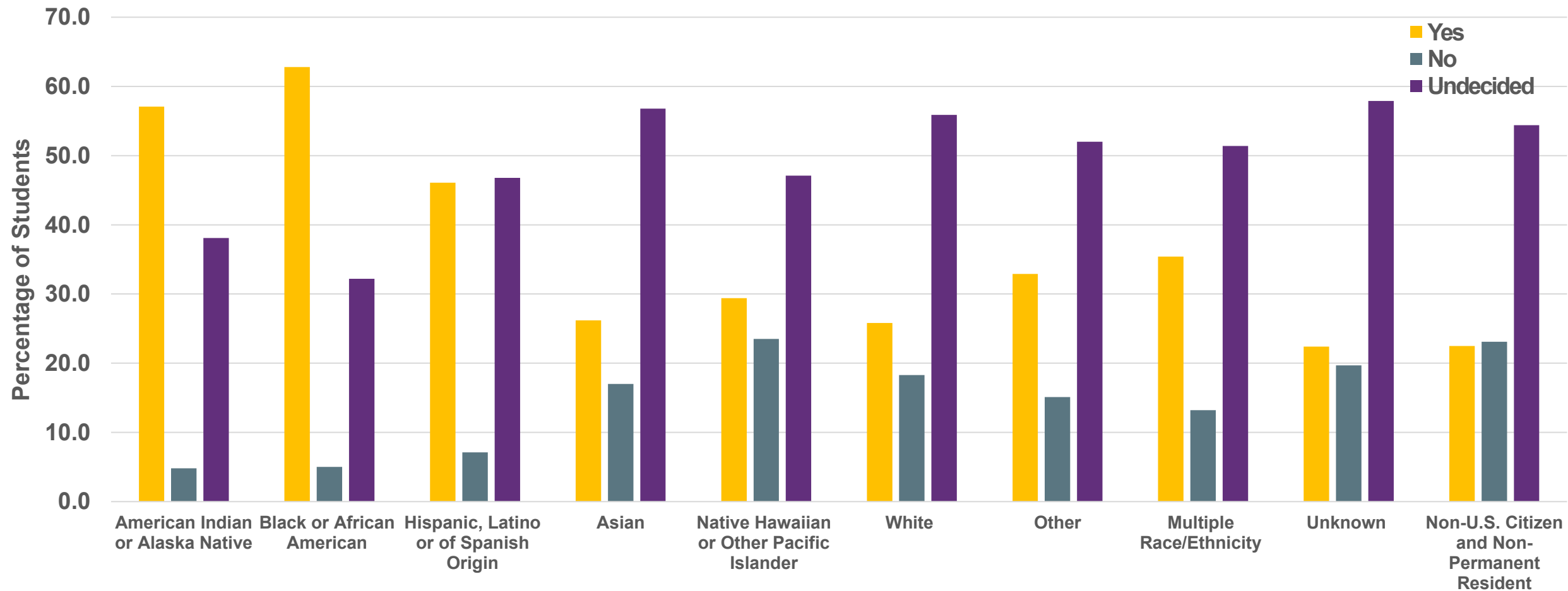
Workforce Diversity matters to the elimination of health disparities

- 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



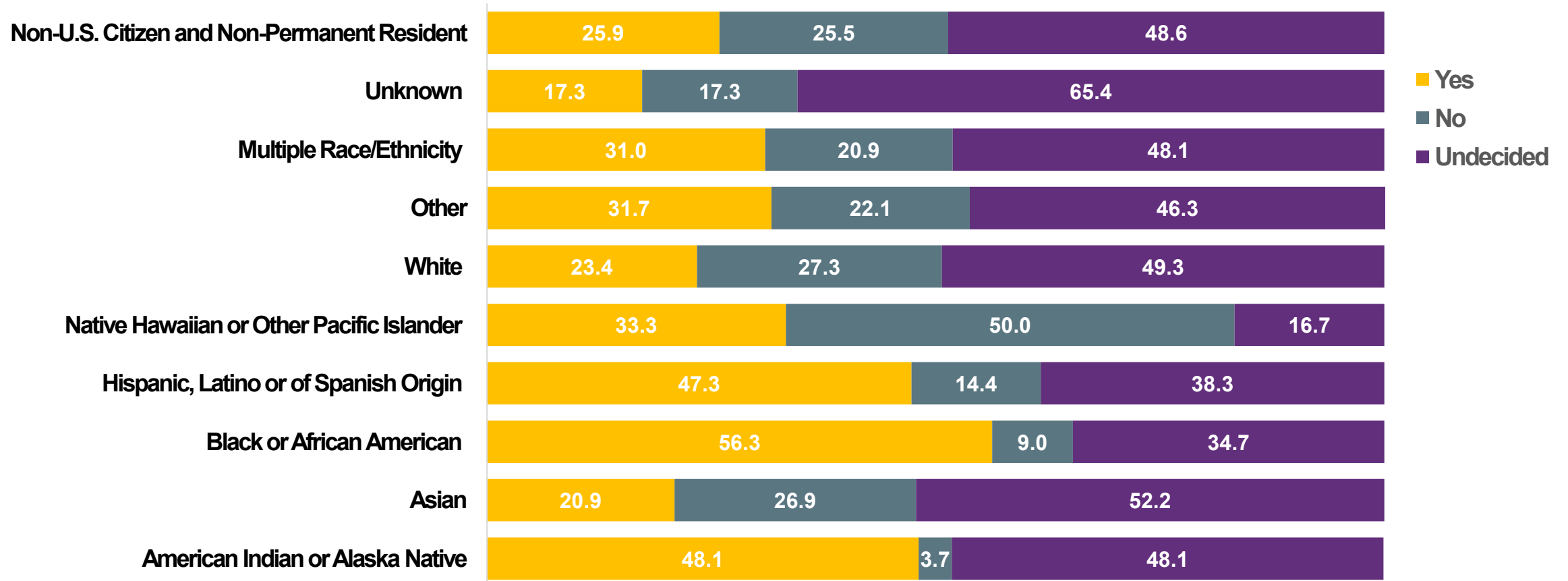
Adopted by ACGME Board of Directors September 2020

2019 MSQ Results: Do you plan to practice primarily in an underserved community?



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.

2020 GQ Results: Do you plan to practice primarily in an underserved community?



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. (%)		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
	Millions of Patients With a White Physician	Millions of Patients With a Black Physician					
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.



Primary care physicians who treat Blacks and Whites

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



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.

Increasing racial/ethnic diversity in the physician workforce

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

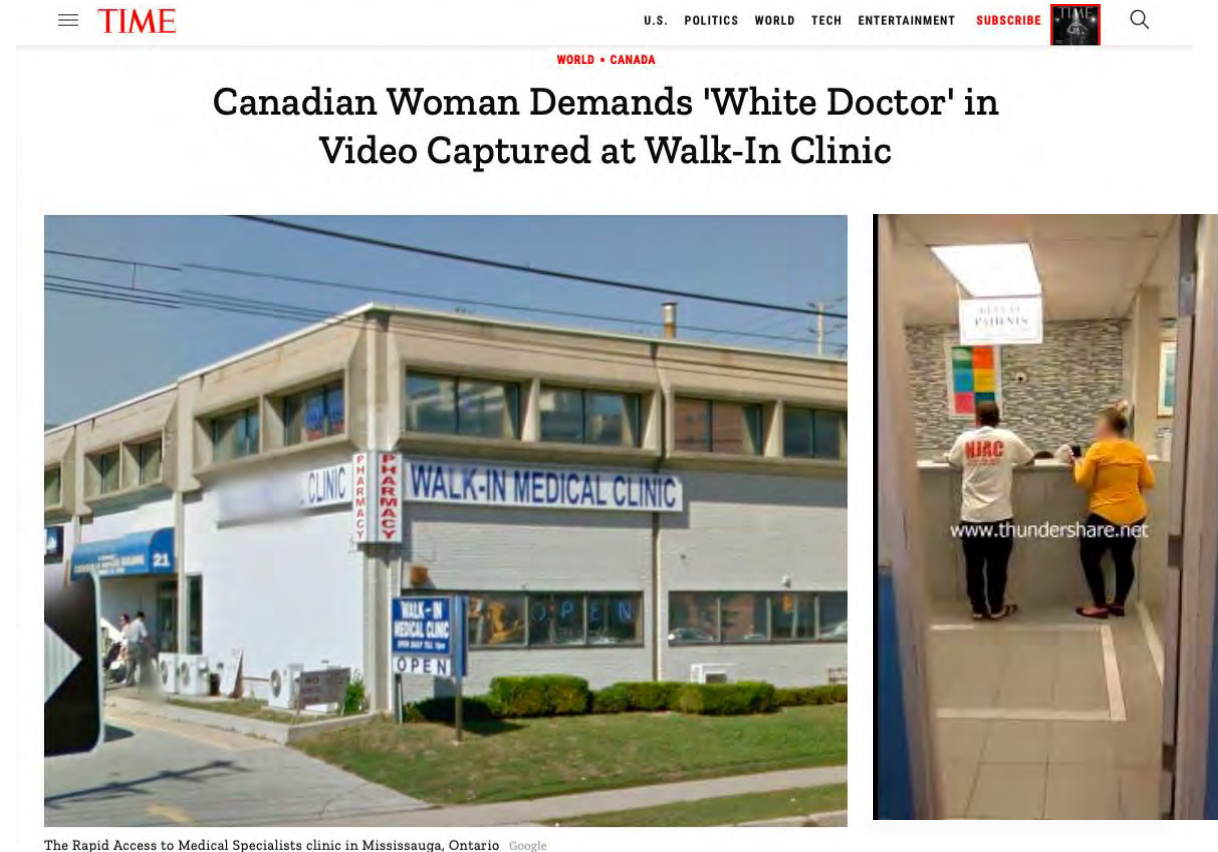
Physicians' willingness to work in disadvantaged communities and to accept Medicare/Medicaid

Patient choice plays a role



What might be driving this preference?

- Trust, respect, communication, self-advocacy
- Intention to adhere to medical advice
- Patient satisfaction
- Improved clinical outcomes?



<https://youtu.be/ZI5JKDIIsbU>

Vaccine hesitancy among minoritized individuals

Everyday racism can be tackled in the present.

Framing the conversation about distrust in Covid vaccines in terms of everyday racism rather than historical atrocities may increase underserved communities' willingness to be vaccinated.



POINTS OF VIEW

Beyond Tuskegee — Vaccine Distrust and Everyday Racism

J. Marion Sims, Henrietta Lacks. The Tuskegee Syphilis Study.

With two authorized SARS-CoV-2 vaccines now available, particular concerns have emerged regarding whether Black communities will choose to be vaccinated. In a pandemic that has disproportionately burdened Black Americans, experts have been scrambling to send targeted public health messages and reduce skepticism. But in late November, the National Association for the Advancement of Colored People (NAACP) and partners reported that only 14% of Black survey respondents trusted the vaccines' safety and only 18% said they would definitely get vaccinated.¹ In describing the racial gap on this question, many commentators cite three historical atrocities — Sims, Lacks, Tuskegee — to explain Black communities' distrust in health care systems.² If it were only that simple.

These historical traumas certainly provide critical context for interpreting present-day occurrences. But attributing distrust primarily to these instances ignores the everyday racism that Black communities face. Every day, Black Americans have their pain denied, their conditions misdiagnosed, and necessary treatment withheld by physicians. In these moments, those patients are probably not historicizing their frustration by recalling Tuskegee, but rather contemplating how an institution sworn to do no harm has failed them. As Harvard historian Evelyn Hammonds told the *New York Times*, "There has never been

tutions, perhaps even more so during this pandemic. Daily subtle mental assaults are more salient in explaining a lack of trust in medical institutions and, by extension, in Covid vaccines.³

And trust is critical to health. We know that Black patients prefer to be seen by Black physicians and will go well out of their way to do so. Despite genuinely wanting to address their obesity, for example, Black women will wait months for an appointment with one of us (F.C.S.) because they believe a physician who shares their background will care for them in a way that others cannot or will not. In light of the recent death of Dr. Susan Moore from Covid-19 after substandard care, this reality is all too clear.

Unfortunately, there is even further reason for this belief. Infant mortality is halved when Black newborns are cared for by Black rather than White physicians.³ Physician-patient racial concordance makes the difference between life and death for these infants even though they cannot contemplate historical traumas: they can still experience everyday racism and disrespect. Similarly, in 2018, Victor and colleagues showed that 64% of Black men brought their blood pressure to normal levels after a barbershop-based health intervention, as compared with only 12% of the control group.⁴ As safe, trusted fixtures within their communities, barbershops represent forums of culture and camaraderie for Black men, where they can be heard by someone who can relate to their experiences. These findings

Bajaj, S.S. and Stanford, F.C., 2021. Beyond Tuskegee—Vaccine Distrust and Everyday Racism. *NEJM*, p.e11.

Concordance and Communication

Information seeking was higher among Black participants after they viewed messages from Black physicians

Supports the important role that health professionals and other leaders in communities of color play in enhancing the acceptance of COVID-19 vaccination and other interventions

Concordance across dimensions other than ethnicity may be more important for Latinx patients

Ensuring that messages are accurate, available, and comprehensible is insufficient —recipients must also trust the messenger. Trust is most likely when information is delivered by a messenger who is known and has a positive relationship with the community.



Annals of Internal Medicine

ORIGINAL RESEARCH

Comparison of Knowledge and Information-Seeking Behavior After General COVID-19 Public Health Messages and Messages Tailored for Black and Latinx Communities

A Randomized Controlled Trial

Marcella Alsan, MD, MPH, PhD*; Fatima Cody Stanford, MD, MPH, MPA*; Abhijit Banerjee, PhD; Emily Breza, PhD; Arun G. Chandrasekhar, PhD; Sarah Eichmeyer, MA; Paul Goldsmith-Pinkham, PhD; Lucy Ogbu-Nwobodo, MD, MS, MAS; Benjamin A. Oken, PhD; Carlos Torres, MD; Anirudh Sankar, MMath; Pierre-Luc Vautrey, MSc; and Esther Duflo, PhD

Background: The paucity of public health messages that directly address communities of color might contribute to racial and ethnic disparities in knowledge and behavior related to coronavirus disease 2019 (COVID-19).

Objective: To determine whether physician-delivered prevention messages affect knowledge and information-seeking behavior of Black and Latinx individuals and whether this differs according to the race/ethnicity of the physician and tailored content.

Design: Randomized controlled trial. (Registration: ClinicalTrials.gov, NCT04371419; American Economic Association RCT Registry, AEARCTR-0005789)

Setting: United States, 13 May 2020 to 26 May 2020.

Participants: 14267 self-identified Black or Latinx adults recruited via Lucid survey platform.

Intervention: Participants viewed 3 video messages regarding COVID-19 that varied by physician race/ethnicity, acknowledgement of racism/inequality, and community perceptions of mask-wearing.

Measurements: Knowledge gaps (number of errors on 7 facts on COVID-19 symptoms and prevention) and information-seeking behavior (number of Web links demanded out of 10 proposed).

Results: 7174 Black (61.3%) and 4520 Latinx (38.7%) participants were included in the analysis. The intervention reduced the knowledge gap incidence from 0.085 to 0.065 (incidence rate ratio, [IRR], 0.737 [95% CI, 0.600 to 0.874]) but did not significantly change information-seeking incidence. For Black participants, messages from race/ethnic-concordant physicians increased information-seeking incidence from 0.329 (for discordant physicians) to 0.357 (IRR, 1.085 [CI, 1.026 to 1.145]).

Limitations: Participants' behavior was not directly observed, outcomes were measured immediately postintervention in May 2020, and online recruitment may not be representative.

Conclusion: Physician-delivered messages increased knowledge of COVID-19 symptoms and prevention methods for Black and Latinx respondents. The desire for additional information increased with race-concordant messages for Black but not Latinx respondents. Other tailoring of the content did not make a significant difference.

Primary Funding Source: National Science Foundation; Massachusetts General Hospital; and National Institutes of Health, National Institute of Diabetes and Digestive and Kidney Diseases.

Ann Intern Med. doi:10.7326/M20-6141

Annals.org

For author, article, and disclosure information, see end of text. This article was published at Annals.org on 21 December 2020.

* Drs. Alsan and Stanford contributed equally.

Alsan, Marcella, et al. "Comparison of Knowledge and Information-Seeking Behavior After General COVID-19 Public Health Messages and Messages Tailored for Black and Latinx Communities: A Randomized Controlled Trial." *Annals of internal medicine* (2020).

Cooper, Lisa A., and Catherine M. Stoney. "Messages to Increase COVID-19 Knowledge in Communities of Color: What Matters Most?." *Annals of Internal Medicine* (2020).

Does Diversity Matter for Health?

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

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

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

Diabetes, cholesterol screening and invasive testing were up 20%

Flu shots were significantly more likely

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 Sophie Shank. The study was made possible by a grant through the Abdul Latif Jameel Poverty Action Lab - Health



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

Race matters in perinatal mortality

1.8 million hospital births in Florida between 1992 and 2015; Black newborn deaths are 3x greater than that of whites

Patient–physician concordance benefitted Black newborns with Black physicians by 53–56% compared to discordant care

No significant improvement in maternal mortality based on racial concordance



Physician–patient racial concordance and disparities in birthing mortality for newborns

Brad N. Greenwood^{a,1,2}, Rachel R. Hardeman^{b,1}, Laura Huang^{c,1}, and Aaron Sojourner^{d,1}

^aSchool of Business, George Mason University, Fairfax, VA 22030; ^bSchool of Public Health, University of Minnesota–Twin Cities, Minneapolis, MN 55455; ^cHarvard Business School, Harvard University, Boston, MA 02163; and ^dCarlson School of Management, University of Minnesota–Twin Cities, Minneapolis, MN 55455

Edited by Christopher W. Kuzawa, Northwestern University, Evanston, IL, and approved July 16, 2020 (received for review August 2, 2019)

Recent work has emphasized the benefits of patient–physician concordance on clinical care outcomes for underrepresented minorities, arguing it can ameliorate outgroup biases, boost communication, and increase trust. We explore concordance in a setting where racial disparities are particularly severe: childbirth. In the United States, Black newborns die at three times the rate of White newborns. Results examining 1.8 million hospital births in the state of Florida between 1992 and 2015 suggest that newborn–physician racial concordance is associated with a significant improvement in mortality for Black infants. Results further suggest that these benefits manifest during more challenging births and in hospitals that deliver more Black babies. We find no significant improvement in maternal mortality when birthing mothers share race with their physician.

racial bias | birthing outcomes | concordance | mortality | health care

The relationship between a decision maker's ascriptive characteristics and advocates who do or do not share those characteristics has long been a source of intense scrutiny by scholars across a wide range of disciplines. Researchers in sociology have noted the benefits of female leadership for young women working at firms (1, 2). Management scholars note increased leniency in enforcing regulatory compliance when inspectors and their targets share similar backgrounds (3). Economists have shown that academic performance is higher when students share race with teachers (4). In addition, legal scholars have found higher incarceration rates among defendants paired with judges of a different race (5).

However, despite the prevalence of these findings, little evidence on the effect of gender and racial concordance in medicine existed until recently. Although received work indicates

approaches to address this pressing social issue. Furthermore, to the extent that newborns cannot verbally communicate with their physician, we are able to observe the effects of concordance without trust or communication issues affecting the patient–physician relationship. Inasmuch as prior research has struggled to disentangle the mechanisms behind concordance's effect (10, 26), the setting allows us to explore concordance in the absence of one invoked mechanism—communication. Thus, if concordance effects manifest, we are able to rule out communication as the exclusive mechanism.

Research posits that racial concordance between a newborn and their physician may mitigate disparities for at least two reasons. First, research suggests concordance is not only salient for adults. Indeed, a growing body of literature explores the question of whether actors exhibit different levels of bias toward both children and adults. Wolf et al. (27), for example, examine whether adults' spontaneous racial bias toward children differs from their spontaneous racial bias toward adults, finding that people have significantly greater favorability toward their in-group. Strikingly, this bias was exhibited equally toward adults and children. It is therefore possible that such an effect might manifest exclusively as a function of spontaneous bias. At the same time, extant research indicates that mortality across White and Black newborns is starkly different (28), suggesting Black newborns may have different needs and be more medically challenging to treat due to social risk factors and cumulative racial and socioeconomic disadvantages of Black pregnant women (29). To the extent that physicians of a social outgroup are more likely to be aware of the challenges and issues that arise when treating their group (10, 30, 31), it stands to reason that these physicians may be more equipped to treat patients with complex needs.



PNAS September 1, 2020 117 (35) 20975–20976

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.

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



Race-Conscious Professionalism and African American Representation in Academic Medicine

Brian W. Powers, Augustus A. White, MD, PhD, Nancy E. Otiol, 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

Does a biomedical faculty that resembles the population improve health care?

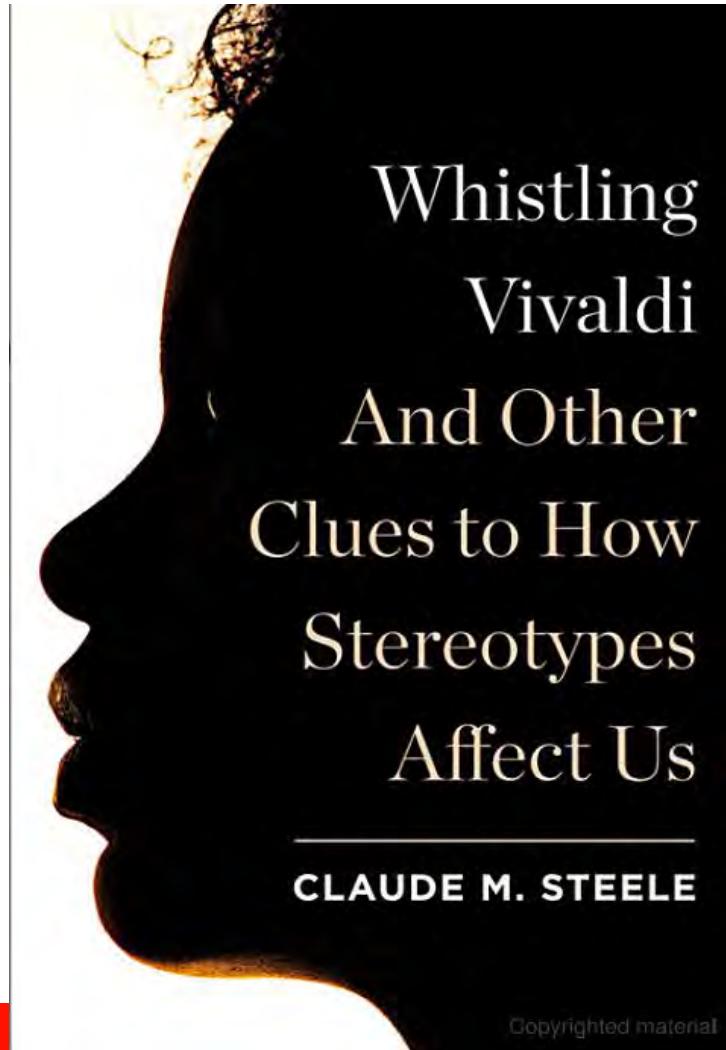
Minority medical scholars tend to study problems that impact minority communities (Ginther et al. 2011 *Science* 333:1015)

Racial congruence may play a role in recruitment of minorities in clinical trials (Fryer et al. (2016) *Qualitative Health Research*, 26(6), 830–841)

Minority faculty serve as role models, mentors and advocates for minority students in the educational process (Pololi LH, et al. (2013) *Academic Medicine* 88: 1308–1314 and many others)



The role as teacher dispels bias and racism



False stereotype disruption
through humanizing the other

Demystifies white intellectual
superiority

Mitigates stereotype threat¹

Disrupts imposter syndrome

Reinforces/restores confidence

¹Steele, Claude M., and Joshua Aronson. "Stereotype threat and the intellectual test performance of African Americans." *Journal of personality and social psychology* 69, no. 5 (1995): 797.



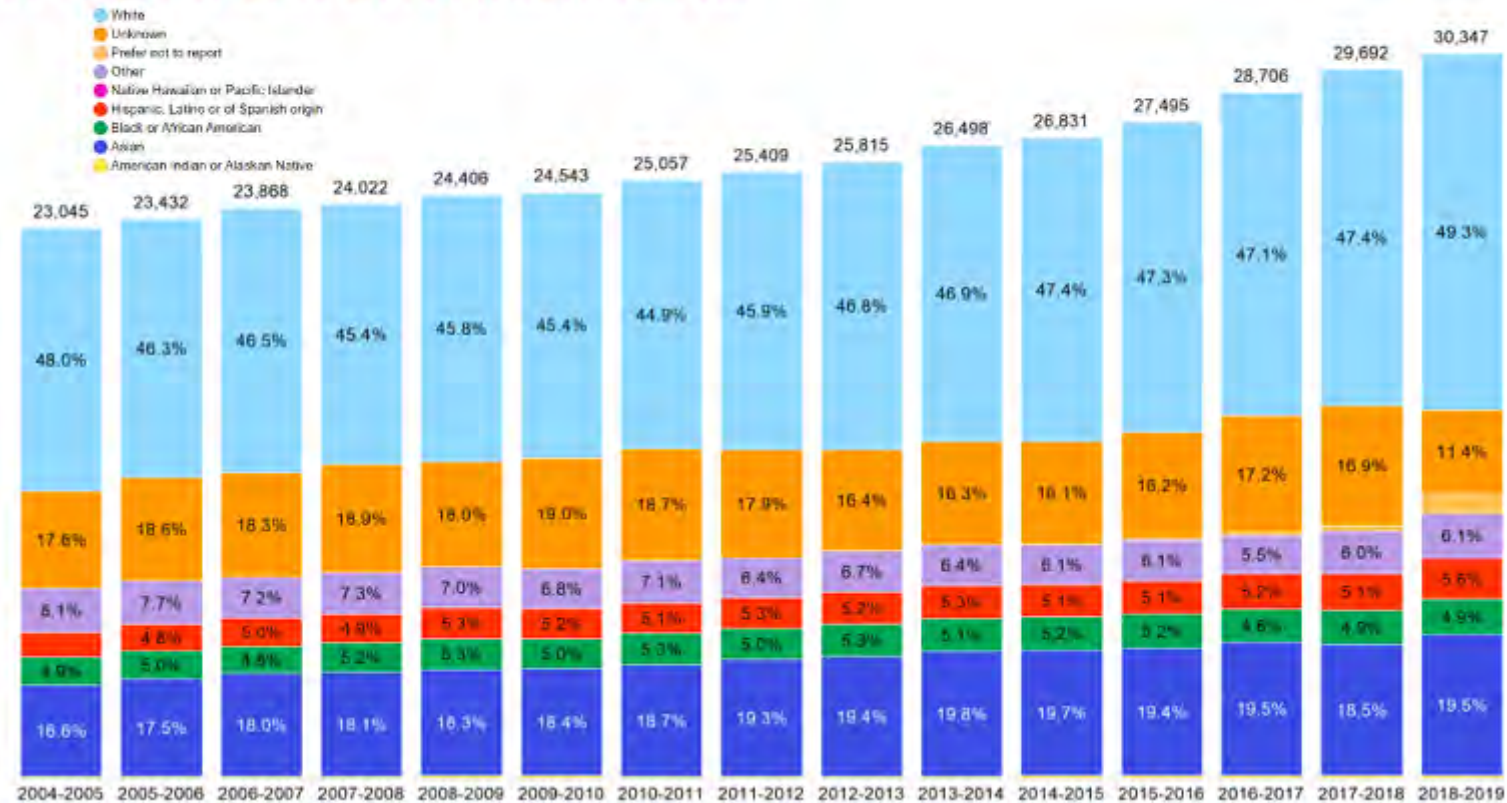
Does this mean that the only solution to eliminate racial and ethnic health disparities is to increase diversity in the workforce?

Disparity in physician number is too wide not to educate all

Patients are free to choose whomever they prefer

All physicians should be comfortable in taking care of anyone

Pipeline Graduates
2004-2005 to 2018-2019 Academic Year



Review of Common Program Requirements

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

Three new program requirements in Sections I.C, V and VI.B.6 bear directly on areas identified by the Planning Committee

Changes went into effect 1 July 2019



Common Program Requirements Section V: First-time Pass Rate

ACGME is interested in improving 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

URiM students have had lower median scores on standardized examinations for MCAT and USMLE Steps 1 and 2



Modified program requirements regarding first-time board pass rates

Intended to reduce importance of 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 currently have little diversity



McDade, W., Vela, M.B. and Sánchez, J.P., 2020. Anticipating the impact of the USMLE Step 1 pass/fail scoring decision on underrepresented-in-medicine students. *Academic Medicine*, 95(9), pp.1318-1321.

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 board 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.



ORIGINAL CONTRIBUTION

Evaluating Obstetrical Residency Programs Using Patient Outcomes

David A. Asch, MD, MBA

Sean Nicholson, PhD

Sindhu Srinivas, MD, MSCE

Jeph Herrin, PhD

Andrew J. Epstein, PhD, MPP

MANY PHYSICIANS AND NON-physicians likely assume that some residency programs tend to produce better physicians than others—either because those residency programs train physicians better or because those residency programs can recruit more capable trainees. Although plausible, these intuitions have not been empirically tested. This information could be useful in at least 2 different ways.¹ First, identifying which training programs produce better physicians and separating out the effects that are due to the ability to attract better trainees might indicate what makes better programs better. Some of these factors might be exportable to other programs, raising the quality of medical education more broadly. Second, by identifying which training programs produce better physicians, patients could use this information when selecting a physician, much as patients in some areas

Context Patient outcomes have been used to assess the performance of hospitals and physicians; in contrast, residency programs have been compared based on non-clinical measures.

Objective To assess whether obstetrics and gynecology residency programs can be evaluated by the quality of care their alumni deliver.

Design, Setting, and Patients A retrospective analysis of all Florida and New York obstetrical hospital discharges between 1992 and 2007, representing 4906169 deliveries performed by 4124 obstetricians from 107 US residency programs.

Main Outcome Measures Nine measures of maternal complications from vaginal and cesarean births reflecting laceration, hemorrhage, and all other complications after vaginal delivery; hemorrhage, infection, and all other complications after cesarean delivery; and composites for vaginal and cesarean deliveries and for all deliveries regardless of mode.

Results Obstetricians' residency program was associated with substantial variation in maternal complication rates. Women treated by obstetricians trained in residency programs in the bottom quintile for risk-standardized major maternal complication rates had an adjusted complication rate of 13.6%, approximately one-third higher than the 10.3% adjusted rate for women treated by obstetricians from programs in the top quintile (absolute difference, 3.3%; 95% confidence interval, 2.8%-3.8%). The rankings of residency programs based on each of the 9 measures were similar. Adjustment for medical licensure examination scores did not substantially alter the program ranking.

Conclusions Obstetrics and gynecology training programs can be ranked by the maternal complication rates of their graduates' patients. These rankings are stable across individual types of complications and are not associated with residents' licensing examination scores.

JAMA. 2009;302(12):1277-1283.

www.jama.com

of those programs. The advantages of using obstetrics to evaluate the connection between training and clinical outcomes, however, are limited. Hemorrhage, infection, and laceration, occur with sufficient frequency and have enough clinical meaning to patients to

Asch DA, et al. JAMA. 2009;302(12):1277-1283.
doi:10.1001/jama.2009.1356

New 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)



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

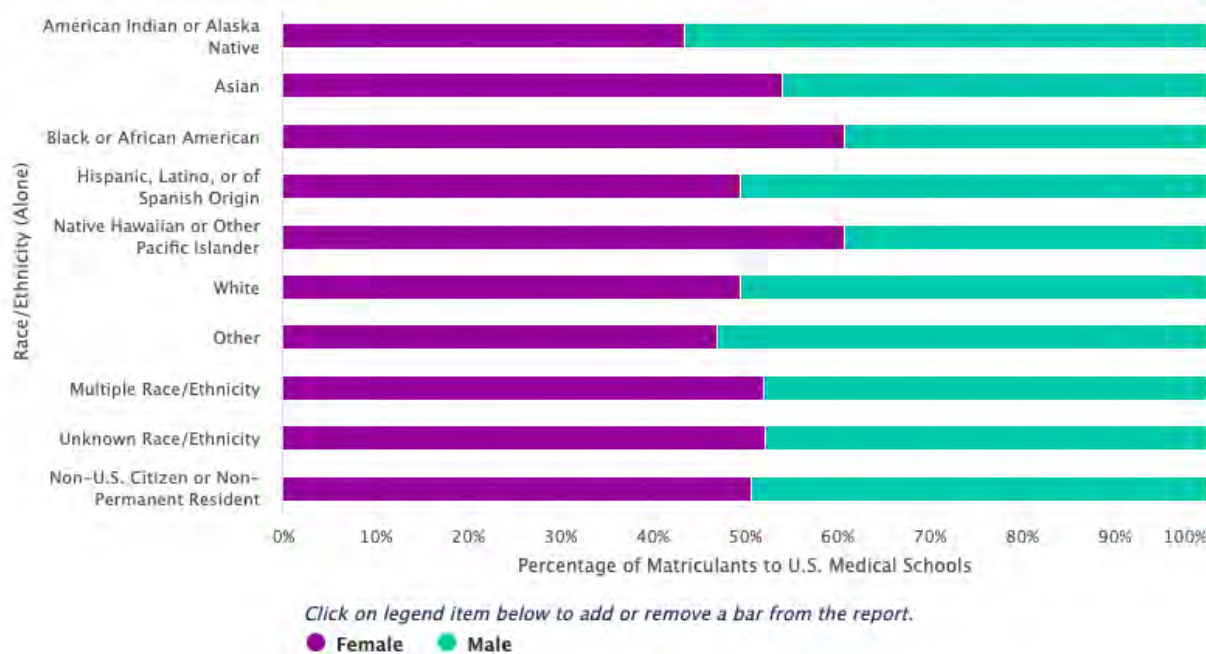
Definition (URiM)

- 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

Figure 9. Percentage of matriculants to U.S. medical schools by race/ethnicity (alone) and sex, academic year 2018–2019.



Science

22 Nov 2019

EDITORIAL

The context of diversity

The term “diversity,” which came about in connection with the passage of the U.S. Civil Rights Act of 1964, has been expanding to include an ever-growing list of identities—from race, gender, and sexual orientation to physical appearance, belief systems, thought styles, socioeconomic status, and rural/urban geographic location, among others. This is a welcome extension of representation, but this added texture has a downside—it threatens to muddle targets and obscure actions when achieving diversity is the goal. This consequence is particularly serious in the context of addressing equity for specific underrepresented racial and ethnic groups. Next week, the U.S. National Academies will convene the Roundtable on Black Men and Black Women in Science, Engineering, and Medicine to focus on confronting issues that threaten the future of Blacks broadly in science. Forging systemic changes that bring Black diversity at all education and career levels will hopefully bring racial equity to practices 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. With so many groups, success in achieving diversity is increasingly measured in a pick-and-choose manner, where progress is defined through any lens that shows success. Also, with so many groups, diversity is often described through the lens of gender, leaving other groups as seemingly less important, or unimportant. And with so many groups, it has become easier for diversity efforts to disregard the historical and present drivers of discrimination that concepts of diversity began with. In other words, the greater context of inclusion and equity can get lost, making strides to diversify meaningless. The latter point is particularly relevant to Blacks in the United States who have experienced slavery, legally enforced segregation and discrimination, and now battle conscious and unconscious racism, and mass incarceration. Institutionalized racism, past and present, has resulted in the disregard, disrespect, and dismissal of Black people from all walks of life, and this is true in science, engineering, and medicine.

These may be factors in the crisis-level changes seen across the academic landscape of Blacks in science, engineering, and medicine. For example, the number of Black males entering medical school between 2013 and 2014 in the United States was only 500, a historic low. Black men represented only 37.7% of Blacks entering medical school, which represented only 2.5% of all students entering medical school. This occurred during a historic increase in the number of medical schools in the nation. While this was happening at the trainee level, the U.S. National Academy of Medicine’s most recent election in 2019 had no Black men in a class that recently increased by over 30% in size. Thus, there is a crisis taking place at all points in the medical educational and career spectrum for this particular group.

In response to this downward trend of Blacks in science and medicine, a number of individuals, including me, convened a U.S. National Academies workshop in 2017 that focused specifically on the growing absence of Black men in medicine in the United States. The ideas became a blueprint for actions that address not only Black men in medicine, but also the trajectory for Black women, and issues in engineering and science overall.

Embracing the expanding definition of diversity is easy, but using the word with focus so as not to weaken the paths for achieving diversity will take great attention. Next week, as leaders from academia, industry, government, foundations, and other nonprofits gather at the U.S. National Academy for this historic first meeting, the goal will be to begin to understand the barriers, explore opportunities, and develop actionable plans to increase the number of Blacks pursuing science, engineering, and medicine. The Roundtable will have a laser focus on racism and bias, early to graduate education, financing, public advocacy, mentorship, and mental health/behavioral factors. We’re at the starting point of a roadmap that could potentially break cycles so rooted in the past for Blacks, and perhaps also help other groups navigate their pursuit of success in science too.

—Gato T. Laurencin



Gato T. Laurencin is the Albert and Wilkie Van Dusen Distinguished Endowed Professor of Orthopaedic Surgery, and the chief executive officer of the Connecticut Convergent Institute for Translation in Regenerative Engineering at UConn Health, Farmington, Connecticut, USA. He is the University Professor at the University of Connecticut, Storrs, Connecticut, USA. laurencin@uconn.edu

Science 366 (6468), 929. DOI: 10.1126/science.ab a2319

Black Men in White Coats



FORBES.COM

Documentary Calls Out Stereotypes, Issues Urgent Call-To-Action For A Black Male Physician Pipeline

Dr. Dale Okorodudu, UT Southwestern



Total number of active residents 2019-20

Race/Ethnicity	Core Programs	Overall specialty and subspecialty
White non-Hispanic	56,077 (47.7%)	68,835 (47.5%)
Asian/ Pacific Islander	22,752 (19.4%)	29,256 (20.2%)
Hispanic	7,291 (6.2%)	8,891 (6.1%)
Black Non-Hispanic	6,153 (5.2%)	7,376 (5.1%)
Native American/Alaska Native	356 (0.3%)	428 (0.3%)
Other	7,430 (6.3%)	9,846 (6.8%)
Unknown	17,437 (14.8%)	20,356 (14.0%)
Total	117,496	144,988



Number of active residents 2019 by school type

Table 6. Race and Hispanic Ethnic Origin of Resident Physicians on Duty December 31, 2019, by Type of Medical School From Which They Graduated^a

Race ^b	No. (%)							
	US and Canadian allopathic		US osteopathic		Non-US		Total	
Black	5193 (64.8)	[6.0]	533 (6.7)	[2.4]	2283 (28.5)	[7.1]	8009	[5.7]
American Indian/Alaska Native	152 (80.0)	[0.2]	19 (10.0)	[0.1]	19 (10.0)	[0.06]	190	[0.14]
White	52 660 (68.4)	[60.9]	14 329 (18.6)	[65.2]	9975 (13.0)	[30.9]	76 964	[54.7]
Asian	19 387 (51.7)	[22.4]	4423 (11.8)	[20.1]	13 667 (36.5)	[42.4]	37 477	[26.6]
Native Hawaiian/Pacific Islander	56 (55.4)	[0.06]	18 (17.8)	[0.08]	27 (26.7)	[0.08]	101	[0.07]
Multiracial	3107 (65.5)	[6.0]	656 (13.8)	[3.0]	977 (20.6)	[3.0]	4740	[3.4]
Other/unknown	5855 (44.6)	[3.6]	1994 (15.2)	[9.1]	5286 (40.2)	[16.4]	13 135	[9.3]
Ethnic origin^b								
Hispanic	7177 (60.5)	[8.3]	846 (7.1)	[3.8]	3837 (32.4)	[11.9]	11 860	[8.4]
Non-Hispanic	79 233 (61.5)	[91.7]	21 126 (16.4)	[96.1]	28 397 (22.1)	[88.1]	128 756	[91.6]
Total ^c	86 410 (61.5)		21 972 (15.6)		32 234 (22.9)		140 616	

^a Includes resident physicians on duty as of December 31, 2019, reported through the 2019 National GME Census. A total of 195 programs (1.6%) did not provide updated information on residents by March 1, 2020. For these nonresponding programs, resident physicians reported from the last received survey were moved into their next year in the program or graduated.

^b The 2019 National GME Census imported self-designated race/ethnicity from

Association of American Medical Colleges databases where available.

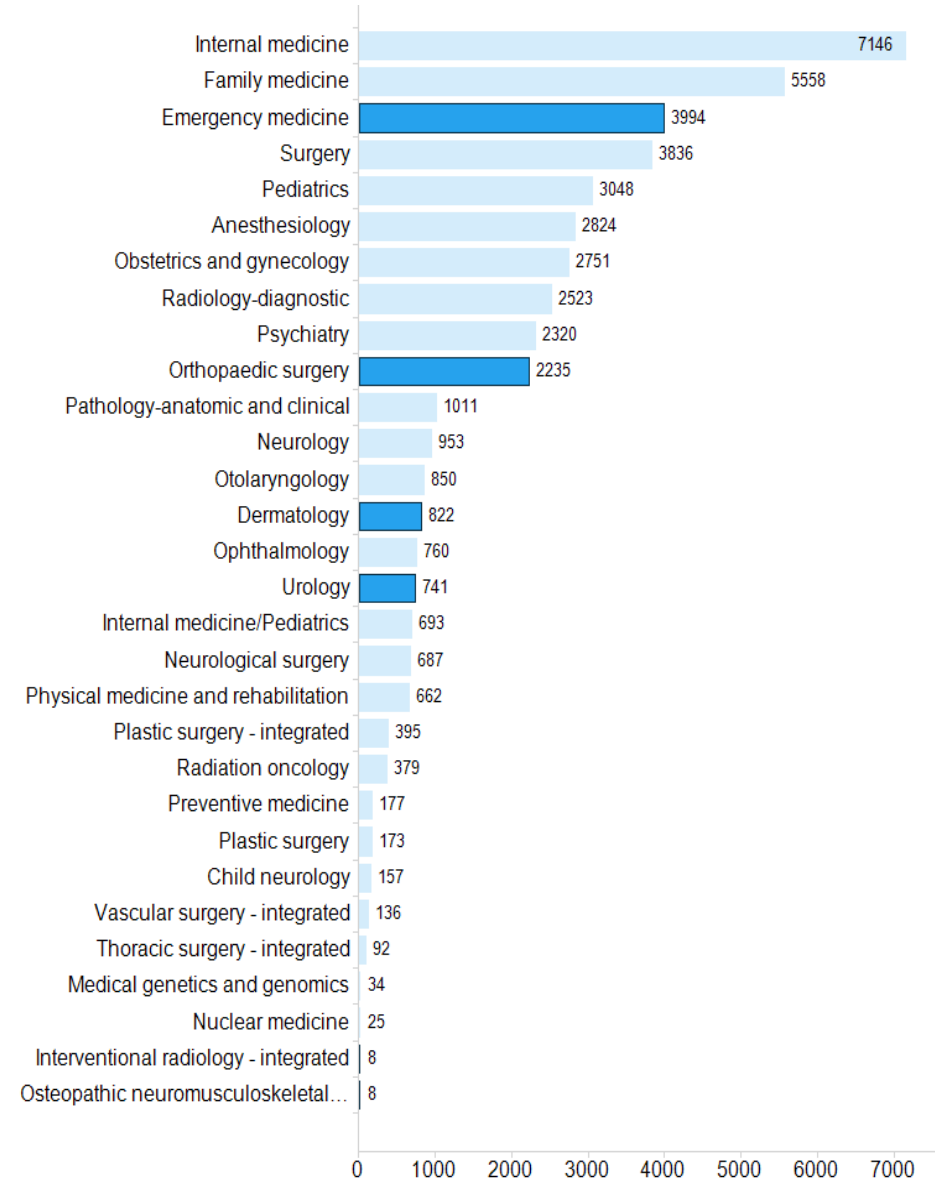
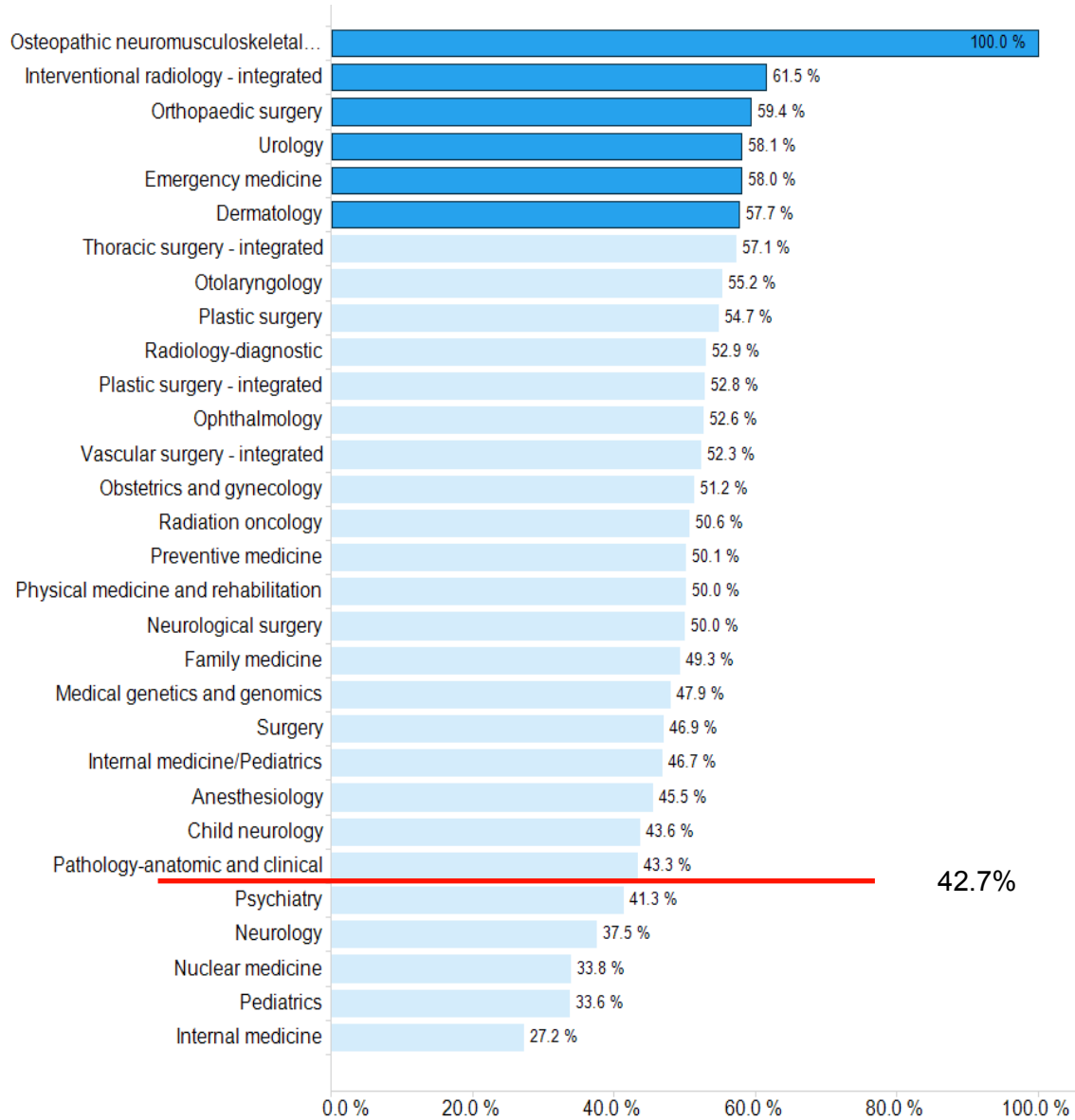
"Multiracial" refers to residents who have self-identified as more than 1 race.

A person of Hispanic ethnicity may be of any race.

^c These total data apply to each subsection separately (ie, total for race and total for ethnic origin).

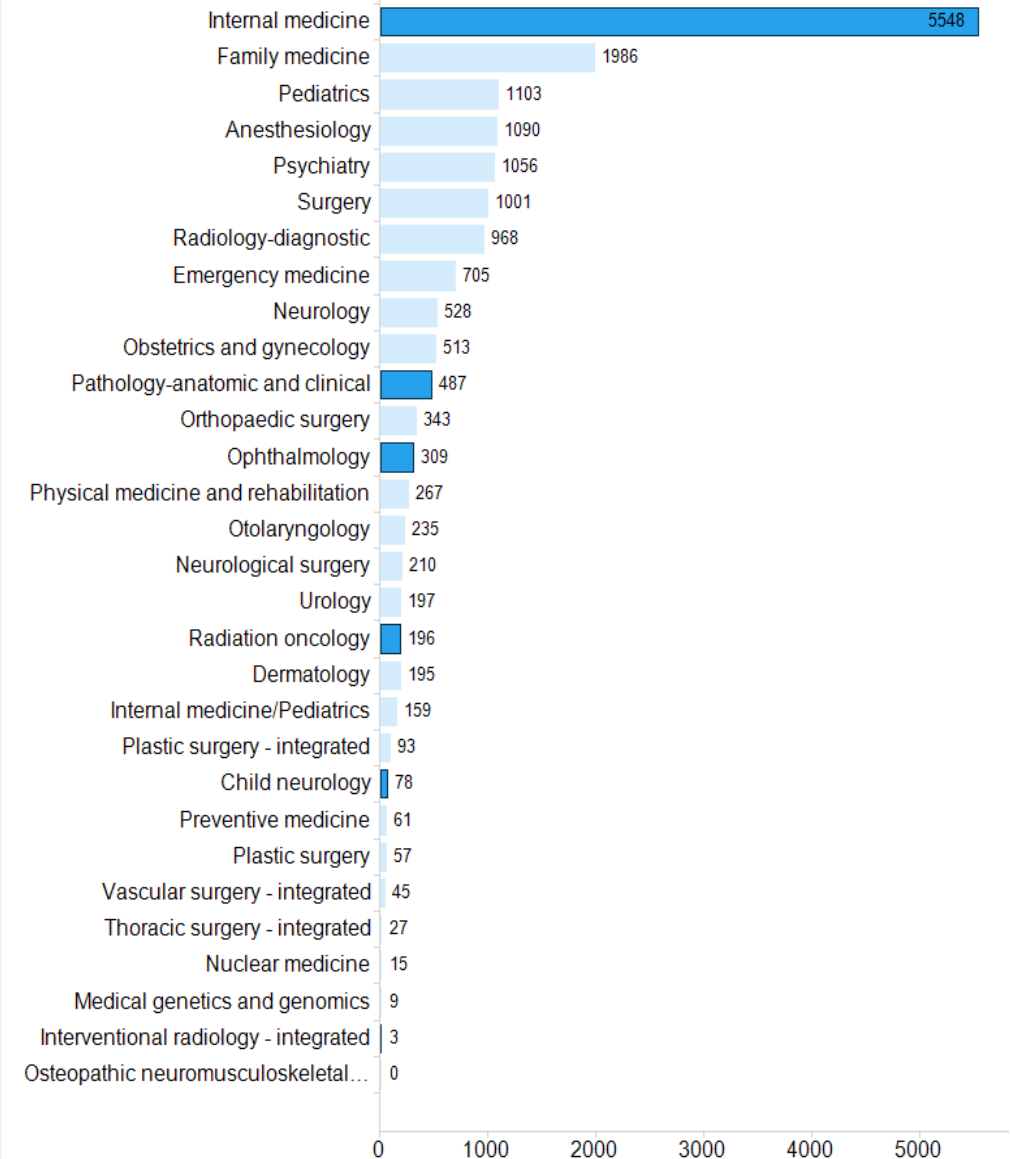
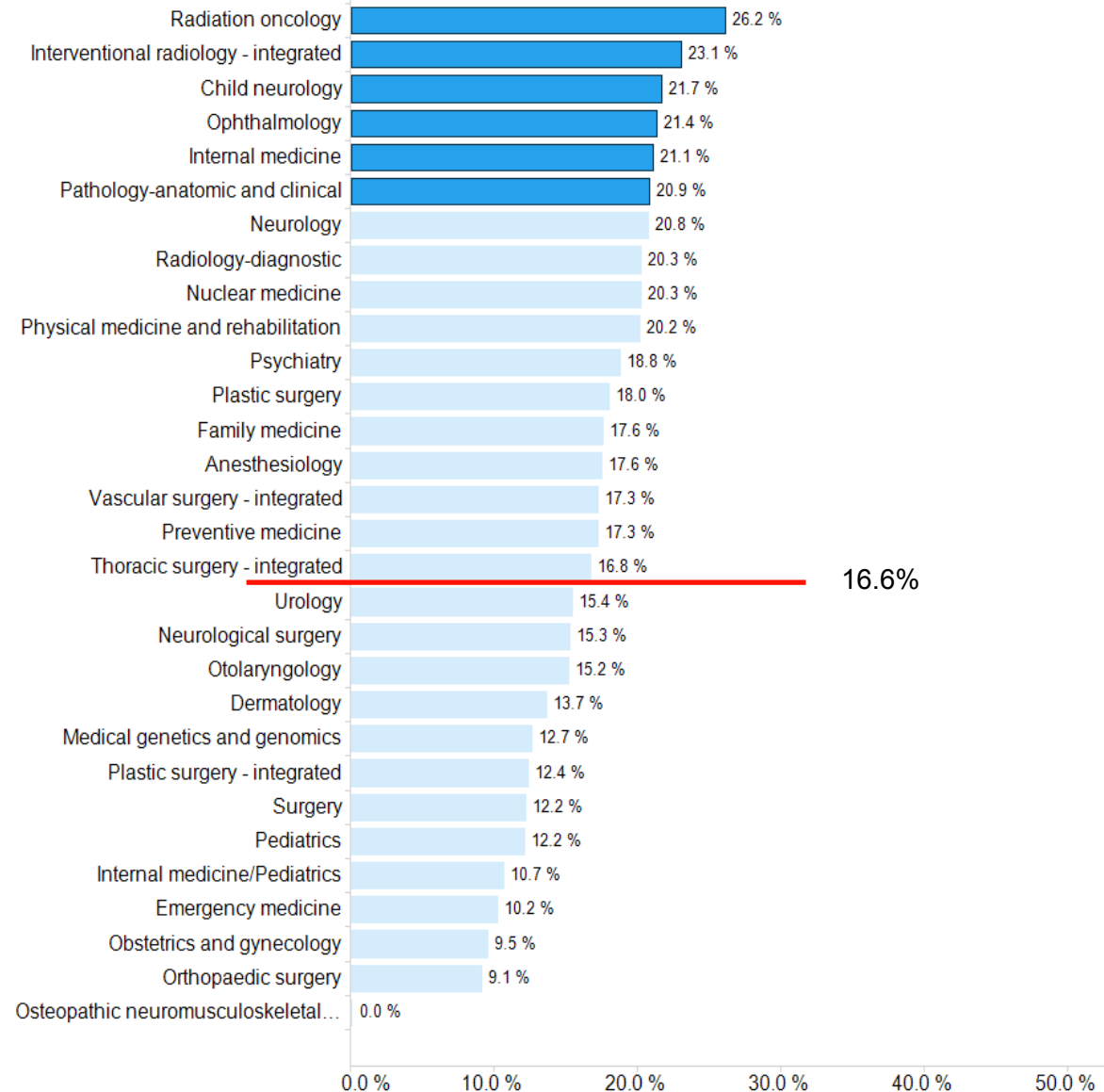
White, Non-Hispanic by Specialty

2016-2017 Academic Year



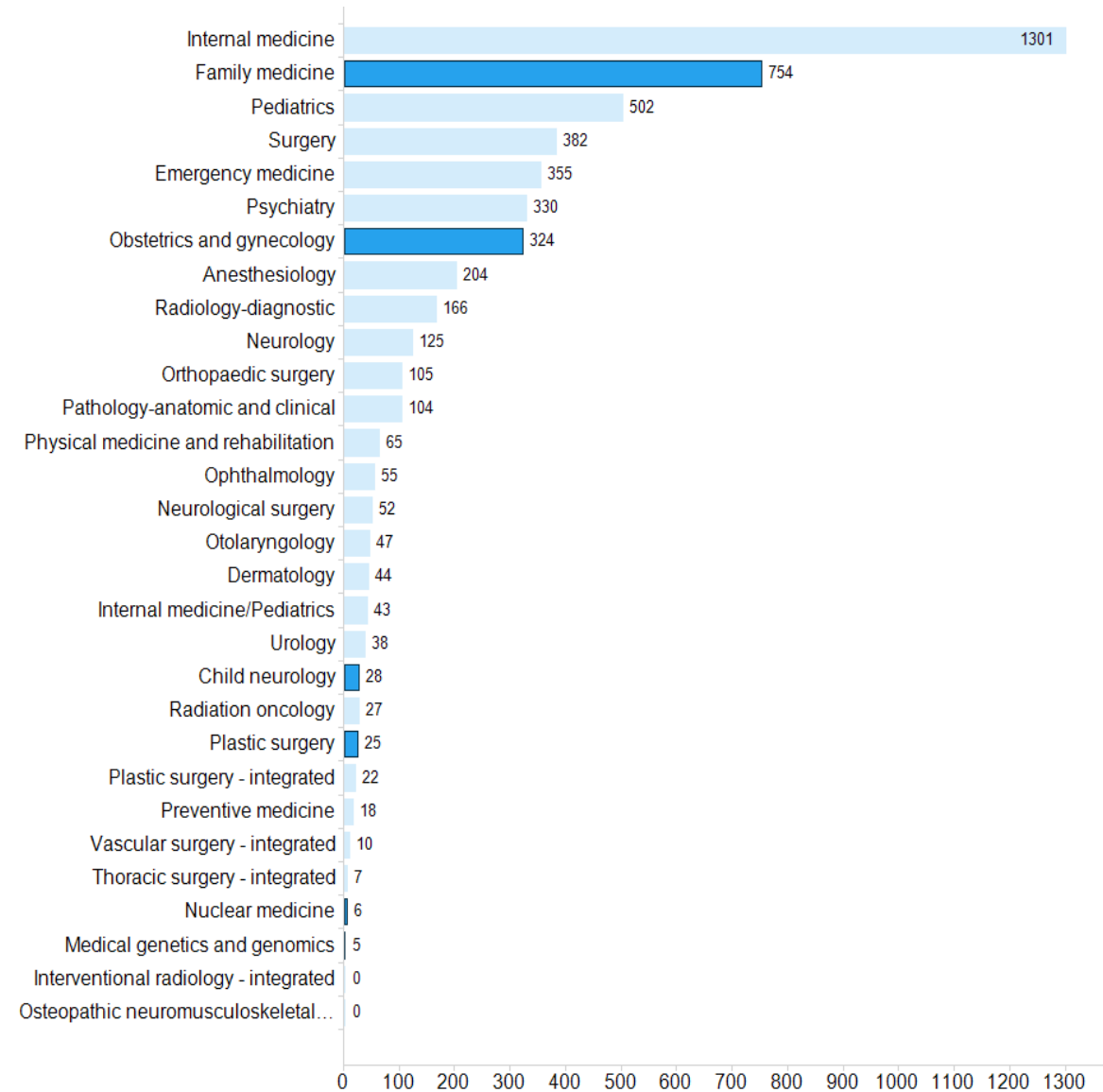
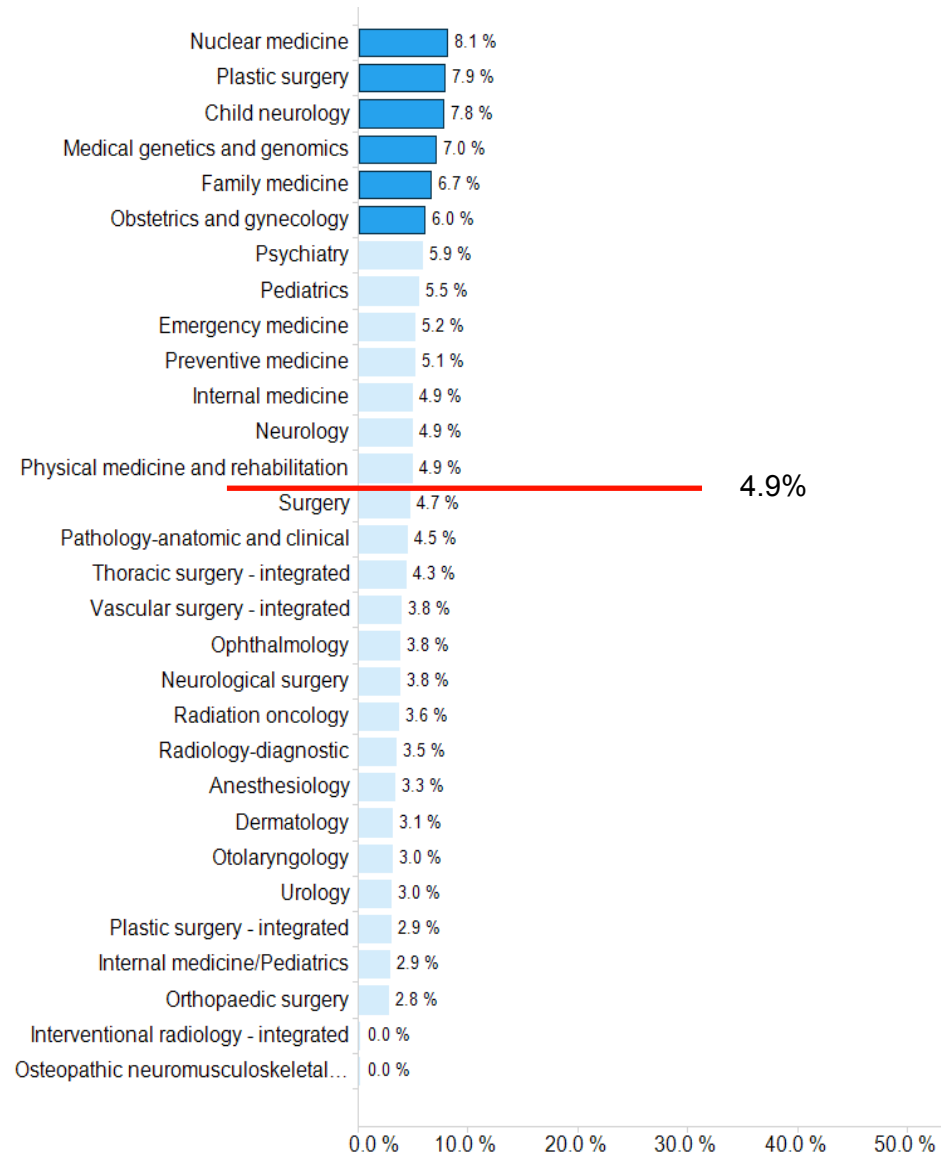
Asian and Pacific Islander by Specialty

2016-2017 Academic Year



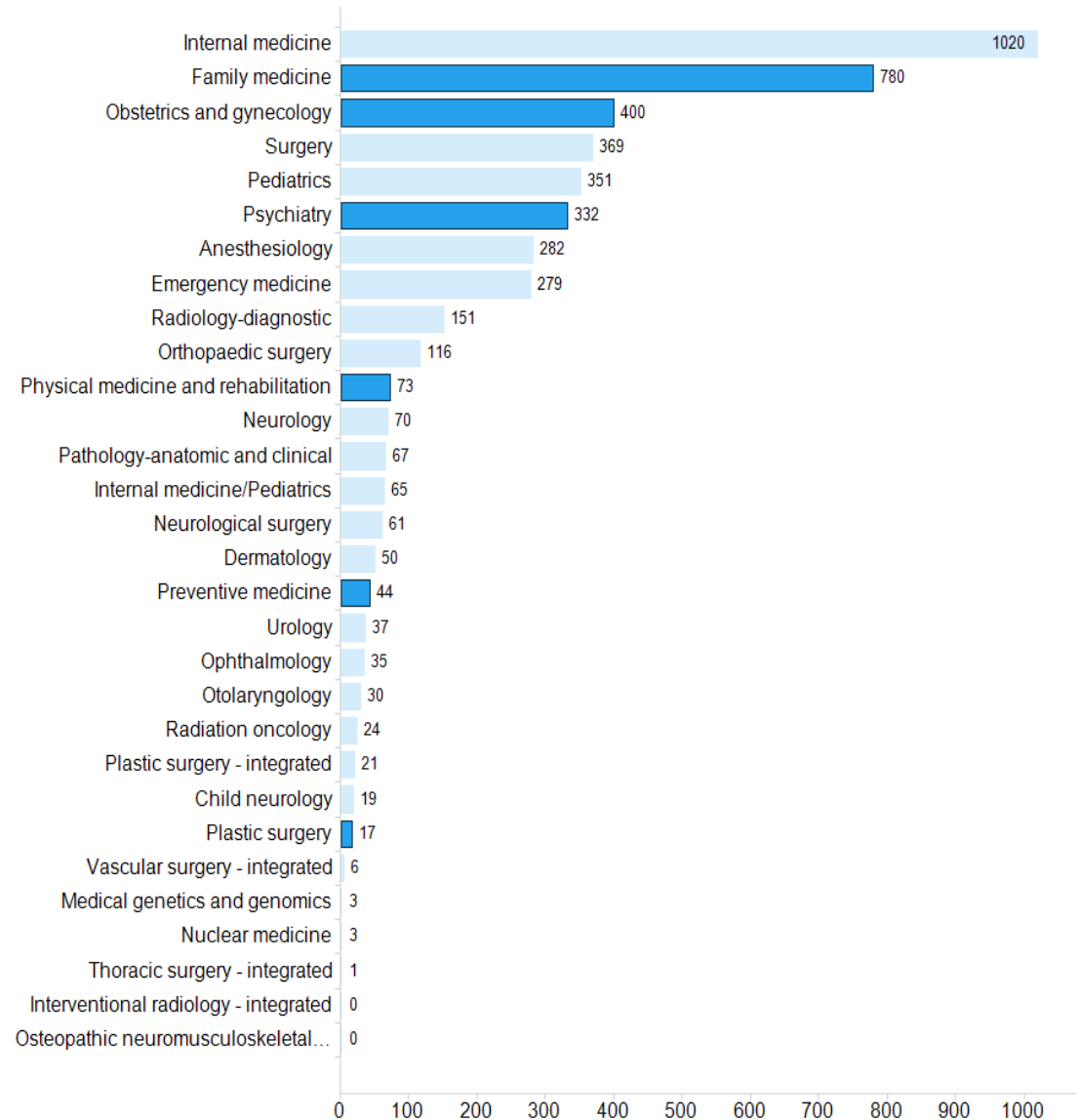
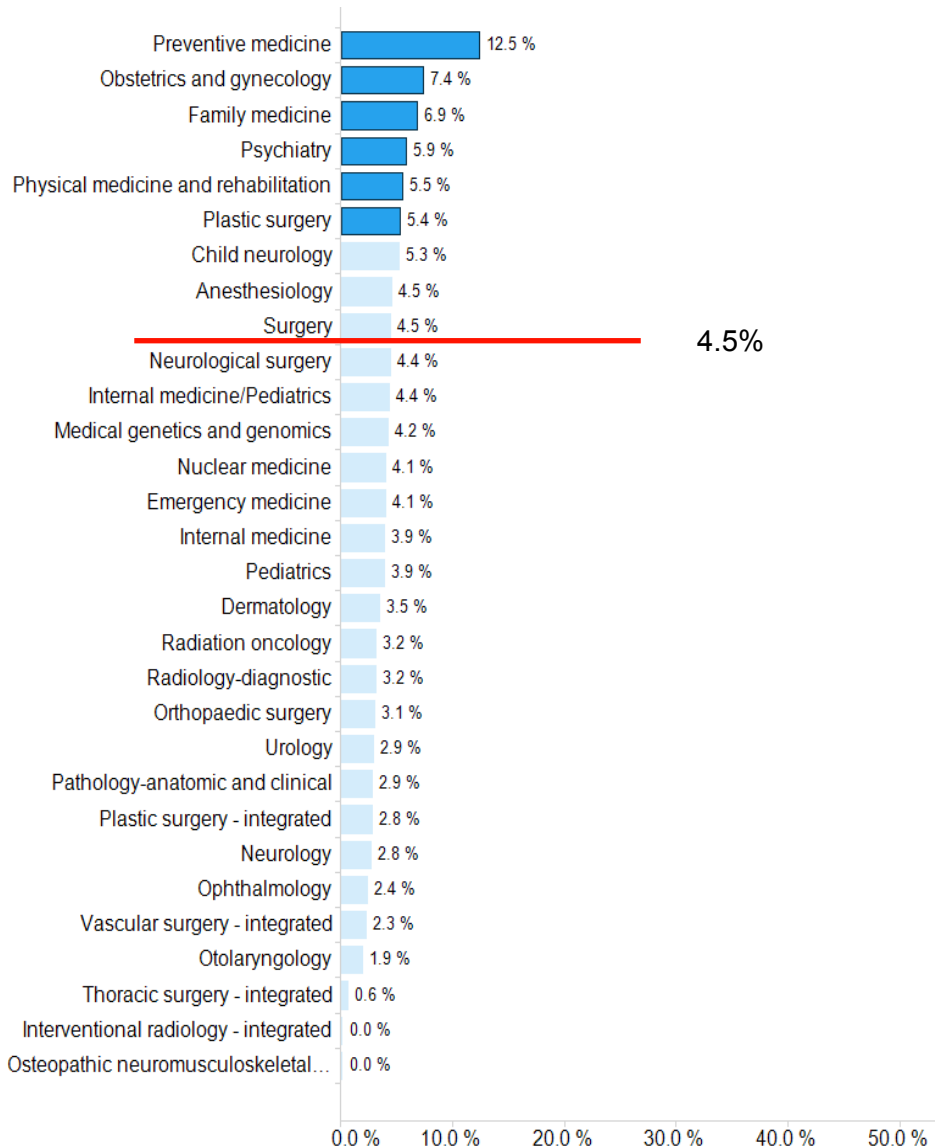
Hispanic by Specialty

2016-2017 Academic Year



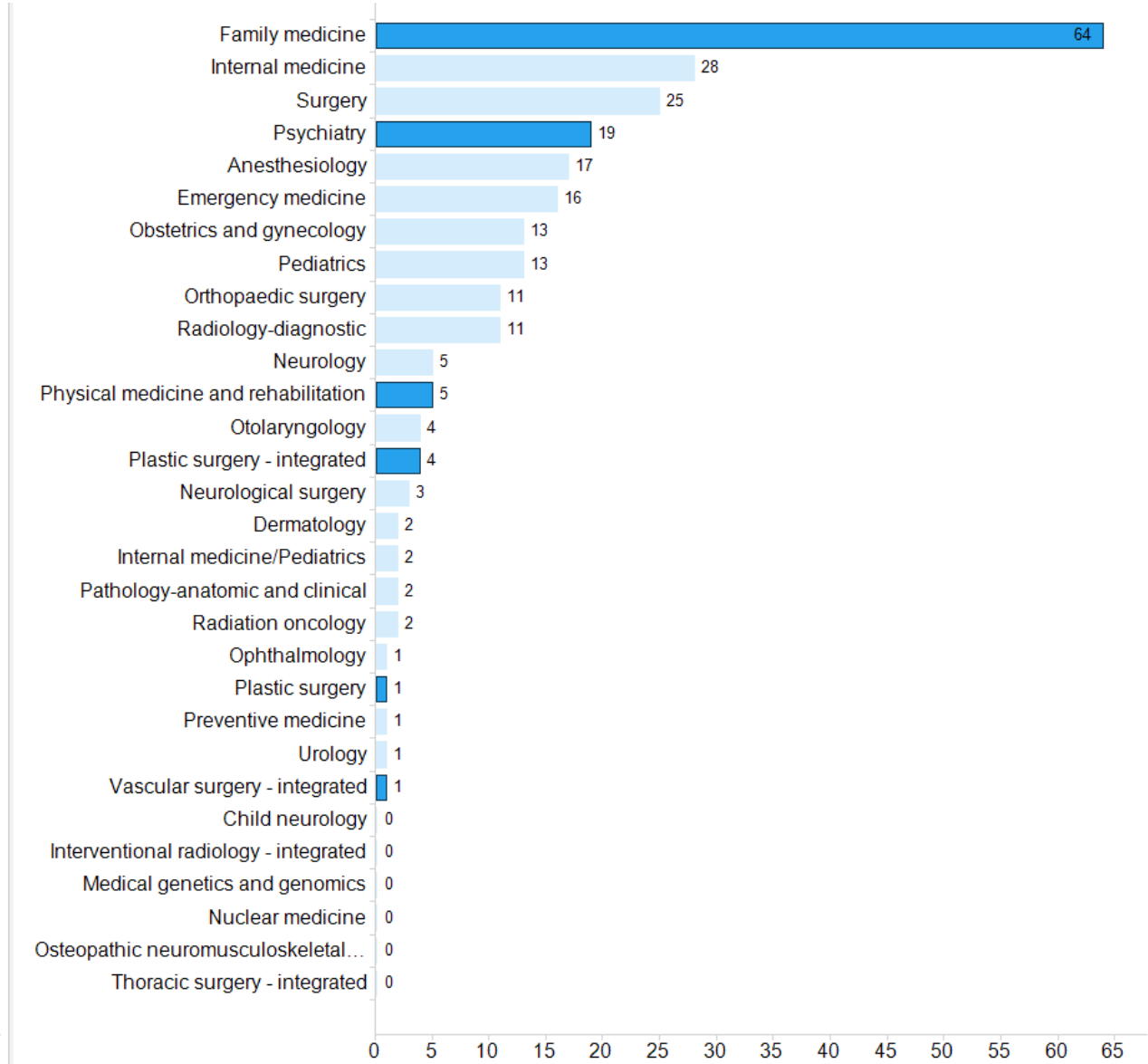
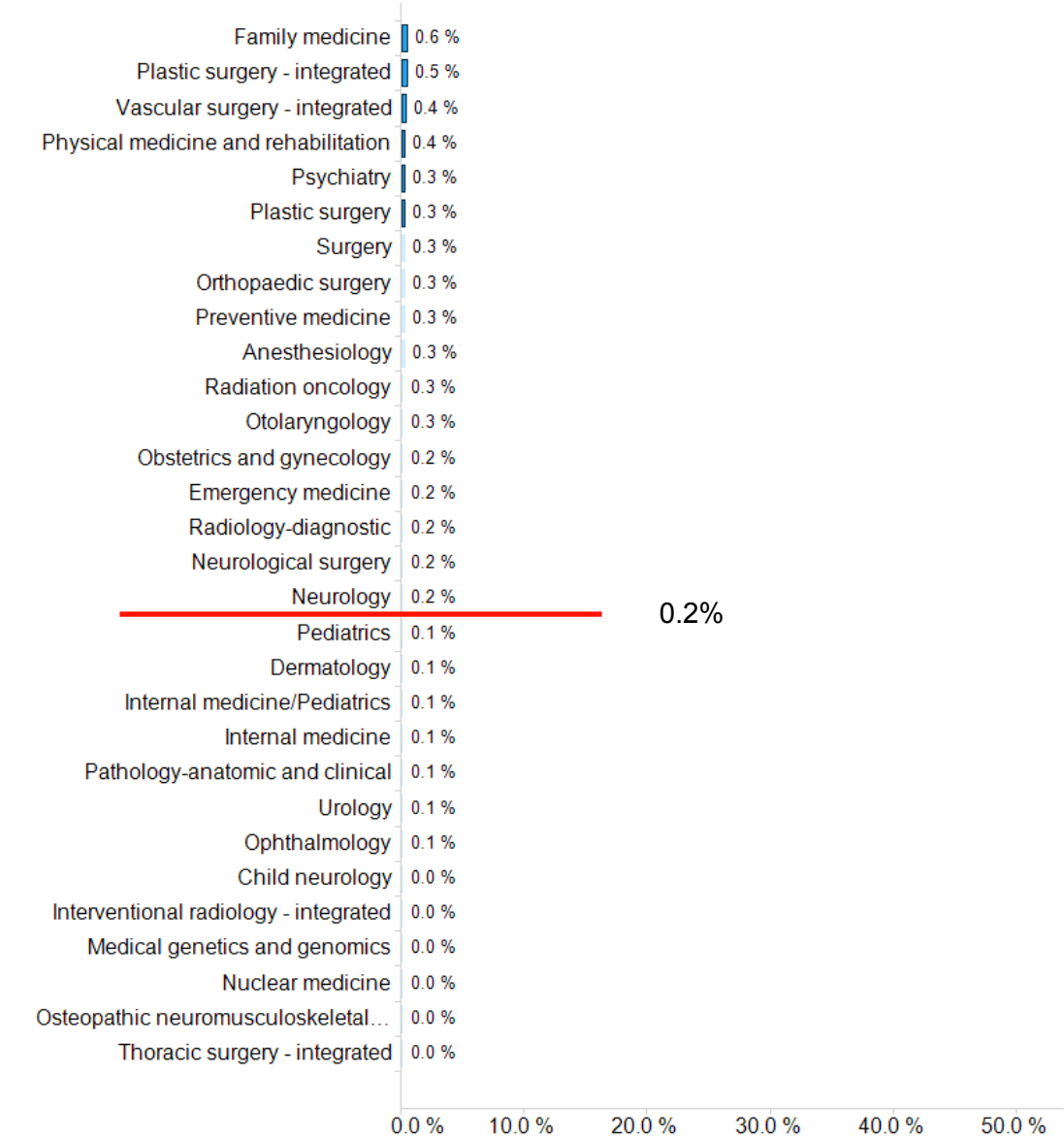
Black, Non-Hispanic by Specialty

2016-2017 Academic Year



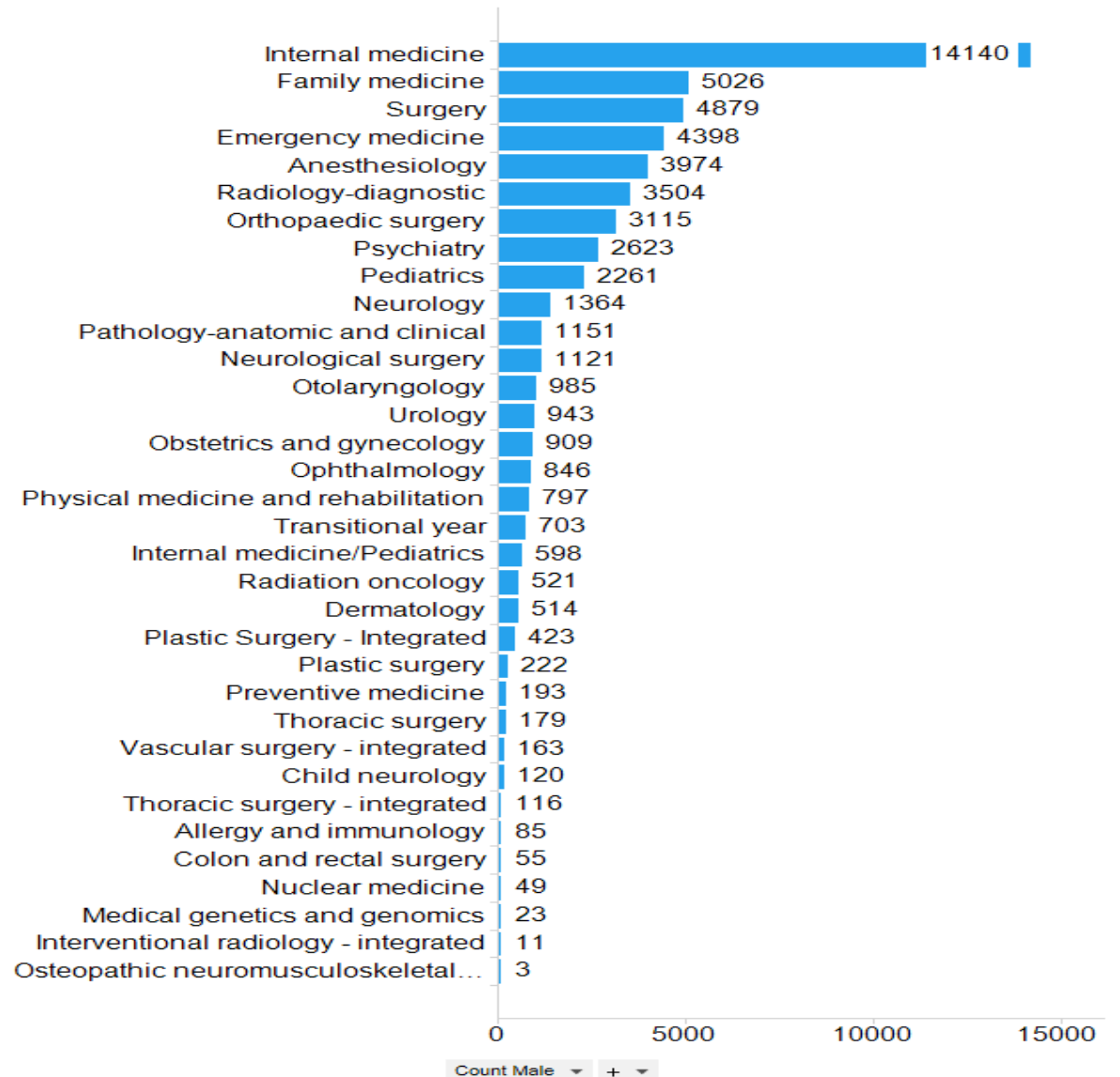
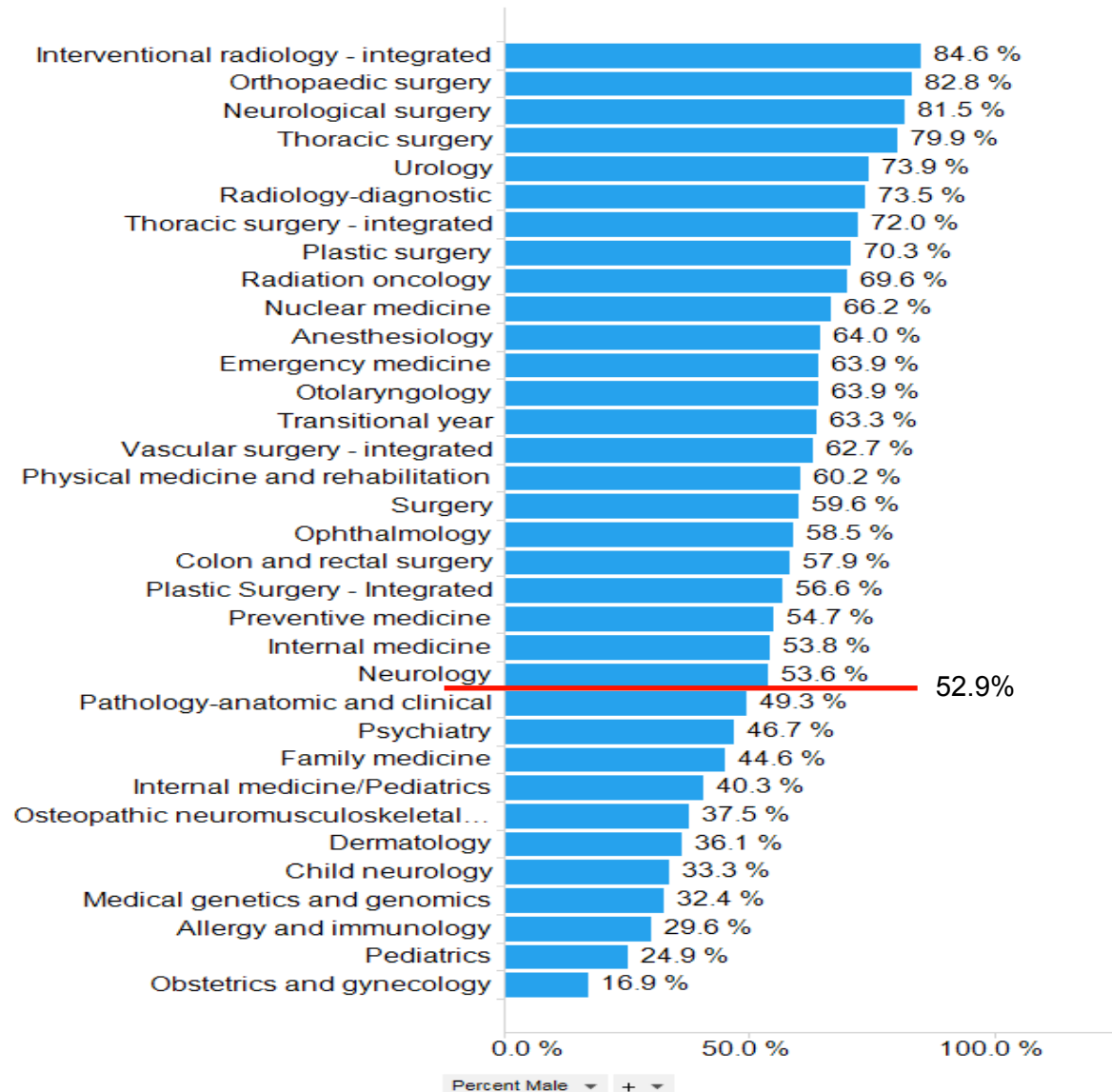
Native American by Specialty

2016-2017 Academic Year



Males by Specialty

2016-2017 Academic Year



Females by Specialty

2016-2017 Academic Year

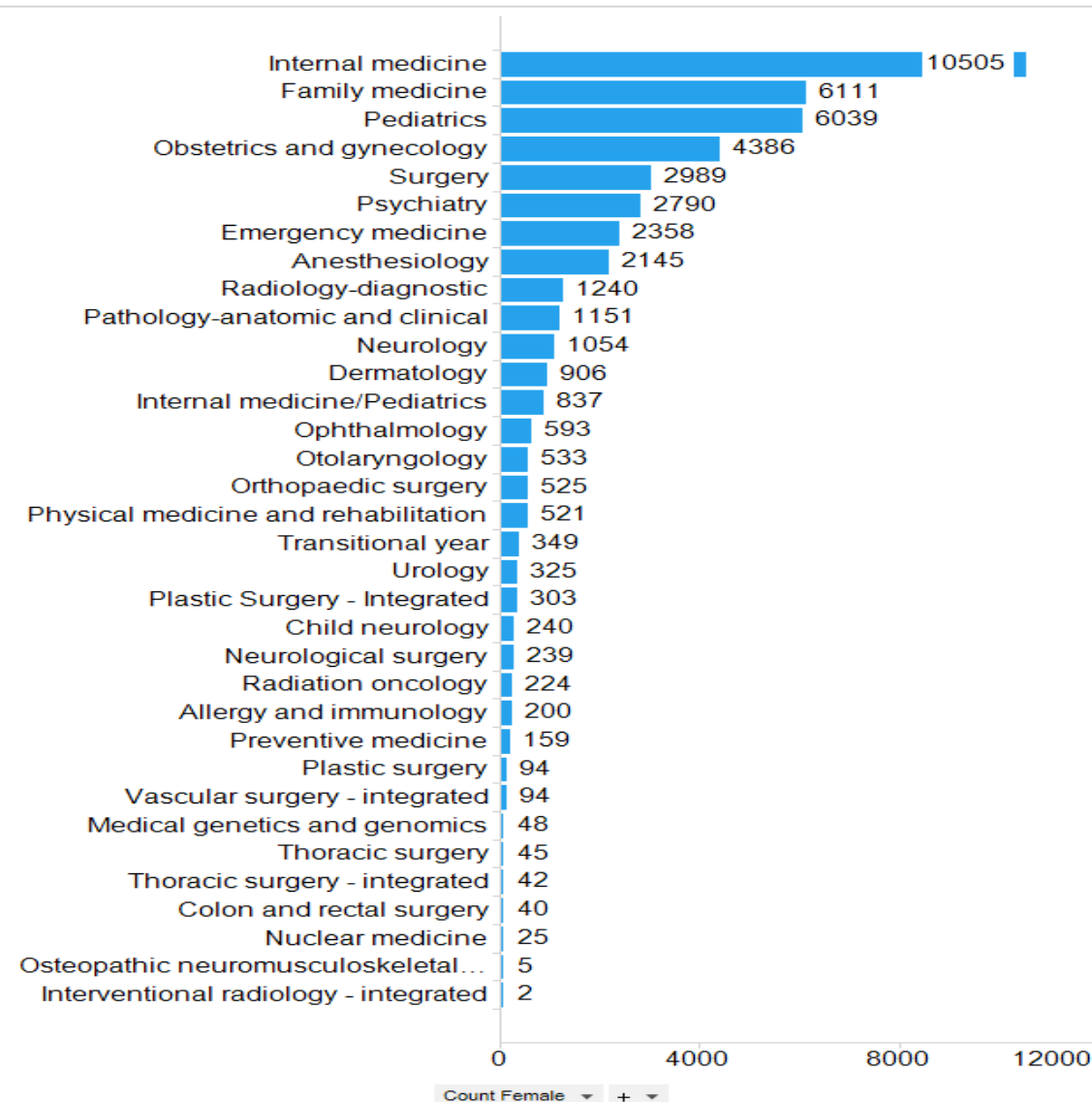
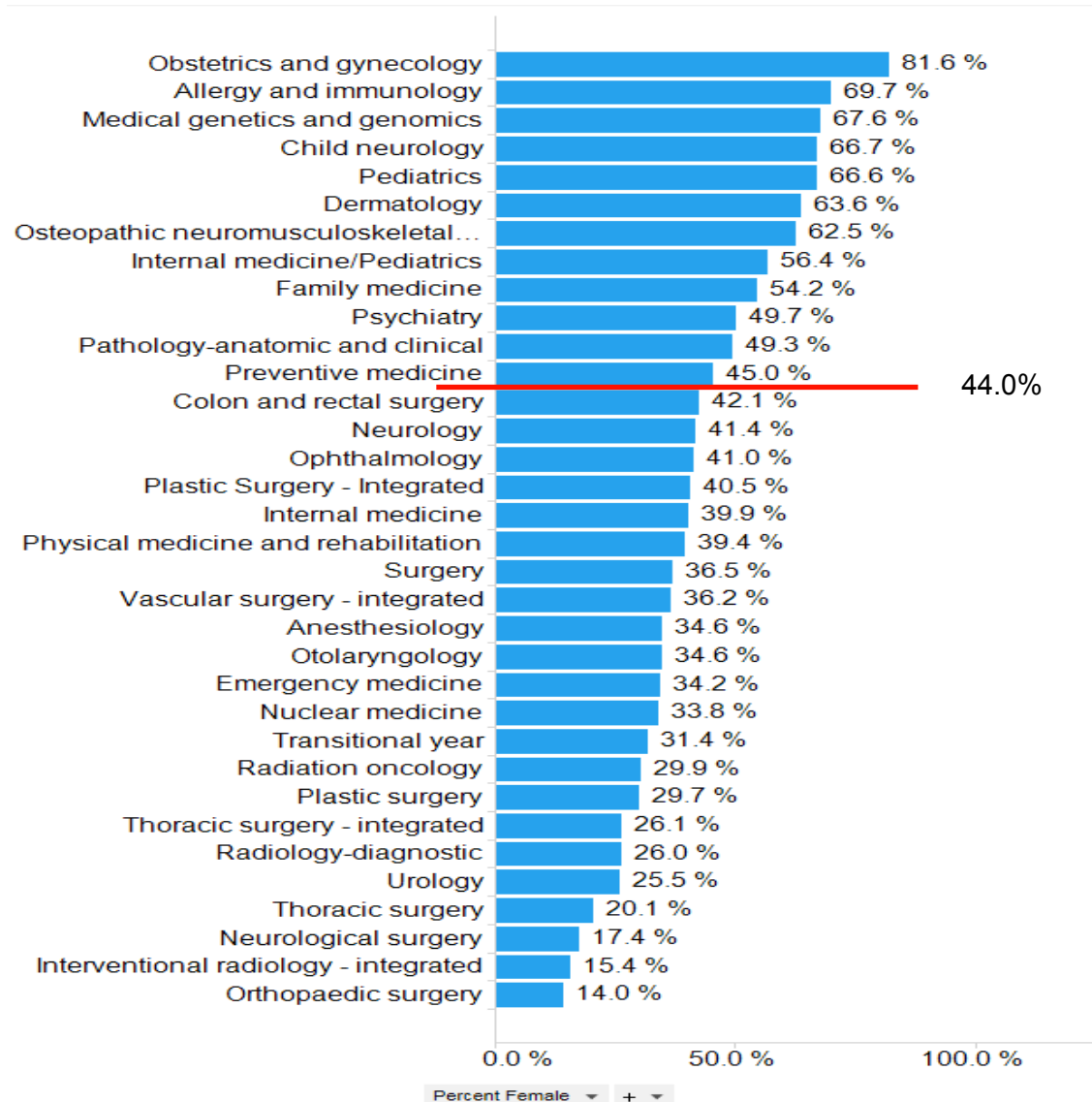


Table 8. Racial and Ethnic Origin of Resident Physicians in ACGME-Accredited and in Combined Specialty Graduate Medical Education (GME) Programs on Duty December 31, 2019, by Specialty

	No. of resident physicians ^{a,b}								
	Black	American Indian/Alaska Native	White	Asian	Native Hawaiian/Pacific Islander	Multi-racial	Other/unknown	Hispanic origin	Total
Family medicine	1038	38	7339	3073	18	461	1264	1208	13 231
Clinical informatics	0	0	3	2	0	3	2	0	10
Geriatric medicine	0	0	17	16	0	1	3	1	37
Sports medicine	14	0	162	30	1	4	16	18	227
Hospice and palliative medicine ^c	10	0	182	70	0	5	46	24	313
Internal medicine	1737	29	11 588	10 267	18	731	3511	2443	27 881
Adult congenital heart disease	0	0	13	4	0	4	1	1	22
Advanced heart failure and transplant cardiology	2	0	30	46	0	2	6	5	86
Cardiovascular disease	160	2	1344	1105	2	119	246	184	2978
Clinical cardiac electrophysiology	13	0	98	95	0	9	13	9	228
Clinical informatics	4	0	13	14	0	1	4	1	36
Critical care medicine	12	0	122	80	0	5	31	17	250
Endocrinology, diabetes, and metabolism	26	0	245	299	1	22	67	73	660
Gastroenterology	84	2	725	727	1	52	143	100	1734
Geriatric medicine	16	0	85	95	0	5	24	19	225
Hematology	1	0	5	9	0	3	3	1	21
Hematology and medical oncology	70	0	833	716	0	51	114	118	1784
Infectious disease	48	1	390	232	0	30	86	85	787
Interventional cardiology	13	0	152	120	0	15	23	25	323
Medical oncology	1	0	10	26	0	1	5	2	43
Nephrology	50	0	281	379	1	30	94	85	835
Pulmonary disease	5	0	24	39	0	1	6	17	75
Pulmonary disease and critical care medicine	68	1	1015	655	4	74	114	125	1931
Rheumatology	19	0	246	168	0	16	50	36	499
Transplant hepatology	2	0	18	26	0	2	3	2	51
Medical genetics and genomics	0	0	34	16	0	1	12	9	63
Medical biochemical genetics	1	0	14	0	0	0	1	2	16
Molecular genetic pathology	0	0	19	17	0	2	4	1	42



What programs can do to increase diversity

Increase diversity and provide an inclusive learning environment

View increasing diversity as a long-term strategy:

- Increase the number of diverse learners in pre-residency (Pathway programs)

- Work cooperatively with other programs in your institution or within your specialty to drive diverse individuals into the medical profession

- Recruit and try to increase your current numbers, but don't compete against one another – **emphasize cooperation not competition**

- If you show active work in pathway programs, eventually showing tracking of participants, even if your residency numbers don't increase for a number of years, your program will still achieve substantial compliance



Physician Pipeline “Pathway” Problem

There are not enough URiMs that reach training in GME

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

Can we turn a dribble into a gusher?



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 and opportunities

AMCs have also constructed barriers and can remove them to enhance access



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:

- Mitigating cultural underexposure or indifference
- Cessation of stereotypical projections
- Reduction of environmental elements that trigger imposter syndrome
- Effectively addressing uncivil behavior

Diversity education, implicit bias training and mandatory demonstration of competence often engender resistance and resentment in the environment. Work is needed in medical education to determine:

- Most effective training (who and how best) and settings (where and why)
- Persistence of training (when)



Naming racism in order to dismantle it

- Institutionalized/Structural
- Personally-mediated
- Internalized



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

The Gardner's Tale

Structural Racism – Racism without Racists

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: Unmasked for and unearned

Remedy requires a change in social structures



“The greatest trick the Devil ever pulled was convincing the world he didn't exist...”

Keyser Söze, by way of Charles Baudelaire



JAMA

@JAMA_current

No physician is racist, so how can there be structural racism in health care? An explanation of the idea by doctors for doctors in this user-friendly podcast from the great @DrKatzNYCHH and @ehJAMA!




Structural Racism for Doctors—What Is It?

edhub.ama-assn.org

7:00 AM · 2/24/21 · Sprinklr

31 Retweets 954 Quote Tweets 91 Likes

This Tweet has been deleted.



Dr. Aletha Maybank @...

4h

Thread on @JAMA_current: (JAMA has complete editorial independence from AMA so this would not come to me or my team for review) The podcast/tweet are/ were wrong, absolutely appalling & at its very core is a demonstration of structural & institutional racism. I am furious. 1/


Structural Racism for Doctors—What Is It?

Educational Objective

To identify the key insights or developments described in this podcast

Listen

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Many physicians are skeptical of structural racism, the idea that economic, educational, and other social systems preferentially disadvantage Black Americans and other communities of color. Mitchell Katz, MD, president and chief executive officer of NYC Health + Hospitals, the largest US public health care system,

JAMA Podcast on Racism in Medicine Faces Backlash

webmd.com



News from the
AMA
AMERICAN MEDICAL ASSOCIATION

AMA statement on JAMA podcast and tweet
ama-assn.org



Howard Bauchner, MD
Editor in Chief, JAMA and the JAMA Network

150 N. Dearborn Avenue, Suite 500
Chicago, IL 60610-5484
howard.bauchner@jamanetwork.com

March 4, 2021

On February 24, 2021 JAMA tweeted about a recently posted podcast discussing structural racism in medicine. The language of the tweet, as well as portions of the podcast, do not reflect my commitment as editorial leader of JAMA and JAMA Network to call out and discuss the adverse effects of injustice, inequity, and racism in medicine and society as JAMA has done for many years. I take responsibility for these lapses and sincerely apologize for both the lapses and the harm caused by both the tweet and some aspects of the podcast. JAMA will schedule a podcast(s) in the future to further discuss issues of structural racism and health, and to address concerns raised about the podcast.



Howard Bauchner, MD
Editor in Chief, JAMA and the JAMA Network

Inclusive Clinical Learning Environment



URiM medical students bear disproportionate burden of mistreatment

- ❑ 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

JAMA Internal Medicine | [Original Investigation](#) | PHYSICIAN WORK ENVIRONMENT AND WELL-BEING

Assessment of the Prevalence of Medical Student Mistreatment by Sex, Race/Ethnicity, and Sexual Orientation

Katherine A. Hill, BA, BS; Elizabeth A. Samuels, MD, MPH, MHS; Cary P. Gross, MD; Mayur M. Desai, PhD, MPH; Nicole Sitkin Zelin, MD; Darin Latimore, MD; Stephen J. Huot, MD, PhD; Laura D. Cramer, PhD, ScM; Ambrose H. Wong, MD, MSc; Dowlin Boatright, MD, MBA, MHS

[Editor's Note page 665](#)

[Supplemental content](#)

IMPORTANCE Previous studies have shown that medical student mistreatment is common. However, few data exist to date describing how the prevalence of medical student mistreatment varies by student sex, race/ethnicity, and sexual orientation.

OBJECTIVE To examine the association between mistreatment and medical student sex, race/ethnicity, and sexual orientation.

DESIGN, SETTING, AND PARTICIPANTS This cohort study analyzed data from the 2016 and 2017 Association of American Medical Colleges Graduation Questionnaire. The questionnaire annually surveys graduating students at all 140 accredited allopathic US medical schools. Participants were graduates from allopathic US medical schools in 2016 and 2017. Data were analyzed between April 1 and December 31, 2019.

MAIN OUTCOMES AND MEASURES Prevalence of self-reported medical student mistreatment by sex, race/ethnicity, and sexual orientation.

RESULTS A total of 27 504 unique student surveys were analyzed, representing 72.1% of graduating US medical students in 2016 and 2017. The sample included the following: 13 351 female respondents (48.5%), 16 521 white (60.1%), 5641 Asian (20.5%), 2433 underrepresented minority (URM) (8.8%), and 2376 multiracial respondents (8.6%); and 25 763 heterosexual (93.7%) and 1463 lesbian, gay, or bisexual (LGB) respondents (5.3%). At least 1 episode of mistreatment was reported by a greater proportion of female students compared with male students (40.9% vs 25.2%, $P < .001$); Asian, URM, and multiracial students compared with white students (31.9%, 38.0%, 32.9%, and 24.0%, respectively; $P < .001$); and LGB students compared with heterosexual students (43.5% vs 23.6%, $P < .001$). A higher percentage of female students compared with male students reported discrimination based on gender (28.2% vs 9.4%, $P < .001$); a greater proportion of Asian, URM, and multiracial students compared with white students reported discrimination based on race/ethnicity (15.7%, 23.3%, 11.8%, and 3.8%, respectively; $P < .001$), and LGB students reported a higher prevalence of discrimination based on sexual orientation than heterosexual students (23.1% vs 1.0%, $P < .001$). Moreover, higher proportions of female (17.8% vs 7.0%), URM, Asian, and multiracial (4.9% white, 10.7% Asian, 16.3% URM, and 11.3% multiracial), and LGB (16.4% vs 3.6%) students reported 2 or more types of mistreatment compared with their male, white, and heterosexual counterparts ($P < .001$).

CONCLUSIONS AND RELEVANCE Female, URM, Asian, multiracial, and LGB students seem to bear a disproportionate burden of the mistreatment reported in medical schools. It appears that addressing the disparate mistreatment reported will be an important step to promote diversity, equity, and inclusion in medical education.



Hill, et al. JAMA Intern Med. Feb 2020;180(5):653-665. doi:10.1001

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

SPECIAL ARTICLE

Discrimination, Abuse, Harassment, and Burnout in Surgical Residency Training

Yue-Yung Hu, M.D., M.P.H., Ryan J. Ellis, M.D., M.S.C.I.,
D. Brock Hewitt, M.D., M.P.H., Anthony D. Yang, M.D., Elaine Ooi Cheung, Ph.D.,
Judith T. Moskowitz, Ph.D., M.P.H., John R. Potts III, M.D., Jo Buyske, M.D.,
David B. Hoyt, M.D., Thomas R. Nasca, M.D., and Karl Y. Bilimoria, M.D., M.S.C.I.

ABSTRACT

BACKGROUND

Physicians, particularly trainees and those in surgical subspecialties, are at risk for burnout. Mistreatment (i.e., discrimination, verbal or physical abuse, and sexual harassment) may contribute to burnout and suicidal thoughts.

METHODS

A cross-sectional national survey of general surgery residents administered with the 2018 American Board of Surgery In-Training Examination assessed mistreatment, burnout (evaluated with the use of the modified Maslach Burnout Inventory), and suicidal thoughts during the past year. We used multivariable logistic-regression models to assess the association of mistreatment with burnout and suicidal thoughts. The survey asked residents to report their gender.

RESULTS

Among 7409 residents (99.3% of the eligible residents) from all 262 surgical residency programs, 31.9% reported discrimination based on their self-identified gender, 16.6% reported racial discrimination, 30.3% reported verbal or physical abuse (or both), and 10.3% reported sexual harassment. Rates of all mistreatment measures were higher among women; 65.1% of the women reported gender discrimination and 19.9% reported sexual harassment. Patients and patients' families were the most frequent sources of gender discrimination (as reported by 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%). Proportion of residents reporting mistreatment varied considerably among residency programs (e.g., ranging from 0 to 66.7% for verbal abuse). Weekly burnout symptoms were reported by 38.5% of residents, and 4.5% reported having had suicidal thoughts during the past year. Residents

Bias toward staff

- M4 pre-rounds on infant and is told by parent that she doesn't want anyone who has gotten into medical school because of affirmative action touching her baby
- On resident work rounds, asked to stay in the hall while the rest of the team sees her patient
- On attending rounds, the attending simply reassigns the student citing we don't want to anger the patient's family and there are other patients you can see...



McDade, W.A., 2001. Commemorative Issue: A Racist Parent. *AMA Journal of Ethics*, 3(11).

Through the Physician's Eyes: The Racist Parent

William McDade, MD, PhD

The woman was from northern Indiana and had come to our regional medical center heralded for its expertise in pediatric medicine. Her child was not doing well and she wanted the best. Further, she was willing to travel into a neighborhood very much different from her own to insure this expertise. On morning pre-rounds, the African American fourth-year medical student entered the infant's room and was confronted by the child's mother who inquired and then accused. The medical student explained her role was to examine the child and to learn what had transpired in his health care overnight. She stated that she was a part of a larger team that included the internationally famous attending physician who was leading the teaching effort. This was unfortunately not sufficient for the mother's satisfaction.

She stated that she did not want any of "your kind" touching her child. She elaborated further that anyone who had been granted admission into medical school through affirmative action should not be there, and that no recipient of societal welfare is going to touch her sick child. The student was aghast. Hurt, anger, doubt, and frustration intermingled within her. She was devastated and now tearfully left the patient's room. I am not sure what must have been going through the mother's mind at that time. Did she feel that she had successfully protected her child from some assault from a poorly educated black woman? Did she feel that the debased medical student would suddenly come to her senses give up her study of medicine through such harshly delivered discouragement? Did she feel good about herself for having

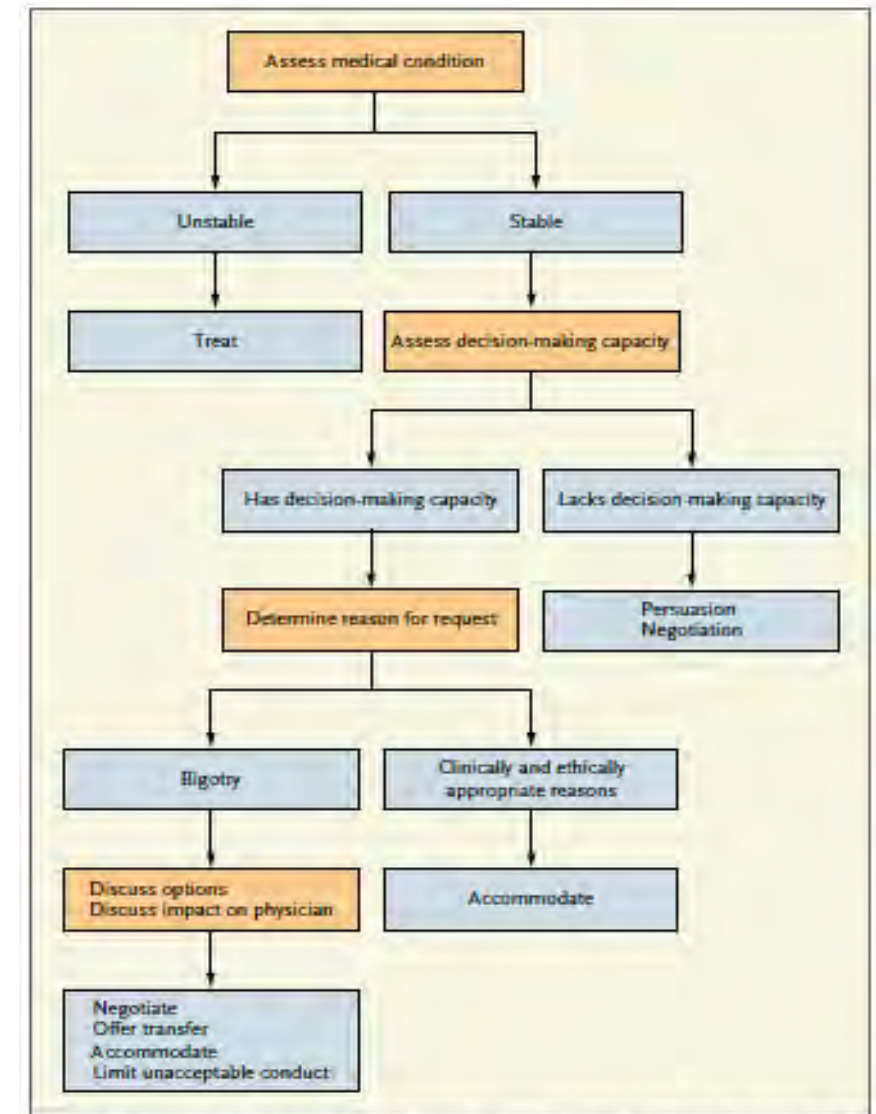
Dealing with Racist Patients

- Patients have a right to refuse care

Autonomy

EMTALA

- Physicians and other health care workers have employment rights that must be balanced with patients' rights.
- Patients should be informed that hateful or racist speech is not allowed, and this should be institutional policy



Considering a Patient's Request for Physician Reassignment Based on Race or Ethnic Background in an Emergency Setting.

Actions in the orange boxes address factors that physicians should consider when confronted with a request to change clinicians because of a clinician's race or ethnic background. Such requests may be deemed to be clinically and ethically appropriate if, for instance, they are motivated by a desire for racial, ethnic, or language concordance or if the patient has specific mental health issues.



Paul-Emile, Kimani, et al. "Dealing with racist patients." *New England J. Med.* 374 (2016): 708.

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%



Hu et al. April 15, 2020. doi:10.1001/jamasurg.2020.0260

Letters

RESEARCH LETTER

National Evaluation of Racial/Ethnic Discrimination in US Surgical Residency Programs

Discrimination in medicine has been associated with decreased productivity, as well as increased alcohol use, depression, attrition, and suicidality among physicians.^{1,2} In surgical training, discrimination is common² but has not been comprehensively evaluated among racial/ethnic minorities. The objectives of this study were to (1) determine the national prevalence and sources of discrimination based on race/ethnicity in US general surgery programs, (2) identify factors associated with discrimination, and (3) assess its association with resident wellness.

Methods | Resident physicians training in Accreditation Council for Graduate Medical Education-accredited general surgery programs were administered a survey following the 2019 American Board of Surgery In-Training Examination. Residents were asked about their experiences with various types of discriminatory behavior based on race/ethnicity or religion^{3,4} within that academic year. Burnout, thoughts of attrition, and suicidality were assessed with established instruments.² The proportion of minority faculty members within each program was obtained from the Association of American Medical Colleges. This study was reviewed by the Northwestern University institutional review board office and was determined to not meet the definition of human-subjects research. As a re-

sult, this study was deemed exempt from full review and informed consent procedures.

Descriptive statistics were calculated. A multivariable regression model was developed to examine resident and program characteristics associated with discrimination. Adjusted analyses were repeated with stratification by sex to evaluate for potential interactions between race and sex. We performed χ^2 tests to assess the associations of discrimination with burnout, thoughts of attrition, and suicidality. All tests were 2-sided with $\alpha = .05$, using Stata version 15.1 (StataCorp). Data were collected in January 2019. The dates that data were analyzed include June 2019 to August 2019.

Results | A total of 6956 clinically active residents from 301 programs completed the survey (response rate, 85.6%). Of the 5679 who responded to the relevant questions, 1346 (23.7%) reported experiencing discrimination based on race/ethnicity or religion. Discrimination rates were higher in black respondents (171 of 242 [70.7%]), Asian respondents (442 of 963 [45.9%]), Hispanic respondents (122 of 482 [25.3%]), and other nonwhite respondents (175 of 526 [33.3%]) compared with white respondents (435 of 3455 [12.6%]). The most common discriminatory behavior was being mistaken for another person of the same race, experienced by 135 of 240 black residents (56.3%; 2 individuals did not respond to this question) and 361 of 963 Asian residents (37.6%; 4 individuals did not respond), with nurses and staff as the most common source (413 [43.8%]). Black residents frequently reported being mis-

Table 1. Prevalence and Most Common Sources of Discrimination Based on Race/Ethnicity or Religion^a

Characteristic	Respondents, No. (%)						Most common source of discrimination ^a		
	All (N = 5679) ^b	White (n = 3455)	Black (n = 242)	Hispanic (n = 482)	Asian (n = 963)	Other/prefer not to say (n = 526)	P value ^c	Source	Respondents reporting this type of discrimination No. (%)
Overall prevalence	1346 (23.7)	435 (12.6)	171 (70.7)	122 (25.3)	442 (45.9)	175 (33.3)	<.001	NA	NA
Discrimination components									
Different standards of evaluation	468 (8.2)	100 (2.9)	92 (38.0)	52 (10.8)	137 (14.2)	86 (16.3)	<.001	Attending physicians	243 (63.0)
Denied opportunities	250 (4.4)	69 (2.0)	39 (16.1)	27 (5.6)	59 (6.1)	55 (10.5)	<.001	Attending physicians	138 (67.3)
Mistaken for a nonphysician	482 (8.5)	51 (1.5)	151 (62.4)	66 (13.7)	150 (15.6)	63 (12.0)	<.001	Patients and their families	327 (73.2)
Slurs and/or hurtful comments	416 (7.3)	116 (3.4)	60 (24.8)	40 (8.3)	129 (13.4)	70 (13.3)	<.001	Patients and their families	126 (35.5)
Socially isolated	208 (3.7)	65 (1.9)	28 (11.6)	26 (5.4)	37 (3.8)	51 (9.7)	<.001	Colleagues	117 (70.1)
Mistaken for another person of the same race	998 (17.6)	300 (8.7)	135 (55.8)	74 (15.4)	361 (37.5)	127 (24.2)	<.001	Nurses/staff	413 (43.8)

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”

JAMA
Network | Open.



Original Investigation | Medical Education

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

Osseo-Asare A, et al. MDs; Libanti E, et al. MDs; Stephen J, et al. MD, PhD; Danyali A, et al. PhD; David E, et al. PhD; Marcella N, et al. MD, MPH; Ingbin G, et al. MD; Darrin L, et al. MD; Darrin E, et al. MD, MPH, MPH

Abstract

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

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

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

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

RESULTS: Among 27 participants, race/ethnicities were 19 (70.4%) Black, 3 (11%) Hispanic, 1 (4%) Native American, and 4 (15%) mixed race/ethnicity. 15 (56%) were female. Participants described the following 3 major themes in their training experiences in the workplace: a daily barrage of microaggressions and bias; minority residents tasked as race/ethnicity ambassadors; and challenges negotiating professional and personal identity while seen as “other.”

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

JAMA Network Open. 2018;1(5):e182723. doi:10.1001/jamanetworkopen.2018.2723

Key Points

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

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

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

+ Invited Commentary

Authors of this study and invited commentary are included at the end of this article.



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

Microaggressions

“Nice to see you are finally trying”

“Are you the first person in your family to be a doctor?”

“You speak English really well”

“Is that your real hair, can I touch it?”

“Your name is too difficult for me, do you have a nickname?”

“You have such a chip on your shoulder”

Not just spoken insults

Entire world, in all aspects of your life

Rarely said with misguided love

Small daily insults and indignities perpetrated against marginalized people because of their being in that group

More than just annoyances



Oluo, Ijeoma. *So you want to talk about race*. Hachette UK, 2019

Microaggressions

Cumulative reminder that you are less than

On their own, each microaggression does not seem like a big deal, but as a cumulative process, it has a definite impact on the quality of your life and relationships with others

Come from multiple people, and since each microaggression seems small:

- Exhausting to confront each source

- Appear hypersensitive

Often done without awareness of causing harm



Oluo, Ijeoma. *So you want to talk about race*. Hachette UK, 2019

Microaggressions

Cause isolation, invalidation,
unworthiness of respect

Inability to predict where and when they
will occur leads to hypervigilance and
keep you off balance, distracted and
defensive

Find a way into every part of every day,
constant reminders that you don't belong

They steal your joy and can ruin your day

Hard to address in real life because they
are hard to see

Small and can be easily explained
away as a misunderstanding or
mistake

Those subjected to microaggressions
are more likely to exhibit depression



Oluo, Ijeoma. *So you want to talk about race*. Hachette UK, 2019

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.



Research Report

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

Liselotte N. Dyrbye, MD, MHPE, Natalie M. Wittlin, MS, Rachel R. Hardeman, PhD, MPH, Mark Yeazel, MD, MPH, Jenh Herrin, PhD, John F. Dovidio, PhD, Sara E. Burke, 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 ($n = 2,455$) 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.

The Depression-PI stratified four risk groups. Compared with the low risk group, those in the intermediate, high, and very high risk groups had an odds ratio of developing depression of, respectively, 1.75, 3.98, and 9.19 ($c = 0.71$). The replication dataset confirmed the risk groups.

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.



Dyrbye, LN et al. Acad Med. 2019 Feb;94(2):217-226

Burnout impairs job performance

Ability to focus wanes

Engagement with work suffers

Feelings of apathy and hopelessness

Increased irritability, emotional exhaustion

Lack of productivity and poor performance



Dyrbye, LN et al. JAMA (2010) 304(11):1173

Relationship Between Burnout and Professional Conduct and Attitudes Among US Medical Students

Lisette N Dyrbye, MD, MPH
E Stanford Masie Jr, MD
Anne Escher, MD
William Harper, MD
David Powell, MD, MPH
Steven J Durning, MD
Matthew R Thomas, MD
Christine Moutier, MD
Daniel Sokol, BA
Jeff Sloan, PhD
Tali D Sharash, MD

PROFESSIONALISM IS A CORE competency for all physicians.^{1,2} Professionalism includes being honest, acting with integrity, advocating for the needs of patients, reducing barriers to equitable health care, and adhering to an ethical code of conduct. How best to instill professionalism in future physicians and maintain it throughout the course of a career is unknown. Research suggests that medical students may find when attempting to develop a professional identity consistent with the expectations of society and the profession.³⁻⁵ These findings are concerning because evidence suggests that some unprofessional behaviors during medical school predict subsequent unprofessional conduct once in practice.⁶⁻⁸

Despite the widely acknowledged importance of professionalism, how

See also pp 1181 and 1281.

Context: The relationship between professionalism and distress among medical students is unknown.

Objective: To determine the relationship between measures of professionalism and burnout among US medical students.

Design, Setting, and Participants: Cross-sectional survey of all medical students attending 7 US medical schools (overall response rate, 2682/4400 [61%]) in the spring of 2008. The survey included the Maslach Burnout Inventory (MBI), the PRIME-MD depression screening instrument, and the SF-8 quality of life (QOL) assessment tool, as well as items exploring students' personal engagement in unprofessional conduct, understanding of appropriate relationships with industry, and attitudes regarding physicians' responsibility to society.

Main Outcome Measures: Frequency of self-reported cheating/deonest behaviors, understanding of appropriate relationships with industry as defined by American Medical Association policy, attitudes about physicians' responsibility to society, and the relationship of these dimensions of professionalism to burnout, symptom of depression, and QOL.

Results: Of the students who responded to all the MBI items, 1354 of 2566 (52.8%) had burnout. Cheating/deonest academic behaviors were rare (endorsed by <10%) in comparison to unprofessional conduct related to patient care (endorsed by up to 48%). Only 14% (362/2581) of students had opinions on relationships with industry consistent with guidelines for 6 scenarios. Students with burnout were more likely to report engaging in 1 or more unprofessional behaviors than those without burnout (35.0% vs 21.9%; odds ratio [OR], 1.88; 95% confidence interval [CI], 1.59-2.24). Students with burnout were also less likely to report holding altruistic views regarding physicians' responsibility to society. For example, students with burnout were less likely to want to provide care for the medically underserved than those without burnout (79.3% vs 85.0%; OR, 0.68; 95% CI, 0.55-0.85). After multivariable analysis adjusting for personal and professional characteristics, burnout was the only aspect of distress independently associated with reporting 1 or more unprofessional behaviors (OR, 1.76; 95% CI, 1.45-2.13) or holding at least 1 less altruistic view regarding physicians' responsibility to society (OR, 1.65; 95% CI, 1.3-2.01).

Conclusion: Burnout was associated with self-reported unprofessional conduct and less altruistic professional values among medical students at 7 US schools.

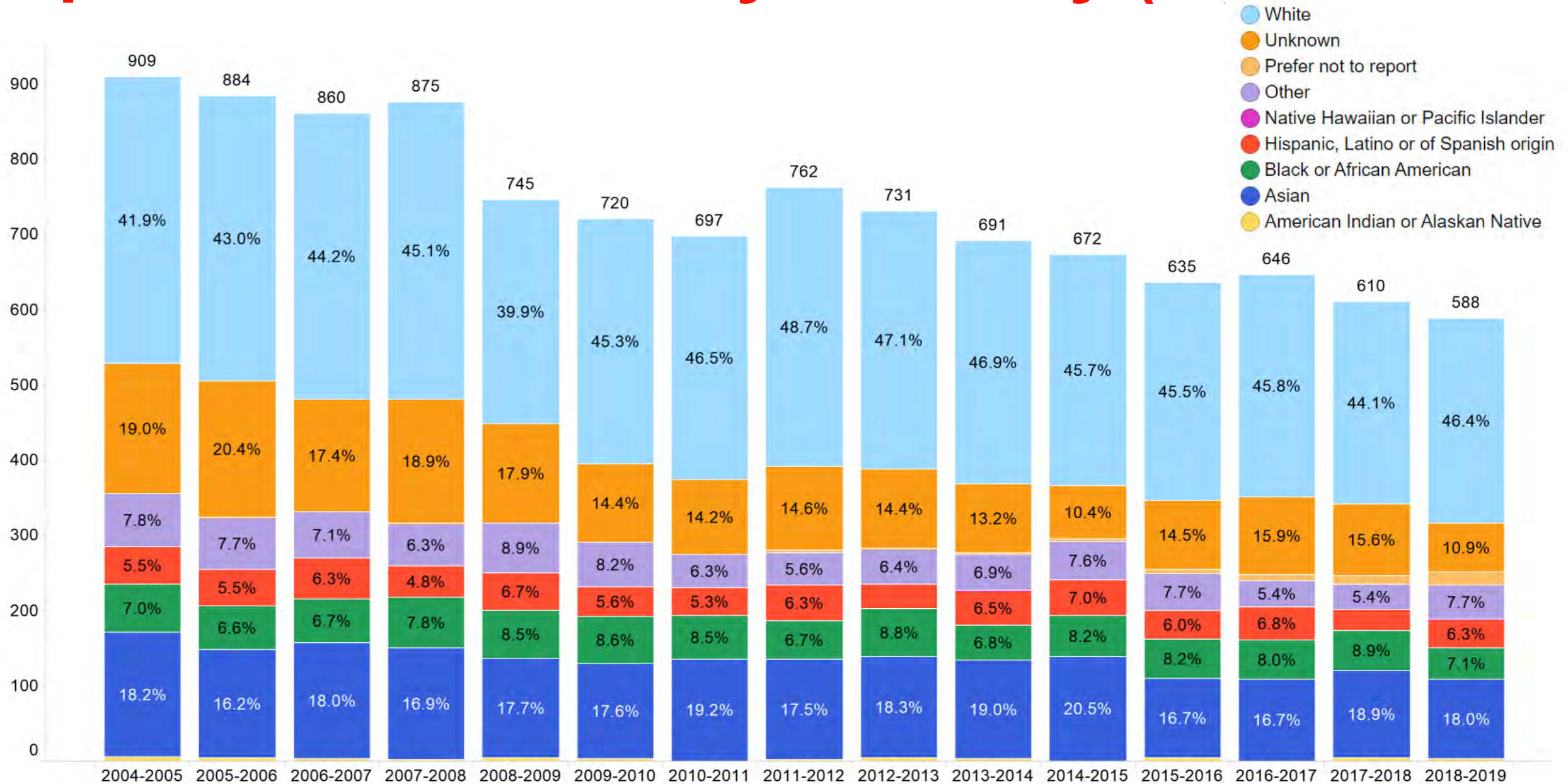
JAMA. 2010;304(11):1173-1180.

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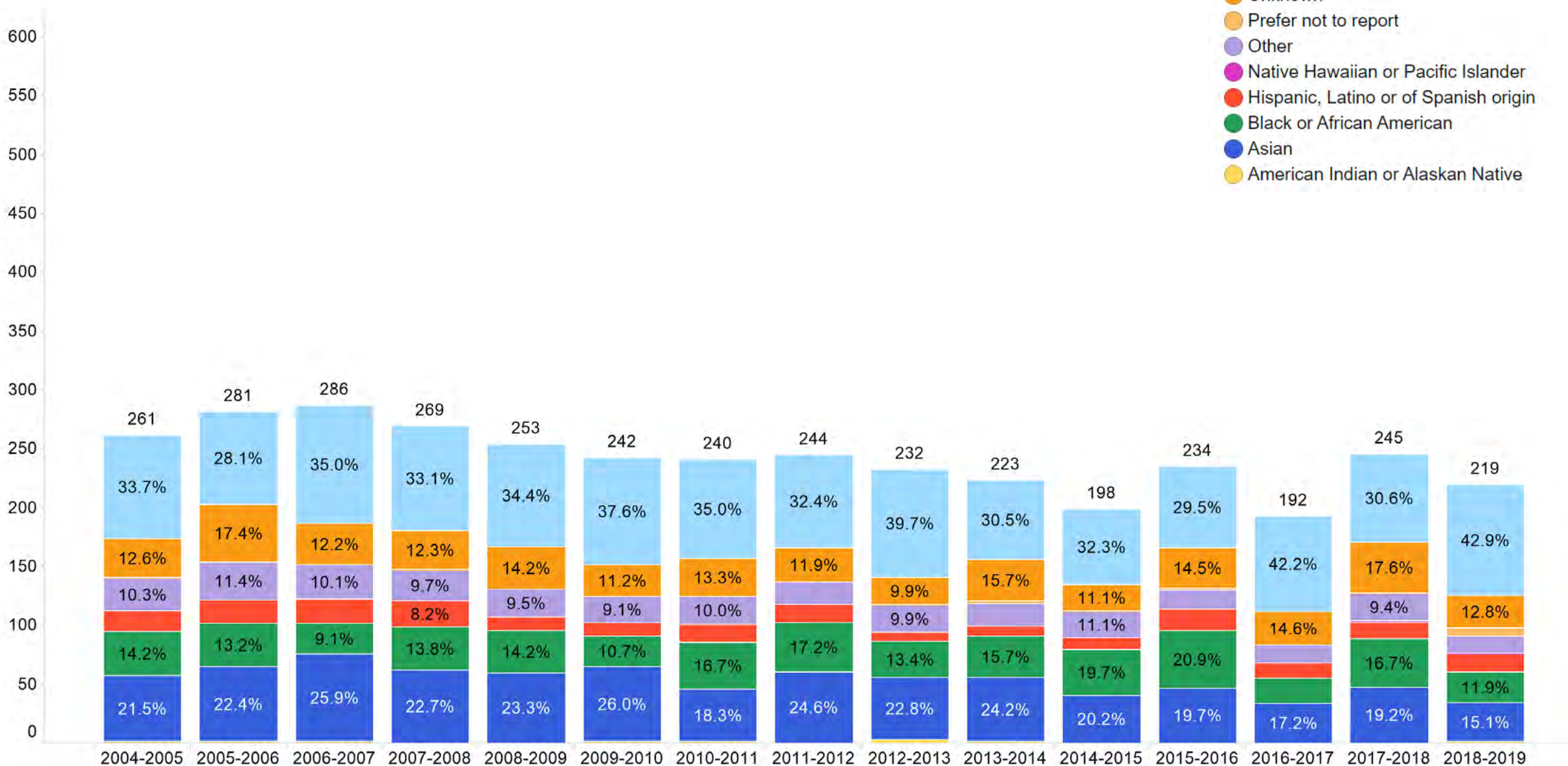
Author Affiliations: Mayo Clinic College of Medicine (Dyrbye, Thomas, and Sharash) and Mayo Clinic Department of Health Services Research (Dyrbye and Sloan); Rochester, Minn (Dyrbye); University of Alabama School of Medicine, Birmingham (Dyrbye); University of Washington School of Medicine, Seattle (Dyrbye); University of Chicago (Dyrbye); School of Medicine, Chicago, Ill (Dyrbye); University of Minnesota Medical School, Minneapolis (Dyrbye); Uniformed Services University of the Health Sciences, Bethesda, Md (Dyrbye); University of California, San Diego (Dyrbye); Corresponding Author: Lisette N. Dyrbye, MD, MPH, 200 First St SW, Rochester, MN 55905 (dyrb@mayo.edu).



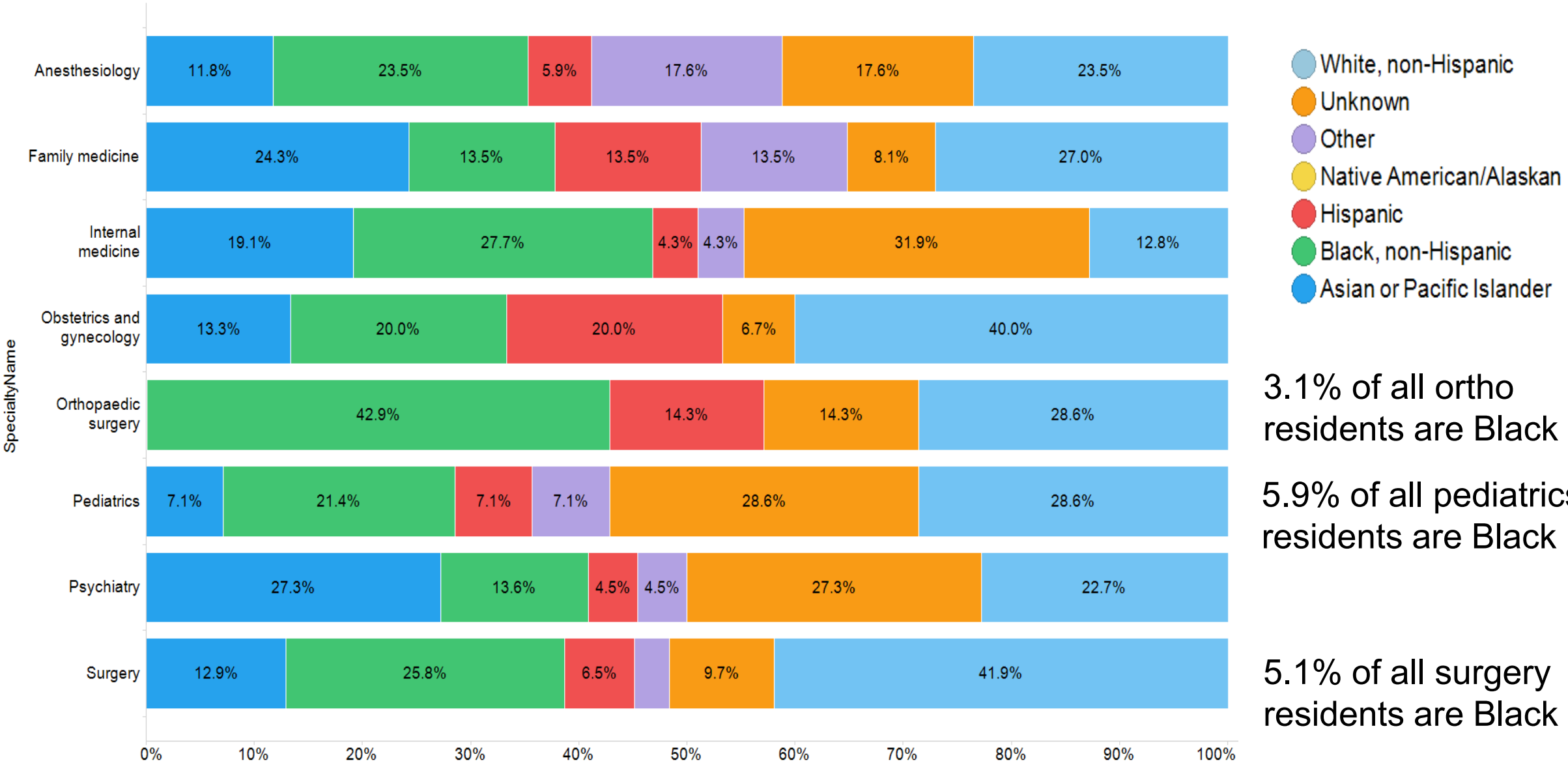
Pipeline Withdrawn by Ethnicity (%)



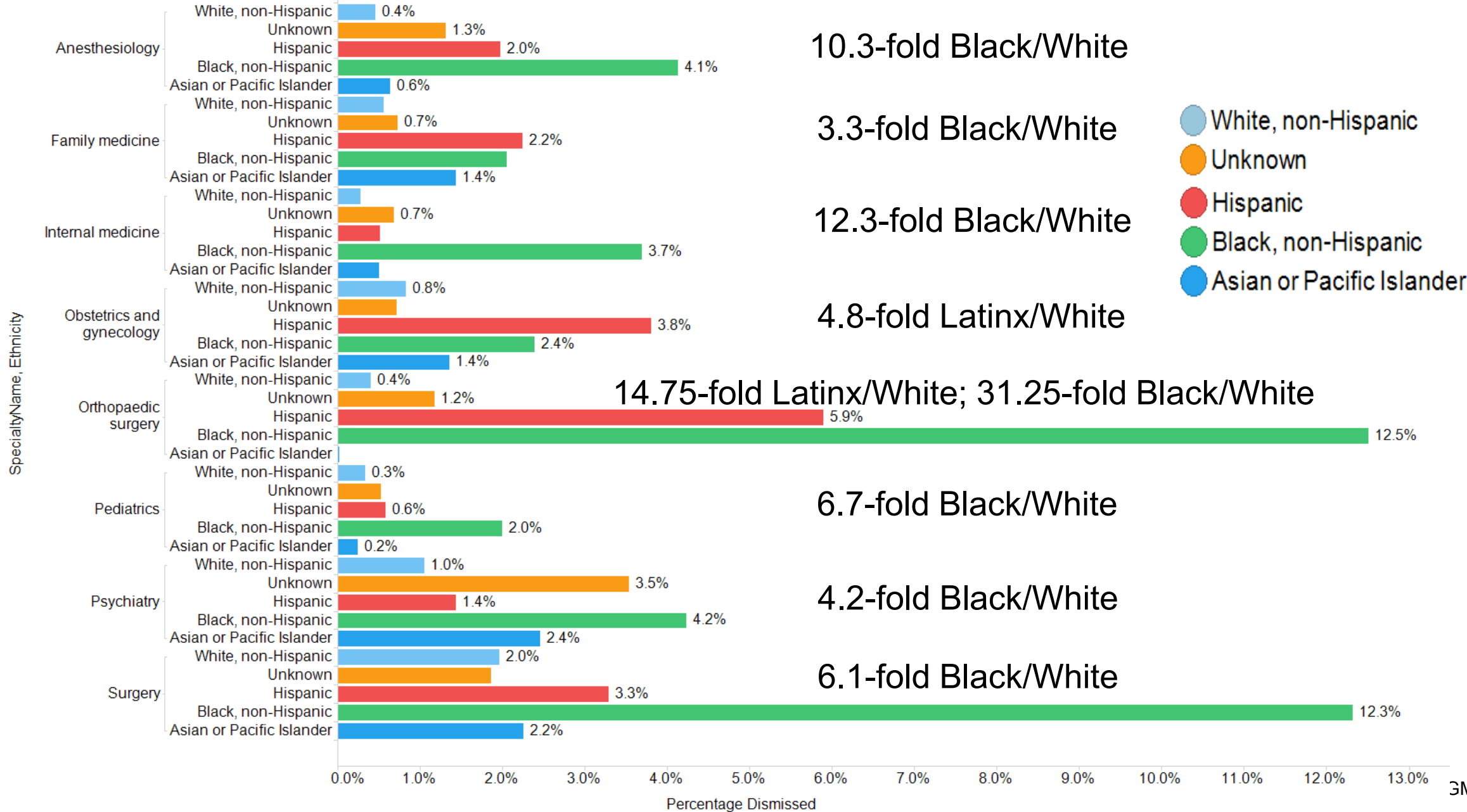
Pipeline Dismissed by Ethnicity (%)



2015-2016 Pipeline Dismissed by Specialty



2015-2016 Pipeline Grads Dismissed by Specialty



Discrimination and Well-being

Monday December 16, 2019 | Today's Paper

The Philadelphia Inquirer

NEWS SPORTS BUSINESS OPINION POLITICS ENTERTAINMENT LIFE FOOD HEALTH REAL ESTATE OBITUARIES JOBS

Female surgical residents face discrimination that can mean burnout, suicidal thoughts, study finds

by Bethany Ao, Updated: December 16, 2019



ROMICA HERNANDEZ / STAFF PHOTOGRAPHERS

When Ilene Wong was a urology resident at Stanford Hospitals and Clinics, she found herself sidelined in favor of her fellow resident — a white man — on 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 discouraging."

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Back From the Brink, Med Student's Plea Brings Promise of Change

— He had a suicide plan. Now, he hopes to start a long-needed movement

by Cheryl Clark, Contributing Writer, MedPage Today March 3, 2021



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 Larner 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.

Table 2. Frequency of Mistreatment, Duty-Hour Violations, Burnout, and Suicidal Thoughts among U.S. Surgical Residents.²⁸

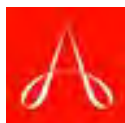
Variable	Overall (N = 7409)	Men (N = 4438)	Women (N = 2935)
	<i>number (percent)</i>		
Gender discrimination	2366 (31.9)	442 (10.0)	1912 (65.1)
A few times per year	1453 (19.6)	325 (7.3)	1123 (38.3)
A few times per month or more frequently	913 (12.3)	117 (2.6)	789 (26.9)
Racial discrimination	1227 (16.6)	671 (15.1)	547 (18.6)
A few times per year	859 (11.6)	477 (10.7)	379 (12.9)
A few times per month or more frequently	368 (5.0)	194 (4.4)	168 (5.7)
Discrimination based on pregnancy or childcare status	532 (7.2)	144 (3.2)	383 (13.0)
A few times per year	361 (4.9)	84 (1.9)	275 (9.4)
A few times per month or more frequently	171 (2.3)	60 (1.4)	108 (3.7)
Any discrimination on the basis of gender, race, or pregnancy or childcare status†	2848 (38.4)	884 (19.9)	1950 (66.4)
A few times per year	1773 (23.9)	645 (14.5)	1122 (38.2)
A few times per month or more frequently	1075 (14.5)	239 (5.4)	828 (28.2)

Only 5.1% (810) of all surgery residents are Black, 8.8% (810) are Latinx, 18.8% (1737) are Asian



Table 2. Frequency of Mistreatment, Duty-Hour Violations, Burnout, and Suicidal Thoughts among U.S. Surgical Residents.^a

Variable	Overall (N=7409)	Men (N=4438)	Women (N=2935)
	<i>number (percent)</i>		
Any mistreatment exposure [†]	3694 (49.9)	1605 (36.1)	2073 (70.6)
A few times per year	2289 (30.9)	1120 (25.2)	1162 (39.6)
A few times per month or more frequently	1405 (19.0)	485 (10.9)	911 (31.0)
Duty-hour violations of the 80-hr rule in the previous 6 mo — no. of mo			
0	4518 (61.0)	2952 (66.5)	1548 (52.7)
1–2	1869 (25.2)	954 (21.5)	906 (30.9)
≥3	1022 (13.8)	532 (12.0)	481 (16.4)
Outcome measures			
Burnout [‡]	2849 (38.5)	1591 (35.9)	1245 (42.4)
Suicidal thoughts	333 (4.5) [§]	173 (3.9)	156 (5.3)

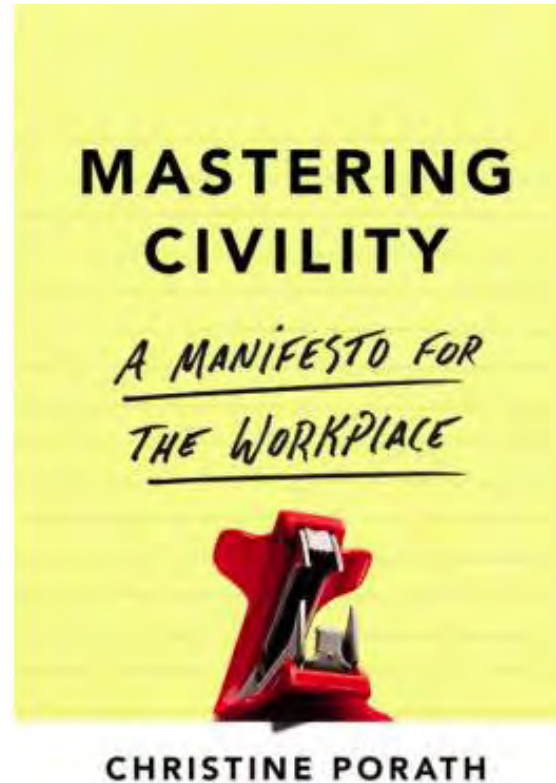


New Program Requirement VI.B.6.

VI.B.6. Programs, in partnership with their Sponsoring Institutions, must provide a professional, equitable, respectful, and civil environment that is free from discrimination, **sexual and other forms of harassment**, mistreatment, abuse, or coercion of students, residents, faculty, and staff. (Core)



The Cost of Incivility



Christine Porath @Porat... · 8/26/19
A1. Customers punish organizations harshly for incivility, even if they don't witness it. [#workhuman](#)



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

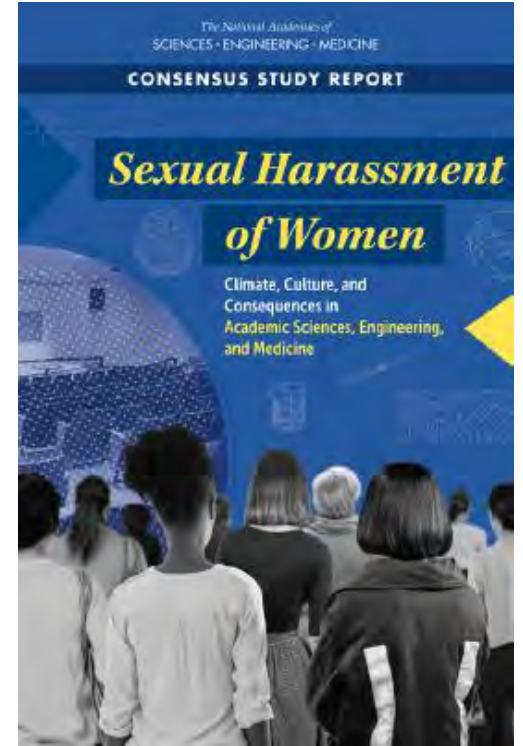


Christine Porath @Porat... · 8/26/19
A1. The human and business costs of incivility are much greater than you think. People experiencing incivility may struggle to get off the side and back into the game. [#workhuman](#)



SEXUAL HARASSMENT OF WOMEN: Recommendations

- Address the most common form of sexual harassment: gender harassment
- Move beyond legal compliance to address culture and climate
- Create diverse, inclusive, and respectful environments
- Improve transparency and accountability
- Diffuse the hierarchical and dependent relationship between trainees and faculty
- Provide support for the target
- Strive for strong and diverse leadership



Report on *Sexual Harassment of Women: Climate, Culture, and Consequences in Academic Science, Engineering, and Medicine* (2018) available from the National Academies Press; <http://www.nap.edu> or at www.nationalacademies.org/sexualharassment.



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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RECOMMENDATIONS

February 24–27, 2020
Atlanta, Georgia



ACGME Office of Diversity and Inclusion

Contact Us

diversity@acgme.org

Bill McDade, MD, PhD

wmcdade@acgme.org

312.755.7472

Gizelle Clemens, MPA

gclemens@acgme.org

312.755.7035

Bonnie Mason, MD

bmason@acgme.org

312.755.7406

Lorraine Jackson

ljackson@acgme.org

312.755.7422





Do We Overemphasize Standardized Examination Performance?

William McDade, MD, PhD

Chief Diversity, Equity and Inclusion Officer

Accreditation Council for Graduate Medical Education

First-time board pass-rate



Changes to ACGME CPR Section V

Changes relating to how programs will be assessed based on specialty board examination pass rate were made by the ACGME Board based on lack of evidence that passing the specialty board exam on the first attempt versus a subsequent attempt led to differences in practice performance

However, there is considerable evidence that correlates MCAT with USMLE Step 1 performance, and that links USMLE Step 1 performance with specialty board examination performance.

So, the practice of using standardized test scores to determine who is “best” relies on what the definition of best should be: Test-taking ability or clinical performance and/or likelihood to serve the underserved



Does USMLE Performance Predict Physician Quality?

The validity argument about using USMLE Step 1 and 2 scores for postgraduate residency selection decisions is neither structured, coherent, nor evidence based.

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

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



Assessment and Testing

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

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

Abstract

Purpose

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

Method

This is a research synthesis using the critical review approach. The study first describes the chain of reasoning that underlies a validity argument about using

test scores for a specific purpose. It continues by summarizing correlations of USMLE Step 1 and 2 scores and reliable measures of clinical skill acquisition drawn from nine studies involving 393 medical learners from 2005 to 2010. The integrity of the validity argument about using USMLE Step 1 and 2 scores for postgraduate residency selection decisions is tested.

Results

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

Conclusions

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



Do we overemphasize standardized examination performance?

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

First-time passage does not correlate with stronger clinical performance.

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

Using standardized test scores to determine who is “best” has little merit



Asch DA, et al. *JAMA*. 2009;302(12):1277–1283. doi:10.1001/jama.2009.1356

ORIGINAL CONTRIBUTION

Evaluating Obstetrical Residency Programs Using Patient Outcomes

David A. Asch, MD, MBA

Sean Nicholson, PhD

Sindhu Srinivas, MD, MSCE

Jeph Herrin, PhD

Andrew J. Epstein, PhD, MPP

MANY PHYSICIANS AND NON-physicians likely assume that some residency programs tend to produce better physicians than others—either because those residency programs train physicians better or because those residency programs can recruit more capable trainees. Although plausible, these intuitions have not been empirically tested. This information could be useful in at least 2 different ways.¹ First, identifying which training programs produce better physicians and separating out the effects that are due to the ability to attract better trainees might indicate what makes better programs better. Some of these factors might be exportable to other programs, raising the quality of medical education more broadly. Second, by identifying which training programs produce better physicians, patients could use this information when selecting a physician, much as patients in some areas

Context Patient outcomes have been used to assess the performance of hospitals and physicians; in contrast, residency programs have been compared based on non-clinical measures.

Objective To assess whether obstetrics and gynecology residency programs can be evaluated by the quality of care their alumni deliver.

Design, Setting, and Patients A retrospective analysis of all Florida and New York obstetrical hospital discharges between 1992 and 2007, representing 4906169 deliveries performed by 4124 obstetricians from 107 US residency programs.

Main Outcome Measures Nine measures of maternal complications from vaginal and cesarean births reflecting laceration, hemorrhage, and all other complications after vaginal delivery; hemorrhage, infection, and all other complications after cesarean delivery; and composites for vaginal and cesarean deliveries and for all deliveries regardless of mode.

Results Obstetricians' residency program was associated with substantial variation in maternal complication rates. Women treated by obstetricians trained in residency programs in the bottom quintile for risk-standardized major maternal complication rates had an adjusted complication rate of 13.6%, approximately one-third higher than the 10.3% adjusted rate for women treated by obstetricians from programs in the top quintile (absolute difference, 3.3%; 95% confidence interval, 2.8%-3.8%). The rankings of residency programs based on each of the 9 measures were similar. Adjustment for medical licensure examination scores did not substantially alter the program ranking.

Conclusions Obstetrics and gynecology training programs can be ranked by the maternal complication rates of their graduates' patients. These rankings are stable across individual types of complications and are not associated with residents' licensing examination scores.

JAMA. 2009;302(12):1277-1283

www.jama.com

of those programs. The advantages of using obstetrics to evaluate the connection between training and clinical outcomes, such as hemorrhage, infection, and laceration, occur with sufficient frequency and have enough clinical meaning to patients to

ACGME modified common program requirements regarding first-time board pass rates

Intended to reduce importance of USMLE Step 1 performance

Reduces the unintended consequences of the emphasis now placed on Step 1

Levels the floor for all specialties in terms of percentage of first-time pass rate

Allows medical schools to stress their distinctive, mission-driven strengths as opposed to having a national curriculum



Academic considerations in holistic admission

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

Charles G. Prober, MD, Joseph C. Kolars, MD, Lewis R. First, MD, and Donald E. Melnick, MD

Abstract

The three-step United States Medical Licensing Examination (USMLE) was developed by the National Board of Medical Examiners and the Federation of State Medical Boards to provide medical licensing authorities a uniform evaluation system on which to base licensure. The test results appear to be a good measure of content knowledge and a reasonable predictor of performance on subsequent in-training and certification exams. Nonetheless, it is disconcerting that the test preoccupies so much of students' attention with attendant substantial costs (in time and money) and mental and emotional anguish.

There is an increasingly pervasive practice of using the USMLE score, especially the Step 1 component, to screen applicants for residency. This is despite the fact that the test was not designed to be a primary determinant of the likelihood of success in residency. Further, relying on Step 1 scores to filter large numbers of applications has unintended consequences for students and undergraduate medical education curricula. There are many other factors likely to be equally or more predictable of performance during residency. The authors strongly recommend a move away from using test scores alone in the applicant screening process and toward a more holistic evaluation of the skills, attributes, and behaviors sought in future health care providers. They urge more rigorous study of the characteristics of students that predict success in residency, better assessment tools for competencies beyond those assessed by Step 1 that are relevant to success, and nationally comparable measures from those assessments that are easy to interpret and apply.

The National Board of Medical Examiners and the Federation of State Medical Boards developed the three-step United States Medical Licensing Examination with an equated numerical score with high reliability (designed to represent equivalent meaning over time) and a pass or fail determination. The passing score has some evidence that the results of licensing examinations may predict future clinical quality and outcomes.³⁻⁷



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

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.”



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

Holistic Approaches to Residency Selection

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

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

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



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



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 Katsufakis, 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.

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

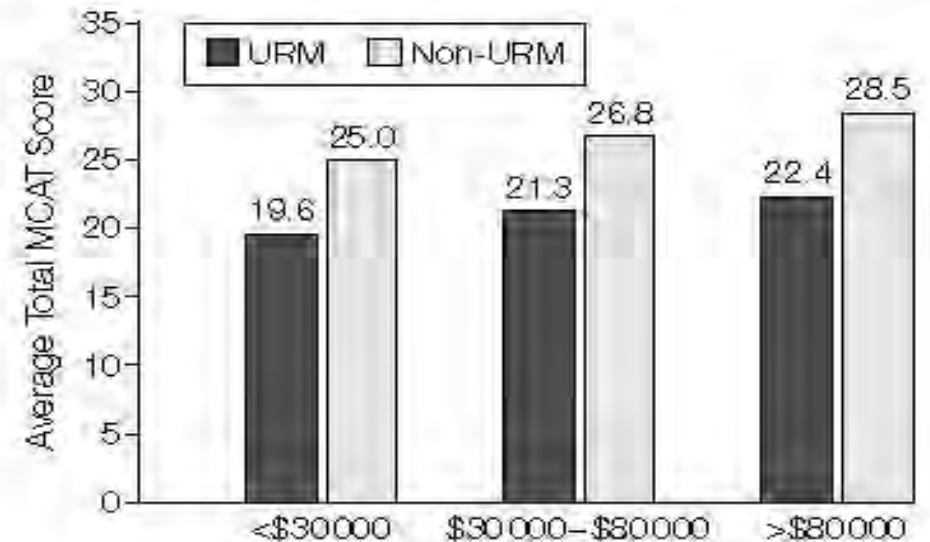
Continued work examining physician performance and linking to training parameters might inform future decisions. As augmented intelligence permits associations to be discovered, prediction of performance may be more accurate



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

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



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



Highland Diversification Initiative

GENERAL MEDICINE/CONCEPTS

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



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

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

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

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

0196 0644/\$ see front matter
Copyright © 2019 by the American College of Emergency Physicians.
<https://doi.org/10.1016/j.annemergmed.2019.01.039>

INTRODUCTION

In 2017, the US Census reported the racial/ethnic breakdown of the population as 60.7% white, 18.1% Hispanic/Latino, 13.4% black, 5.8% Asian, 1.3%

ethnic makeup of the United States may improve health disparities in vulnerable populations.⁸⁻¹⁰



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

No USMLE filter

Increased weight of gestalt score

Diversity Committee

Attending and resident buy-in

Diversity applicant week

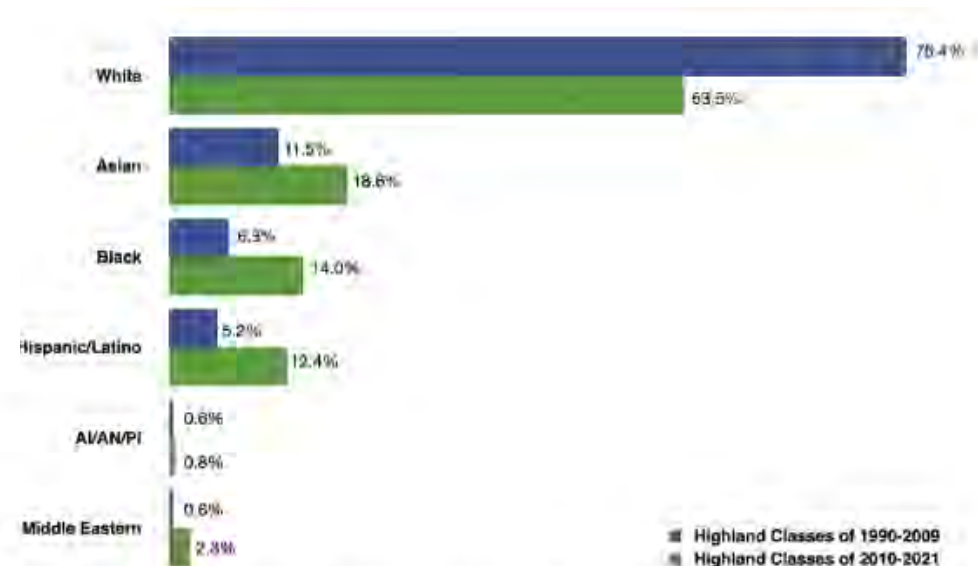


Figure 2. Race/ethnicity of highland emergency medicine residents before and after the Highland diversification initiative. AI/AN/PI, American Indian, Alaska Native, and Pacific Islander.

Program Requirement Changes to Section V: Board Certification

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

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

The program's aggregate pass rate of those taking the examination for the first time must be higher than the bottom fifth percentile of programs in that specialty averaged over 3 years (or 6 years in certain specialties)



Program Requirement Changes to Section V: Board Certification

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

Rolling seven year certification rate

V.C.3.f) Programs must report board certification status annually for the cohort of board-eligible residents that graduated in the seven years earlier.



Appendix



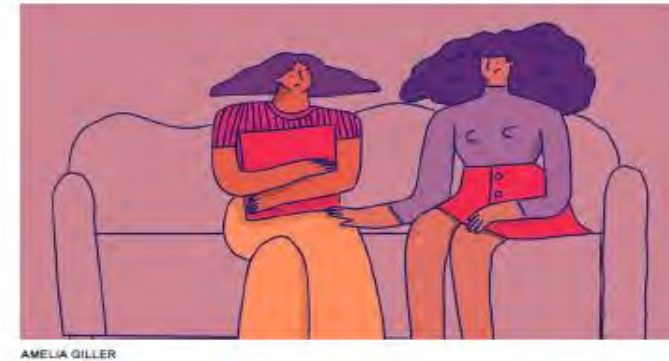
Microaggression prevention



Dr. S et al.

- Be intentional
 - Ask
 - Listen
 - Practice
 - Reaffirm

“The choice not to learn my name renders me invisible. It seeds disappointment and erodes my normally jovial spirit.”



AMELIA GILLER

Identity

Names That Are Unfamiliar to You Aren't "Hard," They're "Unpracticed"

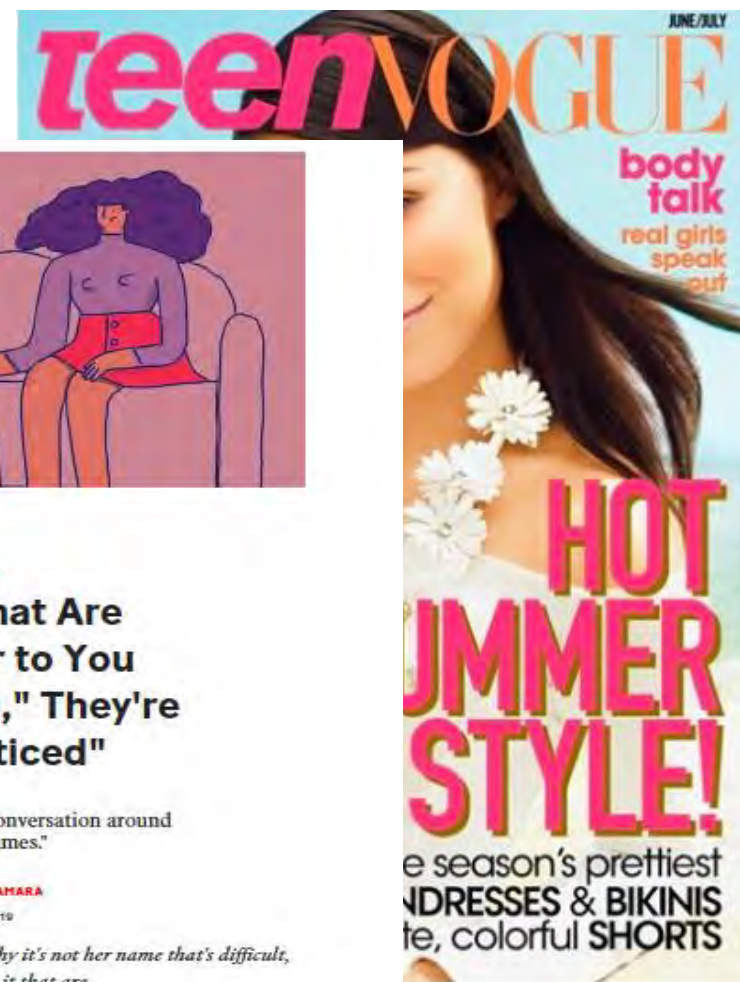
"It's time to change the conversation around 'difficult' names."

BY N'JAMEH CAMARA

JULY 12, 2019

In this op-ed, N'Jameh Camara explains why it's not her name that's difficult, it's the attitudes of those unwilling to learn it that are.

Growing up in the United States, I often hear that my **name** is "hard" to pronounce: N'Jameh (IPA: 'ndʒer me or 'njer mer). It is a Gambian name conferred by my father, whose lyrical, West African accent rounds the vowels and punctuates the consonants into inertia. And yet, the syllables that tether my heritage to The Gambia seem strangely unable to **make the voyage** to my American life. The name I carry with me looks for harbor in the mouths of colleagues — even friendly acquaintances — and sometimes gets lost. My parents did not name me with evil grins and hands wringing: "We are going to make her name hard for everyone to utter!" They named me out of



<https://www.teenvogue.com/story/names-that-are-unfamiliar-to-you-arent-hard-theyre-unpracticed>

What's in a name?

- Honoring your name is honoring you
- Some names automatically get revised/remixed and some don't
- Exhaustion leads to acceptance of a name they don't prefer or isn't even theirs
- Respecting names is an antiracist act
- Pay attention to how people introduce and refer to themselves
- Note the name they sign emails with
- Some preference depend on circumstances
- Some get an automatic formal name/title default while others don't – privilege must be acknowledged



Kimberly D. Manning @gradydoctor



Structural Racism Example



Board Certification Examination

Before 2012, the written exam was administered after the PGY-4 year in a single sitting

Since then, examinees take a staged written exam on fundamental scientific concepts after the PGY-2 year and clinical topics after the PGY-4 year

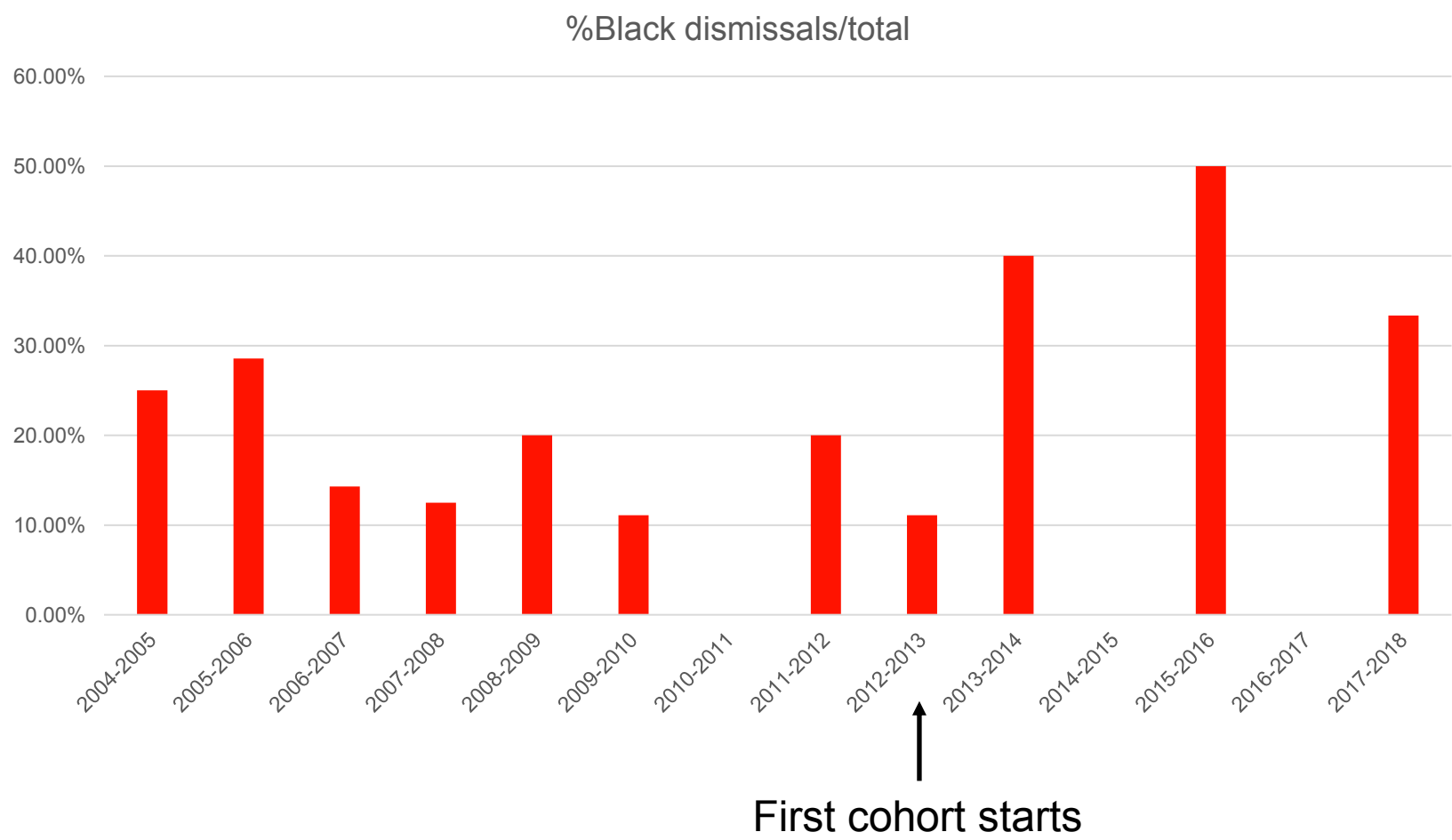
A passing score must be obtained on both in order to sit for the oral examination

ACGME is now working with this board to ask whether race could have played a role for the observed disproportionate increase in dismissals of Black residents in 2015-16

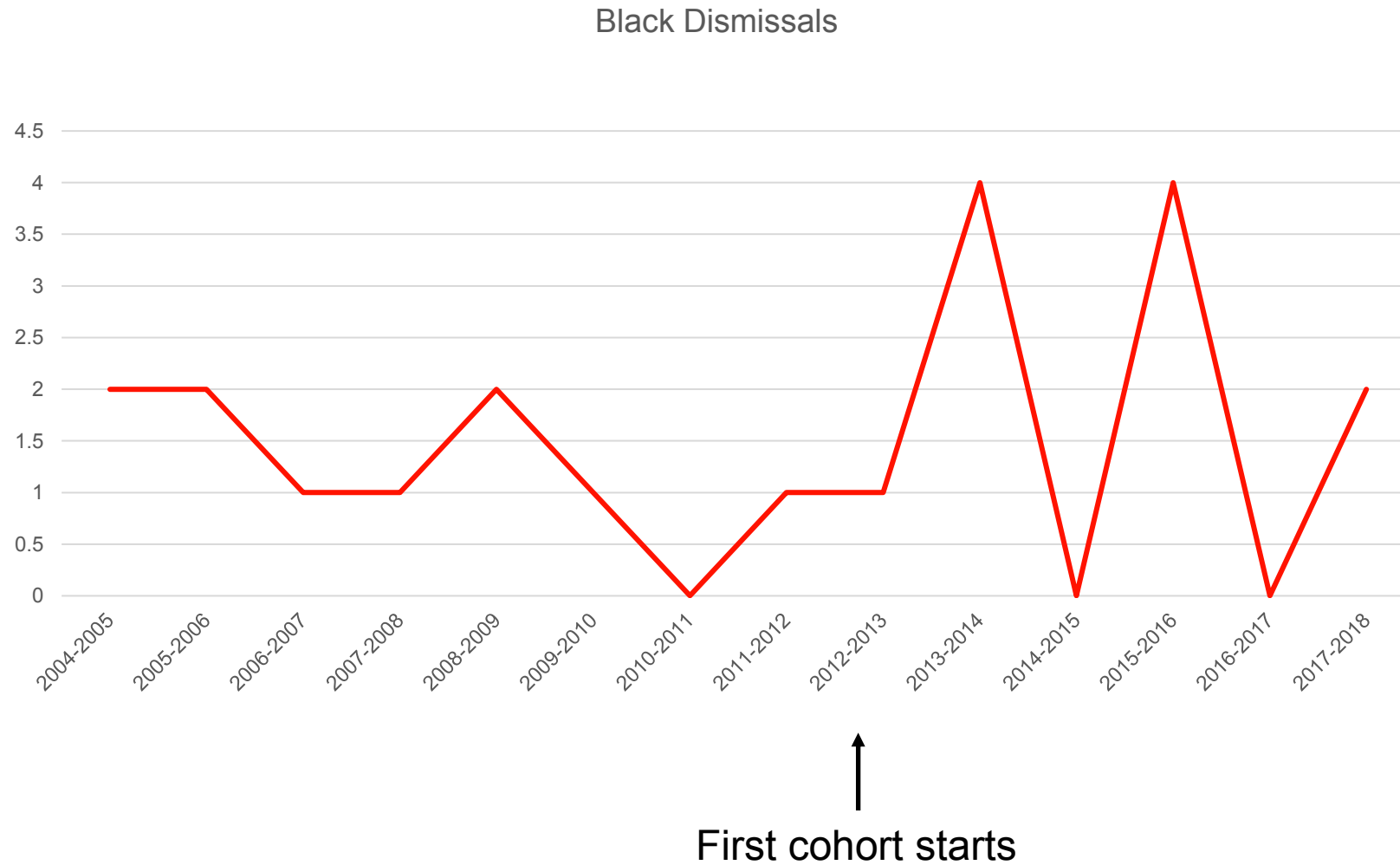
The unintended consequence of splitting the exam, administering it before training is completed, and penalizing failures with loss of advancement in the program could have contributed to outcomes post-2014



Relative dismissal Black to Black+White



Black resident dismissals



Disparate impact analysis

Griggs v. Duke Power Co. (1971) SCOTUS

Employer required a HS diploma and a passing score on two professionally developed tests

Lower court held the plaintiff failed to prove that the employer had a discriminatory motive

Title VII of the 1964 Civil Rights Act proscribes not only overt discrimination but also practices that are fair in form but discriminatory in operation.

“The absence of discriminatory intent does not redeem employment procedures or testing mechanisms that operate as built-in headwinds for minority groups and are unrelated to measuring job capacity”



Examine your practices and policies for structural racism

Does a practice or policy have a disproportionately adverse effect on members of the one group as compared to non-members of that group?

- Blacks have lower income and may be less likely to afford test prep and have experience with high stakes exams prior to residency (Wealth gap)
- Entering MCATs for Blacks are comparatively lower
- Residency is the "Great Equalizer" over four years
 - More inclusive learning communities form in residency
 - Curriculum and pedagogy focused on certification
 - ITEs provide multiple exposures to exam content and practice improves performance
 - Mitigation of stereotype threat –internalized racism

By moving a P/F exam two years earlier in training, the full 4-yr benefit has not been realized

Since failure is linked to not receiving training credit with the board after the second attempt, PDs view this failure as a measure of learner quality and cost to the program (Salary and benefits to be paid after the initial residency period ends)

Many have elected to dismiss residents after failure of the first element of split exam.



Resident as peer and teacher dispels bias and racism



Steele, Claude M. *Whistling Vivaldi: And other clues to how stereotypes affect us (issues of our time)*. WW Norton & Company, 2011.

Stereotype disruption through humanizing the other

Demystifies white intellectual superiority

Mitigates stereotype threat

Disrupts imposter syndrome

Reinforces confidence



Path to dismantling

Acknowledgement

Measure

Compare

Acceptance

Resist urge to deny

Listen to what the data tell you

Determine what must be changed

Action

Inform steps to create positive change on the basis of data and evidence

Look for disparate impact in any action taken

Assessment

Ensure steps taken achieve the goals intended

Continuously re-evaluate to improve



Action now

Every medical education entity should collect data on race/ethnicity/ and language demographics as a best practice

- Promotes transparency
- Mitigates aversive racism and shows where structural racism may be operating

Every medical education entity should perform disparate impact analysis of its test items, processes, norms, mission, values, practices and policies with the goal of promoting equity



Start where you are, use what you have, do what you can – Arthur Ashe, *Days of Grace*

