

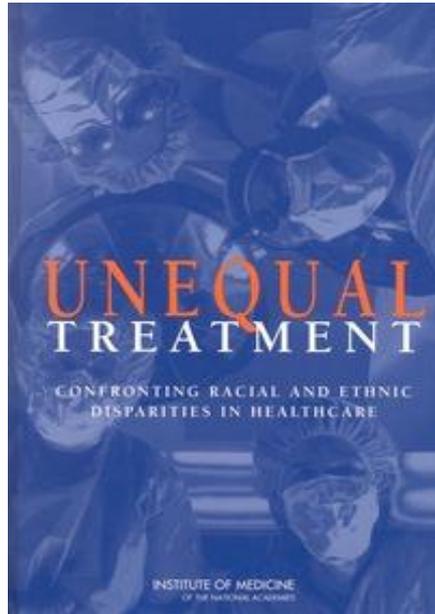


ACGME

Diversity in Graduate Medical Education: Psychiatry

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Evidence of racial and ethnic disparities in healthcare



Nat Academy Press 2002
<http://www.nap.edu/catalog/10260.htm>

1

- 584 pages detailing the extent of racial and ethnic differences in health outcomes that are not otherwise attributable to known factors such as access to health care
- **Disparities consistently found across a wide range of disease areas and clinical services**
- Disparities are found even when clinical factors, such as stage of disease presentation, co-morbidities, age, and severity of disease were adjusted
- Disparities are **found across a range of clinical settings**, including public and private hospitals, teaching and non-teaching hospitals, etc.
- Disparities in care are **associated with higher mortality** among minorities (e.g., Bach et al., 1999; Peterson et al., 1997; Bennett et al., 1995)



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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



Why does diversity matter?

- We live in racially segregated communities
- Disease burden and health and healthcare inequities are strongly concentrated in residential areas of historically marginalized individuals
- People tend to seek medical care within their community
- Historically marginalized practitioners tend to practice in underserved communities and serve their historically marginalized residents
- There are high odds that a Black, Latinx or Asian physician will disproportionately see a patient of their same race or ethnicity
- The percentage of historically marginalized physicians trained in the US has not changed in 15 years



Workforce diversity matters to the elimination of health disparities

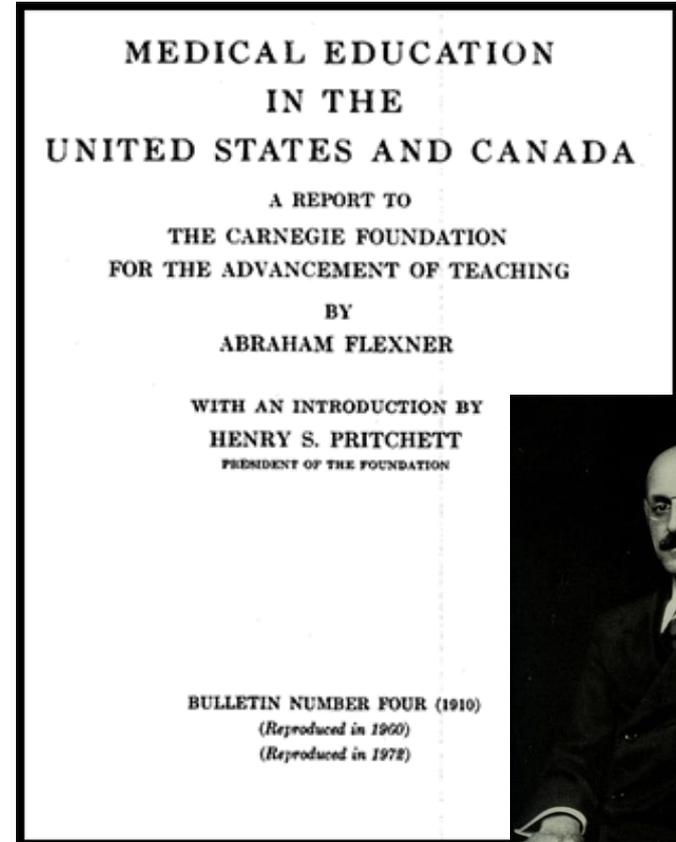
- Eliminating health care disparities is consistent with the mission of the ACGME to improve health care and population health by assessing and enhancing the quality of resident physicians' education through advancements in accreditation and education.
- ACGME envisions a health care system where the 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



Workforce diversity matters to the elimination of health disparities

Stems from the Flexner report in 1910 which stated that the reason to leave the two Black medical schools in place, after suggesting closure of the other five at the time, was to ensure that there would be physicians to serve the black population so as to prevent spread of disease to the overall population.

Racial-concordance in physician care persists to this day with a Black physician 24x more likely to see a Black patient compared to their white counterparts, 19x for LHS+ physicians to see a Latinx patient, and 27x for an Asian physician to see an Asian patient (Marrast et al. JAMA 2014); For primary care, the odds ratio is 40x for Blacks (Bach et al. NEJM 2004)



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

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

Benefits of racially concordant care

- Addresses the unfortunate reality of how we trust in American society
- Intention to adhere to medical advice is heightened
- Patient satisfaction is better among historically marginalized individuals who receive racially concordant care
- Improved clinical outcomes in some categories has been shown
- Improves access to care for individuals who would rather forego care than to receive it in an environment that dehumanizes them, discriminates against them, and fails to communicate effectively with them



Increasing racial/ethnic diversity in the physician workforce supports concordance

- Isn't forcing people to work where they don't want to work
- Isn't limiting patient access to the best physicians
- Isn't forcing patients to only see doctors of their own race/ethnicity
- Proximity is an important factor, but not the only factor
- Physicians' willingness to work in disadvantaged communities and to accept Medicare/Medicaid
- Patient choice plays a role



Care provided by a physician who shares the racial identity of the patient

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

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

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

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



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

Race-Conscious Professionalism and African American Representation in Academic Medicine

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

Abstract

African Americans remain substantially less likely than other physicians to hold academic appointments. The roots of these disparities stem from different extrinsic and intrinsic forces that guide career development. Efforts to ameliorate African American underrepresentation in academic medicine have traditionally focused on modifying structural and extrinsic barriers through undergraduate and graduate outreach, diversity and inclusion initiatives at medical schools, and faculty development programs. Although essential, these initiatives fail to confront the unique intrinsic forces that shape career development.

America's ignoble history of violence, racism, and exclusion exposes African American physicians to distinct personal pressures and motivations that shape professional development and career goals. This article explores these intrinsic pressures with a focus on their historical roots; reviews evidence of their effect on physician development; and considers the implications of these trends for improving African American representation in academic medicine. The paradigm of "race-conscious professionalism" is used to understand the dual obligation encountered by many minority physicians not only to pursue excellence

in their field but also to leverage their professional stature to improve the well-being of their communities. Intrinsic motivations introduced by race-conscious professionalism complicate efforts to increase the representation of minorities in academic medicine. For many African American physicians, a desire to have their work focused on the community will be at odds with traditional paths to professional advancement. Specific policy options are discussed that would leverage race-conscious professionalism as a draw to a career in academic medicine, rather than a force that diverts commitment elsewhere.

Notwithstanding important progress, substantial challenges remain in ameliorating racial inequalities in health and health care in the United States. One enduring challenge is the underrepresentation of minority populations, especially African Americans, among the faculty at academic medical centers (AMCs). At each stage of career development, African Americans remain less likely than other physicians to hold academic appointments. Despite constituting 13% of the American population as of 2014, African Americans accounted for only 7.4% of assistant professors. 7,000 African American physicians

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 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

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

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



Does diversity matter for health?

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

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

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

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

Flu shots were significantly more likely in concordant pairings

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



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

Hazard of depending on racially concordant care to eliminate health disparities

- Racial and ethnic health inequities occur because of other factors, more social than medical.
 - The social determinants of health contribute to excess morbidity and mortality that does not have a solely medical solution:
 - The political determinants of health recognize how inequitable policies, politics, regulations and laws have impaired access to care and contribute to health inequities¹
- Lack of access to healthy foods and food practices
 - Inundation with ultra-processed foods
 - Community and interpersonal violence
 - Lack of access to greenspace for play and exercise
 - Toxic environmental conditions
 - Housing insecurity, Inadequate transportation and education
 - Poverty/wealth gap
 - Allostatic load and exposure to Adverse childhood events
 - Inadequate transportation
 - Neighborhood disinvestment
 - Over-policing
 - Residential segregation
 - Structural racism²

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

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

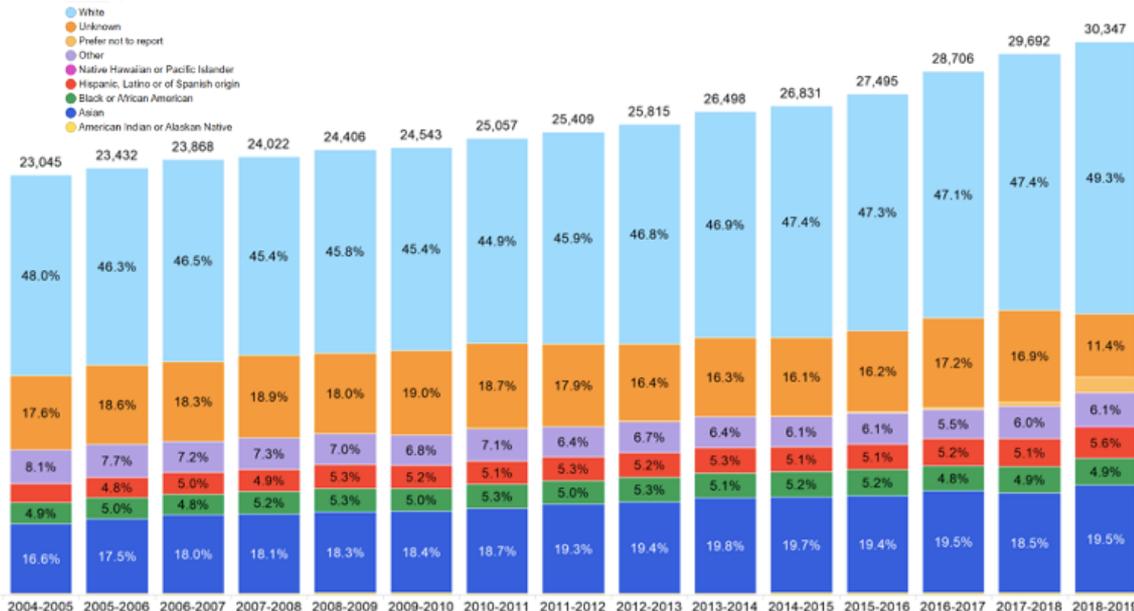
Hazard of depending on racially concordant care to eliminate health disparities

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

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

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

Pipeline Graduates 2004-2005 to 2018-2019 Academic Year



ACGME Data Resource Book Academic Year 2004-2019

ACGME Actions

Common Program Requirements

Section I.C. enjoins programs in partnership with their SIs to engage in practices to increase workforce diversity and provide for inclusivity

Section VI.B.6 enjoins programs to provide a civil, equitable, professional learning environment

Section II.A.4.a).(10) protects whistleblowers from retaliation and intimidation

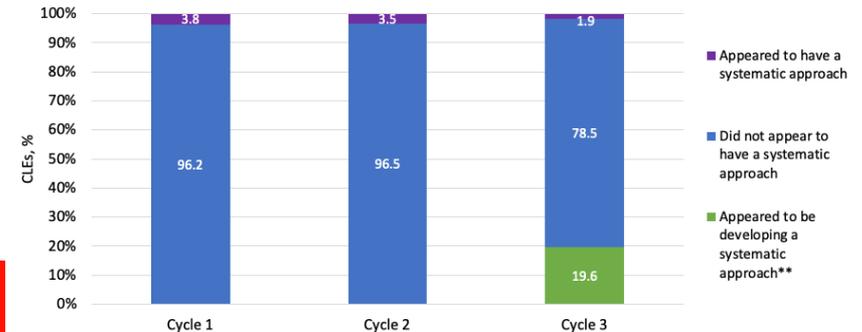
Section V. begins to shift emphasis to ultimate success on specialty board certification examination from the sole use of first-time performance to assess program quality

Clinical Learning Environment Review

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

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

Percentage of CLEs with a Systematic Approach to Eliminating Health Care Disparities



Common Program Requirements Section V: First-time Pass Rate

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

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

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

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

Historically marginalized students have lower median scores on standardized examinations for MCAT and USMLE Steps 1 and 2 than whites



Testing outcome differences are to be anticipated

Wealth gap

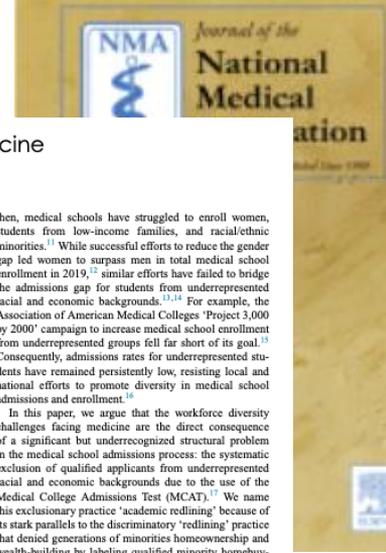
Differential preparation

Exclusion from learning communities

Imposter syndrome

Stereotype threat

Nakae, S. and Subica, A.M., 2021. Academic redlining in medicine. *Journal of the National Medical Association*, 113(5), pp.587-594.



Academic redlining in medicine

Sunny Nakae, Andrew M. Subica

Conflict of interest: The authors have no competing or conflicting interests to disclose.

Abstract: Despite concerted efforts over the past decade to increase diversity in U.S. medical schools, persistent applicant pool enrollment gaps remain for students from underrepresented racial and economic backgrounds. To understand these gaps, we propose a new theory of 'academic redlining' as a widespread practice in medical schools that systematically excludes students from underrepresented backgrounds from entry into medicine through the nearly universal use of Medical College Admissions Test (MCAT) cutoff scores. In this paper, we provide evidence that academic redlining via the MCAT discriminates students from underrepresented backgrounds prior to and during the admissions process due to structural racism, and describe the three core mechanisms that cause medical schools to engage in academic redlining: (1) the social of institutional racism, (2) market competition and pressure, and (3) market bonds. Given the persistent lack of diversity in medicine—which contributes to escalating health care disparities—medical schools should reevaluate their commitments to diversity, equity, and inclusion, structured alternatives within medical school admissions and education practices are offered to curtail the practice of academic redlining in medical school admissions and medicine.

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INTRODUCTION

Despite current efforts to improve diversity, medicine continues to experience a profound lack of diversity due to the striking absence of physicians from underrepresented racial and economic backgrounds.^{1,2} In 2018, despite African Americans and Latinas comprising 13% and 18% of the U.S. population, respectively, only 5% of physicians were African American and 6% were Latina.^{3,4} These low numbers have created severe disparities in physician access, quality medical care, and health status among patients from these underrepresented groups⁵⁻⁷ based on significant evidence that the presence of underrepresented health providers may decrease health disparities by improving patient outcomes, satisfaction, and communication.^{6,7,8}

A major driver of this diversity crisis is the low, unequal medical school admissions rates of students from underrepresented backgrounds.⁹ The *Fleener Report* of 1910 led to the purposeful closure of schools that trained racial, ethnic, and gender minority groups.^{10,11} Since

then, medical schools have struggled to enroll women, students from low-income families, and racial/ethnic minorities.¹² While successful efforts to reduce the gender gap led women to surpass men in total medical school enrollment in 2019,¹³ similar efforts have failed to bridge the admissions gap for students from underrepresented racial and economic backgrounds.^{13,14} For example, the Association of American Medical Colleges' 'Project 3,000 by 2000' campaign to increase medical school enrollment from underrepresented groups fell far short of its goal.¹⁵ Consequently, admissions rates for underrepresented students have remained persistently low, resisting local and national efforts to promote diversity in medical school admissions and enrollment.¹⁶

In this paper, we argue that the workforce diversity challenges facing medicine are the direct consequence of a significant but unrecognized structural problem in the medical school admissions process: the systematic exclusion of qualified applicants from underrepresented racial and economic backgrounds due to the use of the Medical College Admissions Test (MCAT).¹⁷ We name this exclusionary practice 'academic redlining' because of its stark parallels to the discriminatory 'redlining' practice that denied generations of minorities homeownership and wealth-building by labeling qualified minority homebuyers and neighborhoods unworthy of loans based on race.¹⁸

Historical Redlining

Redlining refers to corporate and government housing loan discrimination by federal agencies, lenders, and developers based on racially-biased assessments of minority neighborhoods as inherently undesirable and less valuable—an "unconstitutional and discriminatory racial policy."¹⁹ This discriminatory labeling began in the 1930's with the denial of home loans to qualified minority homebuyers, with banks using racism to manipulate the value of investments and assets at the expense of minority neighborhoods. Over time, redlining wrought numerous ill effects on minorities by (1) denying millions of residents from low-income, mostly African American neighborhoods homeownership, and (2) diminishing property values for existing African American homeowners. Following redlining, residential segregation increased and the chasm of household wealth rose dramatically;

What are we testing and why does it matter?

Parameter	How this is pertinent	Why it matters to patients	Why it may not test what you think
Persistence/endurance	Requires regular attention to details because it is a cumulative test	Patients need thorough, consistent attention to ensure details are not missed	Some who procrastinate in studying, but are skilled in interpreting question responses will do better
Dedication to task	Tests executive skills and time management for a specific task	Managing multiple patients and keeping details straight is key to delivery of safe care	Some who are not well organized may escape detection if they have compensatory retention skills
Self-sacrifice	Requires that personal interest must be set aside to accomplish a grander task	Patients require a degree of altruistic, other-directed behavior from their physicians	Is it altruism, or could motivation for personal gain be what is measured here?
Medical knowledge retention	How much information can be assembled by learners and be shown to be available	Despite access to abundant information in silico, there is a core basis of knowledge that makes caring for patients possible and efficient	Medical knowledge that is available may depend more on experiences and context than on what was read and understood and testable with MCQs
Medical knowledge application	Judgement and skills adequacy demonstrates facility with information and on the doing piece	That correct application of information improves outcomes is why patients engage	Are there better ways than MCQs to assess knowledge application, such as simulation SJT, or observation



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. McGaghi, 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.



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

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

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

with an equated numerical score with high reliability (designed to represent equivalent meaning over time) and a pass or fail determination. The passing score

some evidence that the results of licensing examinations may predict future clinical quality and outcomes.³⁻⁷





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.



Holistic admission is an equity practice that transcends recruitment

- Reverse engineering approach to find those characteristics that are common to individuals who became exemplar physicians that were recognizable prior to beginning their medical careers
- Evidence that holistic admission is not inferior to current selection methods with respect to harm to patient care would be comforting
- Risk of conflating present circumstances with covid disruption with forays into holistic admission
- Providing what is necessary for each learner to be successful in their program defines equity and forms the basis of the ACGME-required individualized learning plan
- Some learners may need skills development in standardized testing, others in cultural humility, others in manual dexterity, others in executive functioning – as educators we have the responsibility to determine what is necessary and to supply it



Do we overemphasize standardized examination performance?

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

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

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

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

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

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

ORIGINAL CONTRIBUTION

Evaluating Obstetrical Residency Programs Using Patient Outcomes

David A. Asch, MD, MBA

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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 do when

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 496 169 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

rhage, infection, and laceration, occur with sufficient frequency and have enough clinical meaning to substitute

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



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What value do you place on AOA?

After controlling for US Medical Licensing Examination Step 1 scores, research productivity, community service, leadership activity, and Gold Humanism membership, the study found that **black** (adjusted odds ratio [aOR], 0.16; 95%CI, 0.07-0.37) and **Asian** (aOR, 0.52; 95%CI, 0.42-0.65) medical students remained less likely to be selected for AQA membership than white medical students.

Boatright, D., Ross, D., O'Connor, P., Moore, E. and Nunez-Smith, M., 2017. Racial disparities in medical student membership in the Alpha Omega Alpha Honor Society. *JAMA internal medicine*, 177(5), pp.659-665.



Research

JAMA Internal Medicine | Original Investigation Racial Disparities in Medical Student Membership in the Alpha Omega Alpha Honor Society

Dawn Boatright, MD, MBA; David Ross, MD, PhD; Patrick O'Connor, MD, MPH; Edward Moore, PhD; Marcella Nunez-Smith, MD, MHS

IMPORTANCE Previous studies have found racial and ethnic inequities in the receipt of academic awards, such as promotions and National Institutes of Health research funding, among academic medical center faculty. Few data exist about similar racial/ethnic disparities at the level of undergraduate medical education.

OBJECTIVE To examine the association between medical student race/ethnicity and induction into the Alpha Omega Alpha (AOA) honor society.

DESIGN, SETTING, AND PARTICIPANTS This study analyzed data from the Electronic Residency Application Service, the official service used by US medical students to apply to residency programs. A total of 4655 US medical students from 123 allopathic US medical schools who applied to 12 distinct residency programs associated with one academic health center in the 2014 to 2015 academic year were studied.

MAIN RESULTS AND MEASURES Membership in the AOA society among black, white, Hispanic, and Asian medical students.

RESULTS A total of 4655 unique applications were analyzed in the study (median age, 26 years; 2123 women [45.8%]). Overall, self-reported race/ethnicity in our sample was 2605 (56.0%) white (691 [71.5%] of AOA applicants were white), 276 (5.9%) black (7 [0.7%] AOA), 186 (4.0%) Hispanic (27 [2.8%] AOA), and 1170 (25.1%) Asian (168 [17.4%] AOA). After controlling for US Medical Licensing Examination Step 1 scores, research productivity, community service, leadership activity, and Gold Humanism membership, the study found that black (adjusted odds ratio [aOR], 0.16; 95% CI, 0.07-0.37) and Asian (aOR, 0.52; 95% CI, 0.42-0.65) medical students remained less likely to be AOA members than white medical students. No statistically significant difference was found in AOA membership between white and Hispanic medical students (aOR, 0.79; 99% CI, 0.45-1.37) in the adjusted model.

CONCLUSIONS AND RELEVANCE Black and Asian medical students were less likely than their white counterparts to be members of AOA, which may reflect bias in selection. In turn, AOA membership selection may affect future opportunities for minority medical students.

[Invited Commentary page 657](#)
[Related articles pages 651 and 722](#)

Author Affiliations: Department of Emergency Medicine, Yale School of Medicine, New Haven, Connecticut (Boatright); Fellow, Robert Wood Johnson Clinical Scholars Program, Veterans Affairs Scholar (Boatright); Department of Psychiatry, Yale School of Medicine, New Haven, Connecticut (Ross); Section of General Internal Medicine, Yale School of Medicine, New Haven, Connecticut (O'Connor); Department of Engineering, Central Connecticut State University, New Britain (Moore); Equity Research and Innovation Center, Section of General Internal Medicine, Yale School of Medicine, New Haven, Connecticut (Nunez-Smith).

Corresponding Author: Dawn Boatright, MD, MBA, Department of Emergency Medicine, Yale School of Medicine, PO Box 208088, New Haven, CT 06520-8088 (dawn.boatright@yale.edu).

JAMA Intern Med. 2017;177(5):659-665. doi:10.1001/jamainternmed.2016.9623
Published online March 6, 2017.

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)



Adopted by ACGME Board of Directors June 2018

Changes went into effect 1 July 2019



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



What programs can do to increase diversity- Increase the size of the pie

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



Opportunity 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
- Half of the programs ACGME accredits are not directly associated with a medical school – If they actively engage with STEMM programs, we can greatly enhance community partnerships. With this requirement, academic medical centers will be looking for community partners.
- AMCs have resources and can provide mentors and opportunities
- AMCs have also constructed barriers and can remove them



What is Systematic Recruitment?

- Multi-level
 - Impacts each element of the workforce mentioned previously
- Multifaceted
 - Will require showing different approaches to address each category in its workforce plan
 - Should address pathway of candidates into medicine at various levels specifically
 - Opportunity to address interprofessional collaboration
- Should demonstrate implementation of best practices from the field



Putting the Annual Program Update to use

- ACGME Equity Matters Collection
- Extractions of practices obtained from the ACGME APU and solicited strategies provided in the applications of the Barbara Ross Lee, DO, Diversity, Equity and Inclusion Award to be made available to the entire GME community



Sample of what psychiatry programs reported

- Program's



Sample of what psychiatry programs reported

- Program



Sample of what psychiatry programs reported

- Program



Sample of what psychiatry programs reported

- Program's



Sample of what psychiatry programs reported

- Department



Sample of what psychiatry programs reported

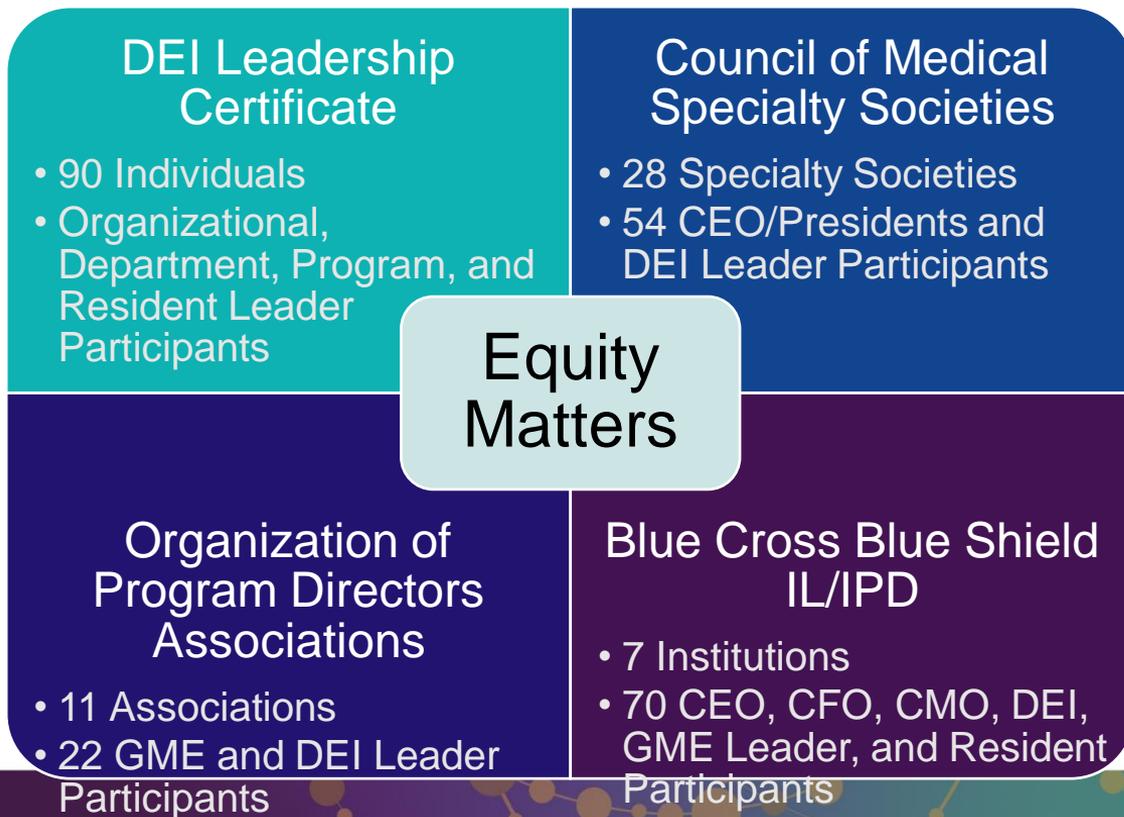
- Department



Equity Matters Resource Collection

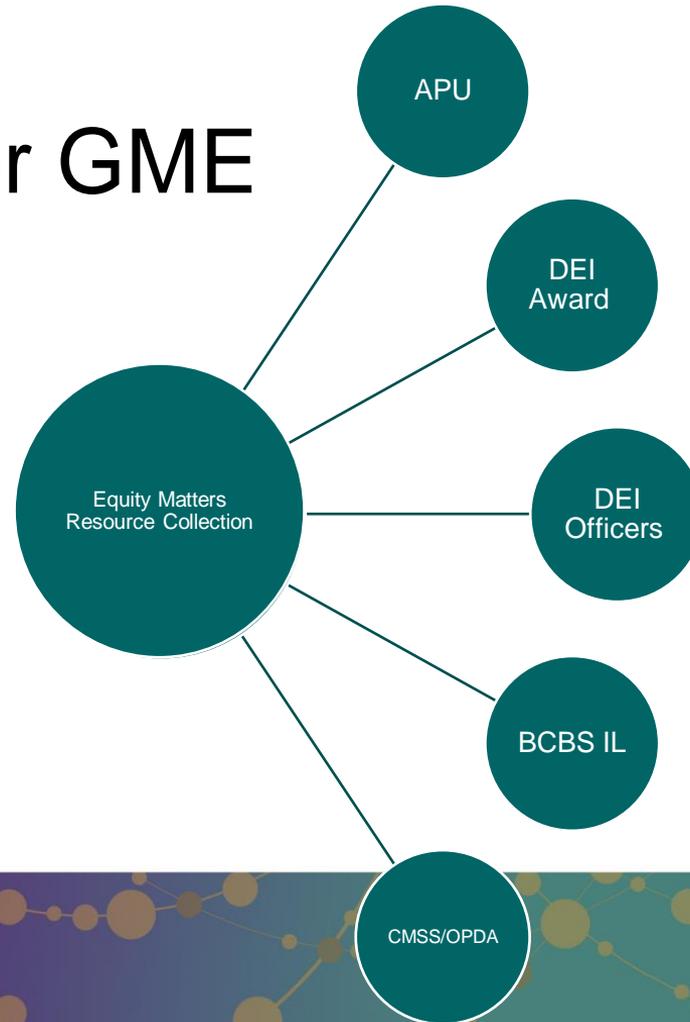
Converting data into information

4 Learning Communities – 2021-2022



Equity Matters Goal - Resource Provision for GME

- Engage
- Analyze, Customize, Innovate
- Guide and Assist



Equity Matters Collection

- Title of strategy
- What: A description of the strategy
- Why: The rationale as to why a program would engage in this effort
- Variations: Various ways in which the general concept has been undertaken
- How: Steps involved in how a program might go about putting this innovation in play – example from another institution
- Who: Individuals at programs who have agreed to be helpful to colleagues wishing to understand the intervention at a more granular level
- References: Any literature that we can identify that describes the method, outcomes or value
- Comments: Experiences from users who will describe their own characteristics and the satisfaction they had in implementing the innovation



LOGOUT

Holistic Application Review



The Toolkit

My Interventions

Webinars

Readiness Assessment

Resources

About

Participating Programs

Contact

FAQs

BACK TO INTERVENTIONS

Strategies to evaluate residency applicants to emphasize mission-driven traits and increase diversity

Add to My Interventions

NO YES

Cost

Effort

Time

Maslow

3

Respect & Inclusion

Domain

Mistreatment

Organizational Culture & Values

WHAT?

- Understand how recruitment strategies impact your ability to match diverse applicants.
- Develop recruitment strategies to holistically evaluate applicants.

WHY?

The [ACGME Common Program Requirements](#) mandates that programs must engage in practices that focus on ongoing, systematic recruitment and retention of a diverse and inclusive workforce. [1] Based on a 2018 review of ERAS applications, a recent study of 10 general surgery residency programs with a stated interest in diversity found that identification as non-White race/ethnicity was a significant independent predictor for decreased likelihood of interview selection (OR = 0.73, 95% CI 0.58-0.89). [2]





Let's look at the numbers



Total number of active residents 2020-21

Race/Ethnicity	Core Programs*	Subspecialty Fellowships**
White non-Hispanic	61,729 (50.1%)	12,296 (47.4%)
Asian/ Pacific Islander	30,338 (24.6%)	8,117 (31.3%)
Hispanic	6,563 (5.3%)	1,428 (5.5%)
Black Non-Hispanic	7,017 (5.7%)	1,288 (5.0%)
Native American/Alaska Native	138 (0.11%)	14 (0.05%)
Other	3,188 (6.2%)	862 (3.3%)
Unknown	5,405 (2.6%)	440 (1.7%)
Total*	123,279	25,921

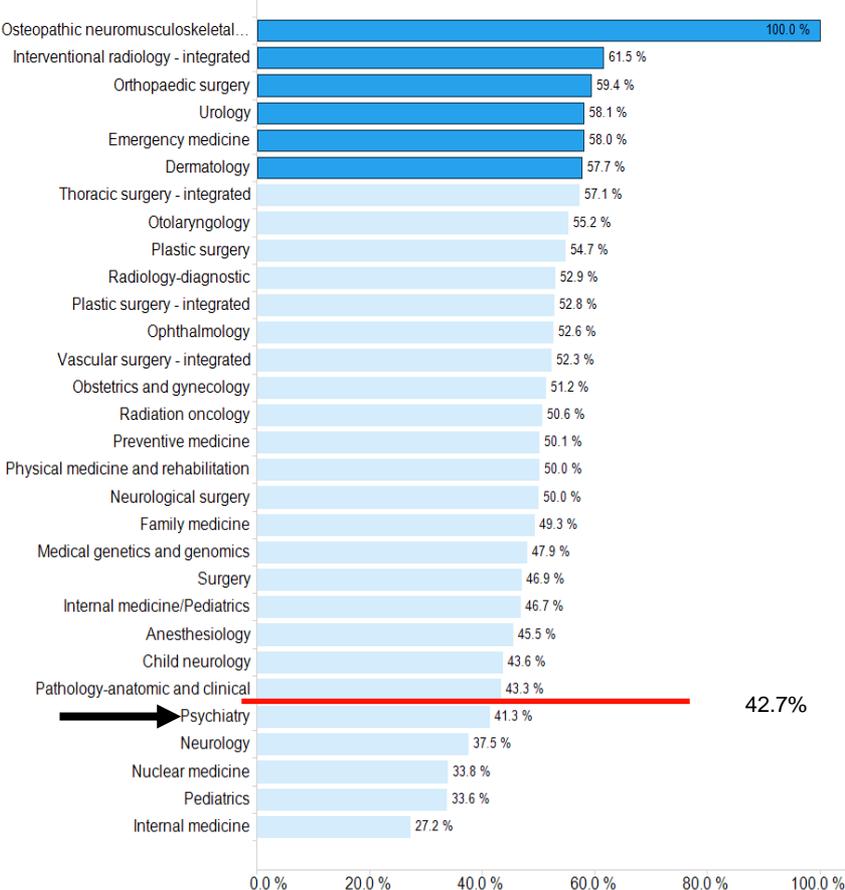
*Omits multiracial, prefers not to disclose (represents 5.4%)

**Omits multiracial, prefers not to disclose (represents 5.8%)

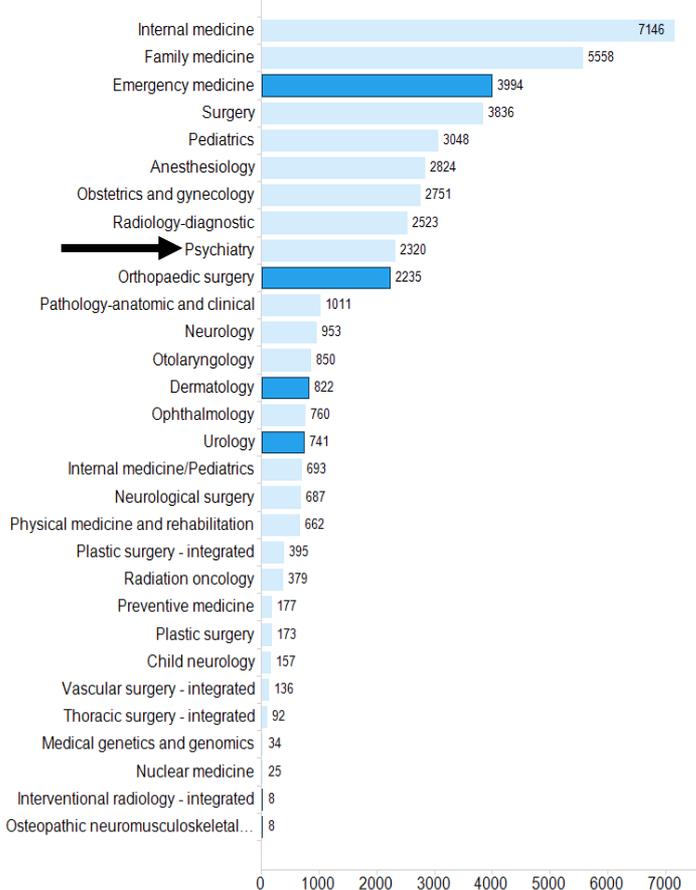
ACGME Data Resource Book Academic Year 2020-2021

White, Non-Hispanic by Specialty

2016-2017 Academic Year

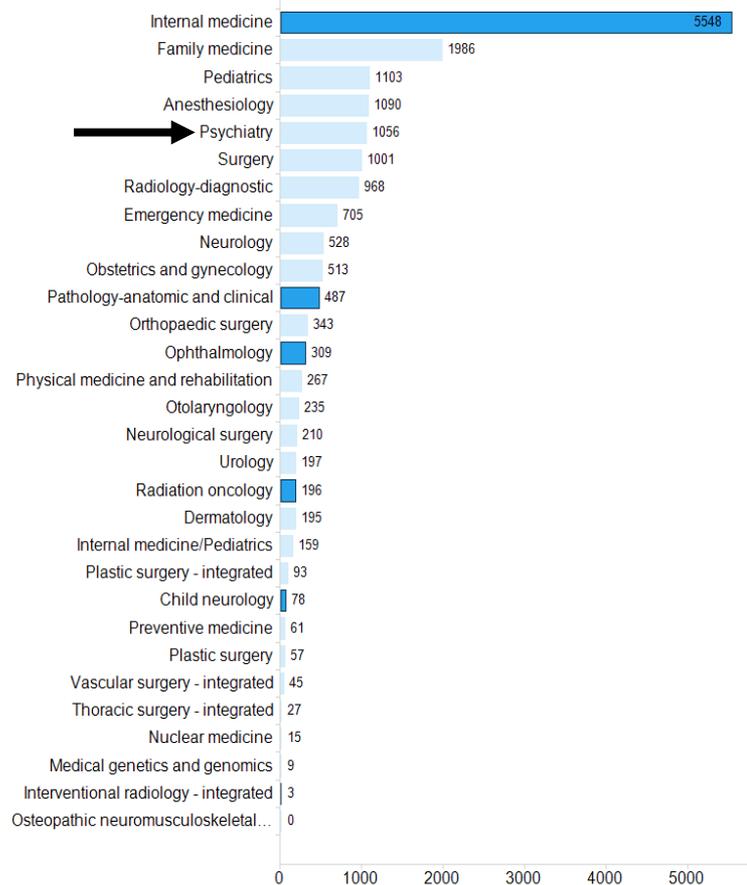
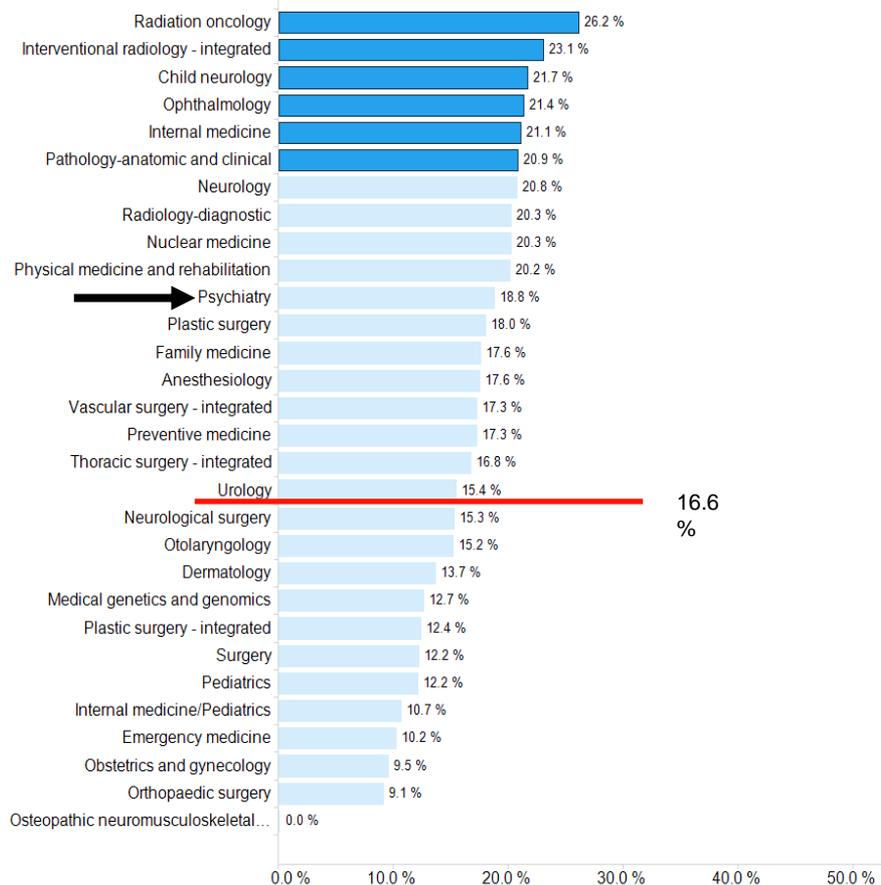


42.7%



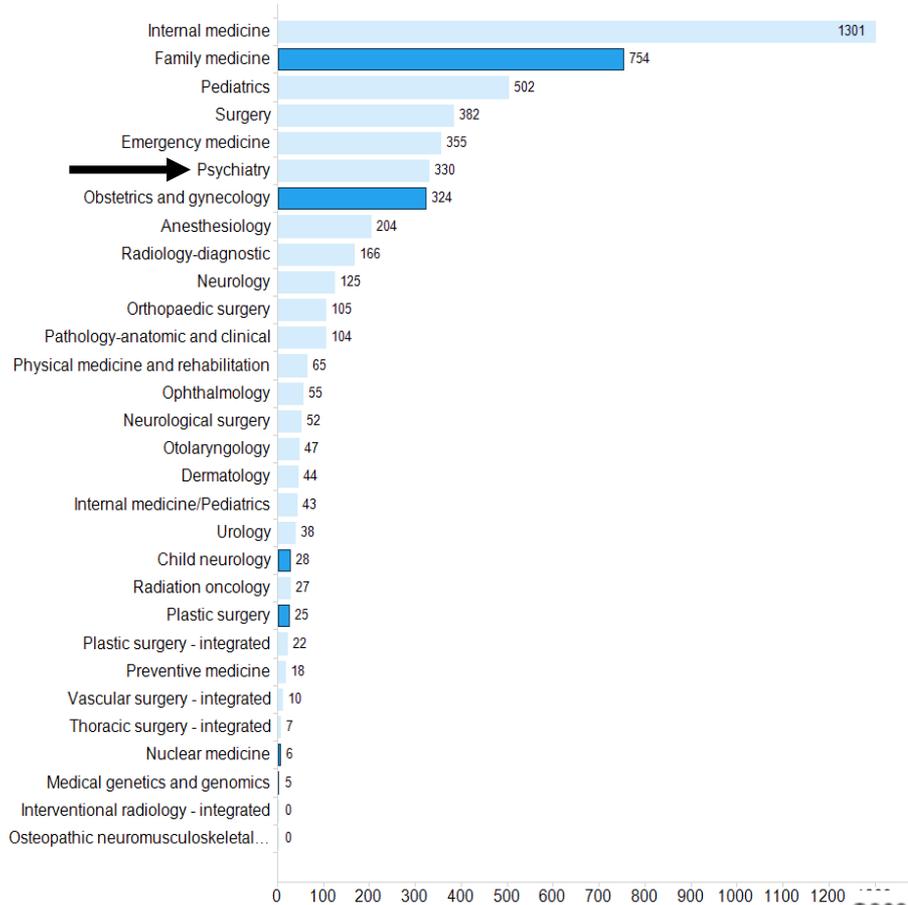
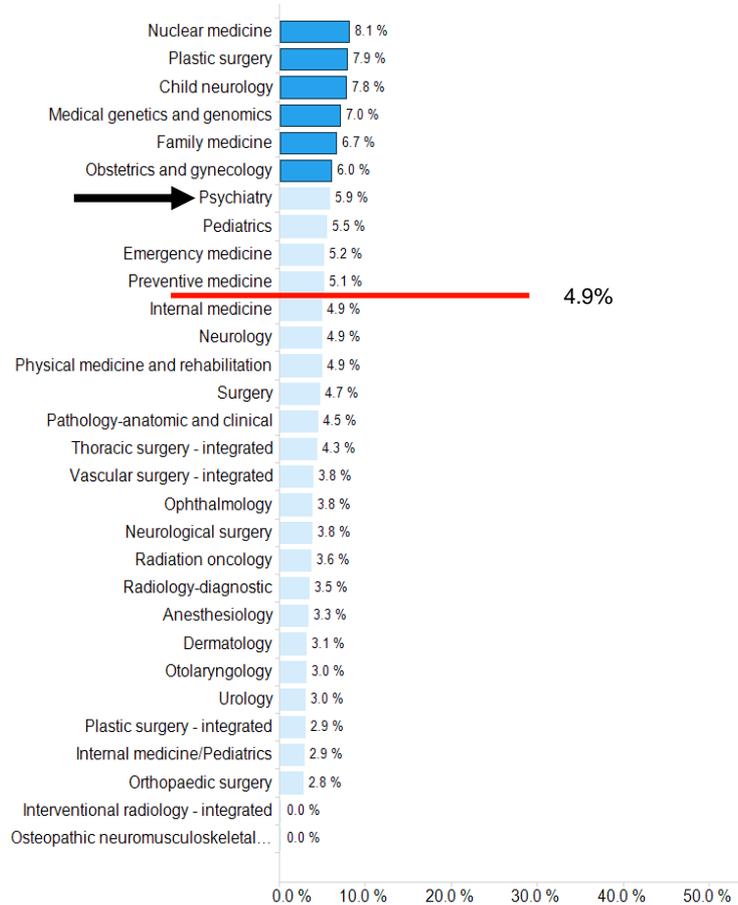
Asian and Pacific Islander by Specialty

2016-2017 Academic Year



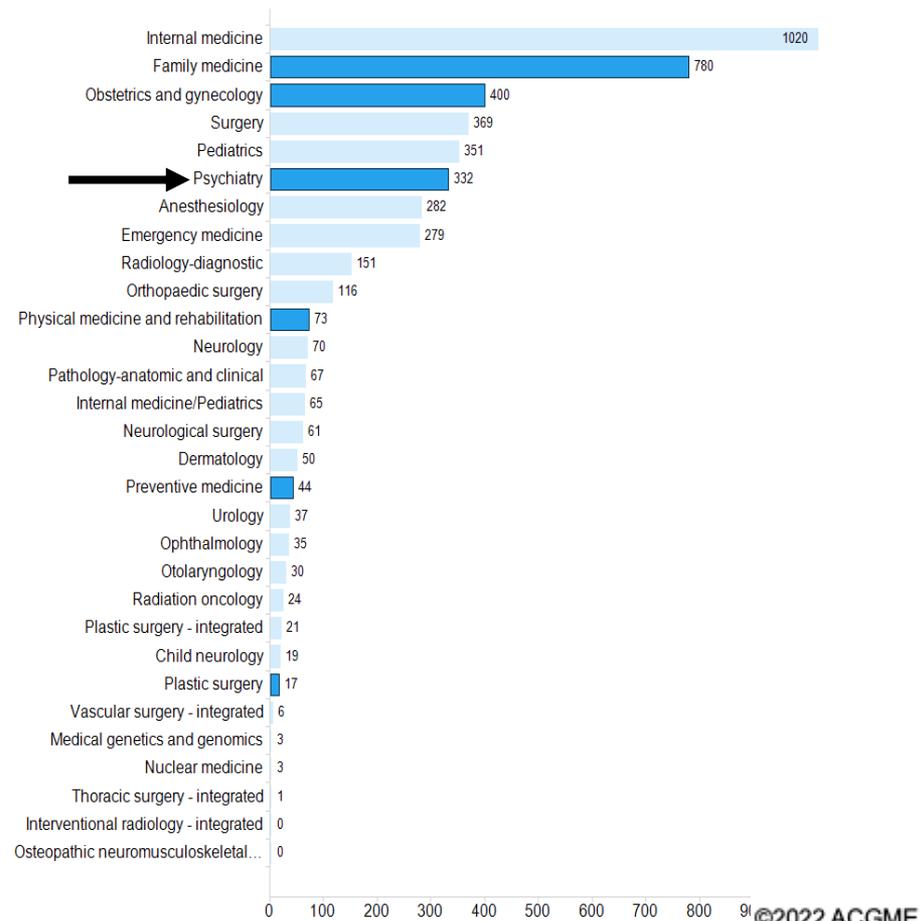
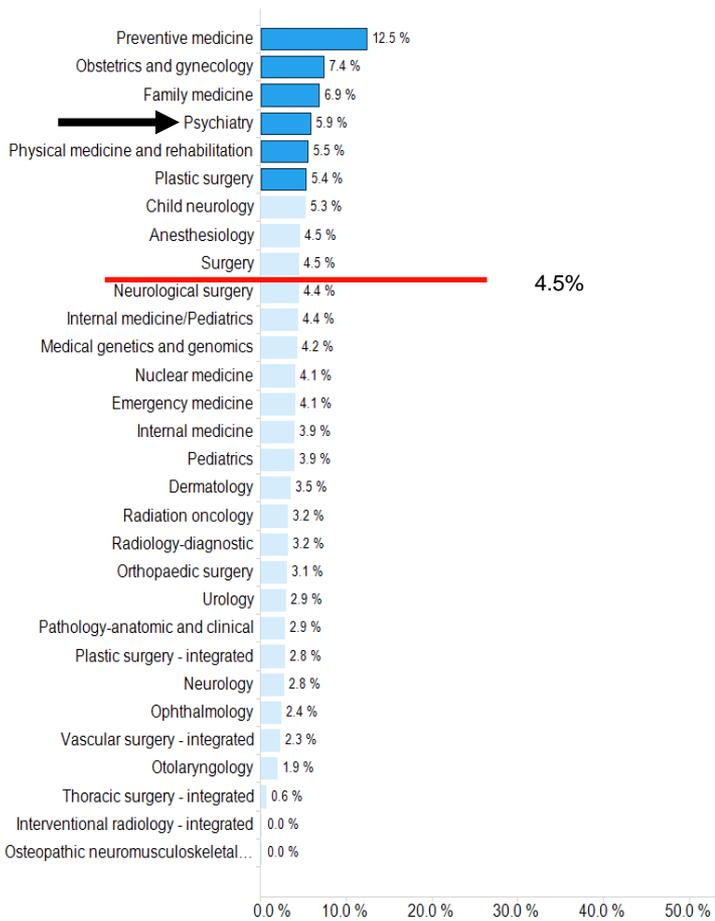
Hispanic by Specialty

2016-2017 Academic Year



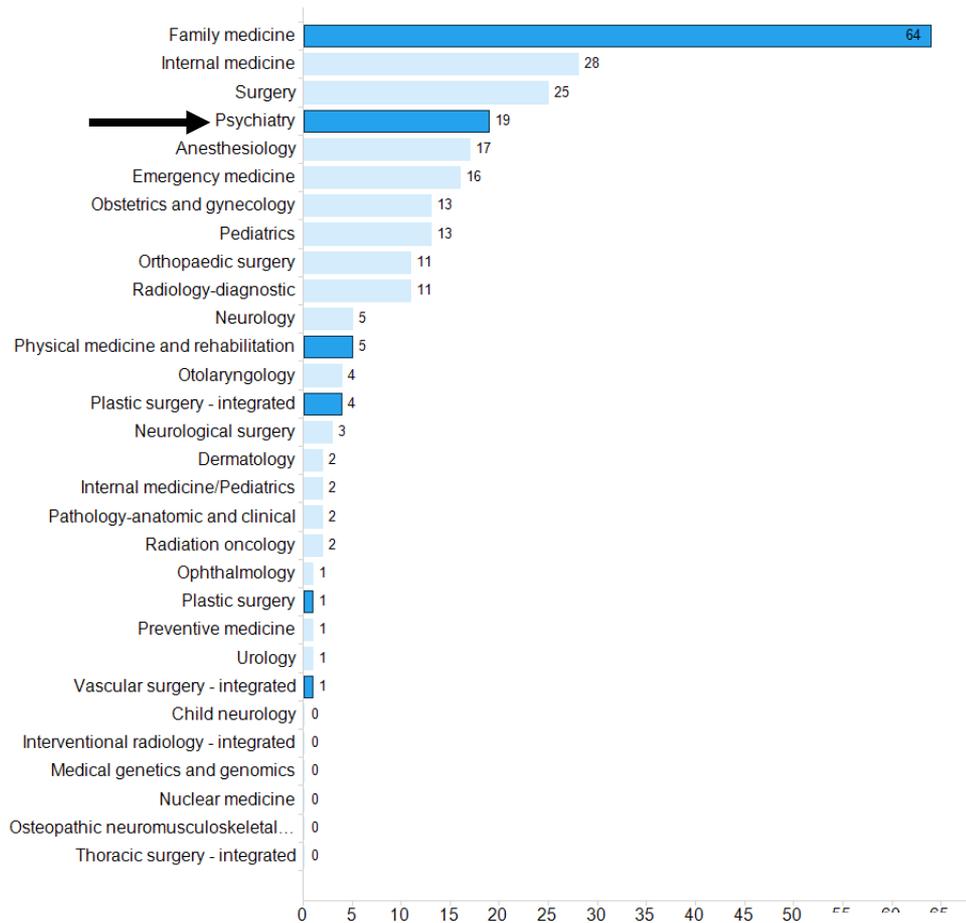
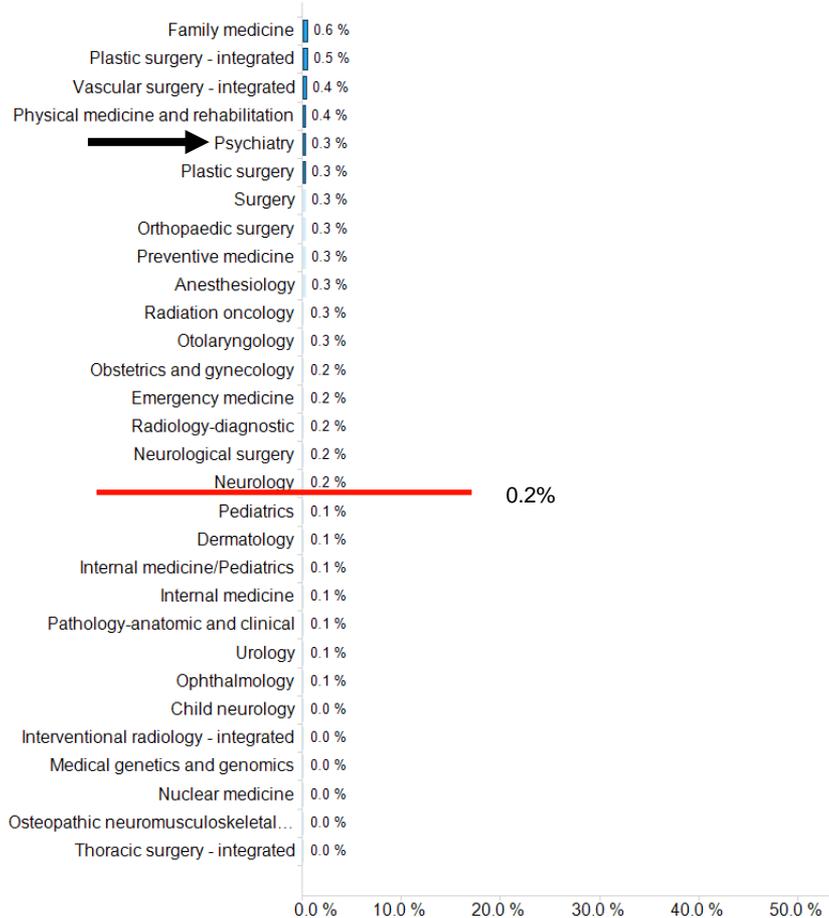
Black, Non-Hispanic by Specialty

2016-2017 Academic Year



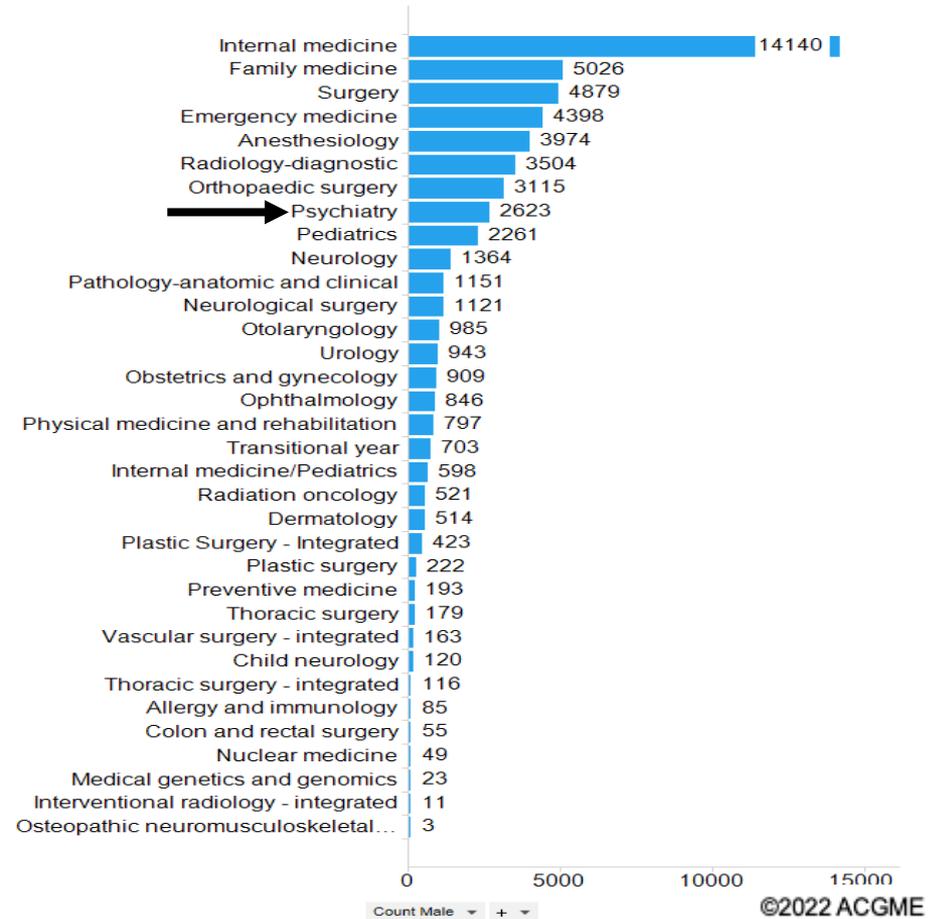
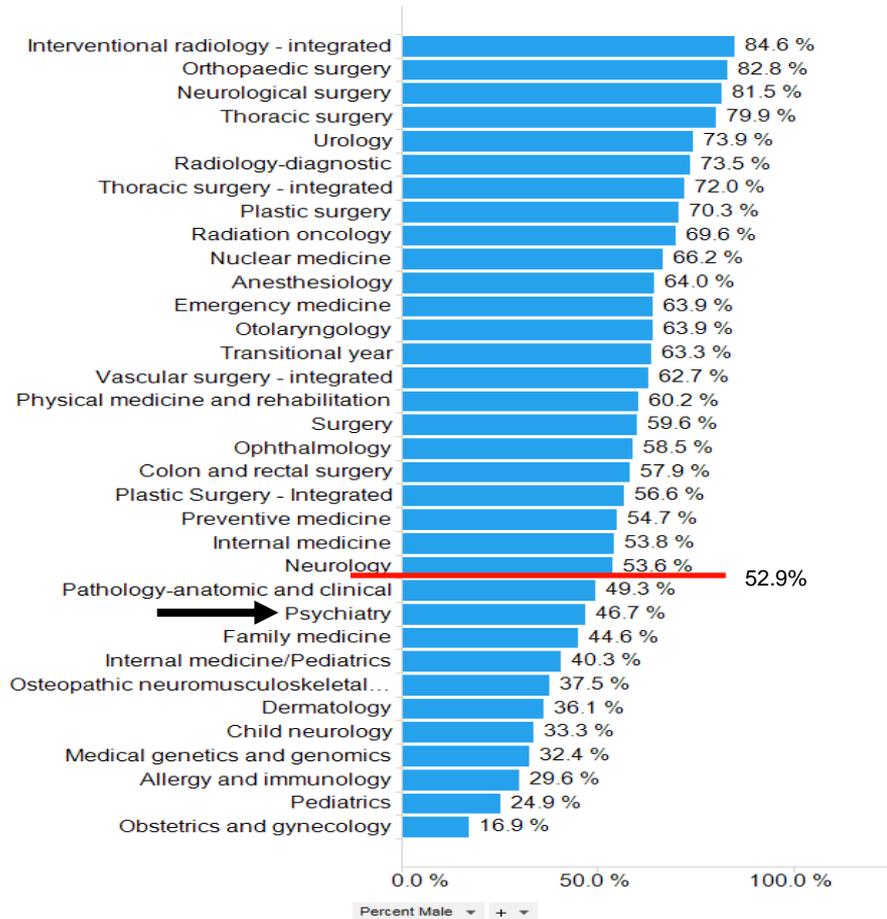
Native American by Specialty

2016-2017 Academic Year



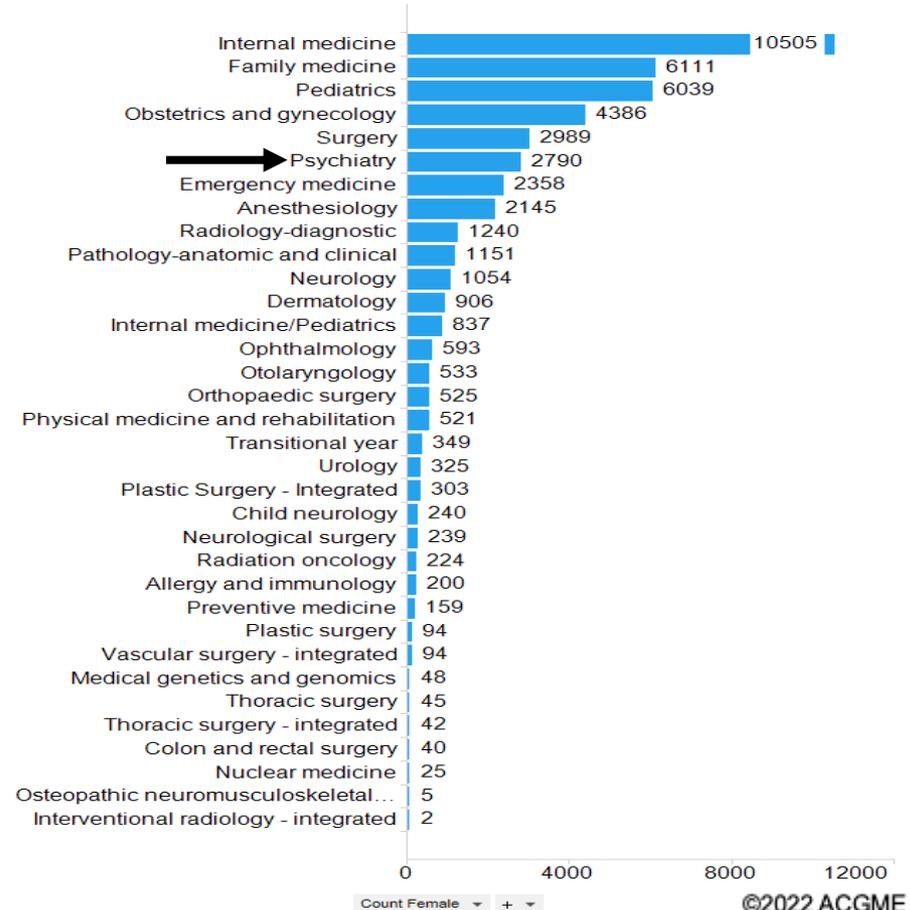
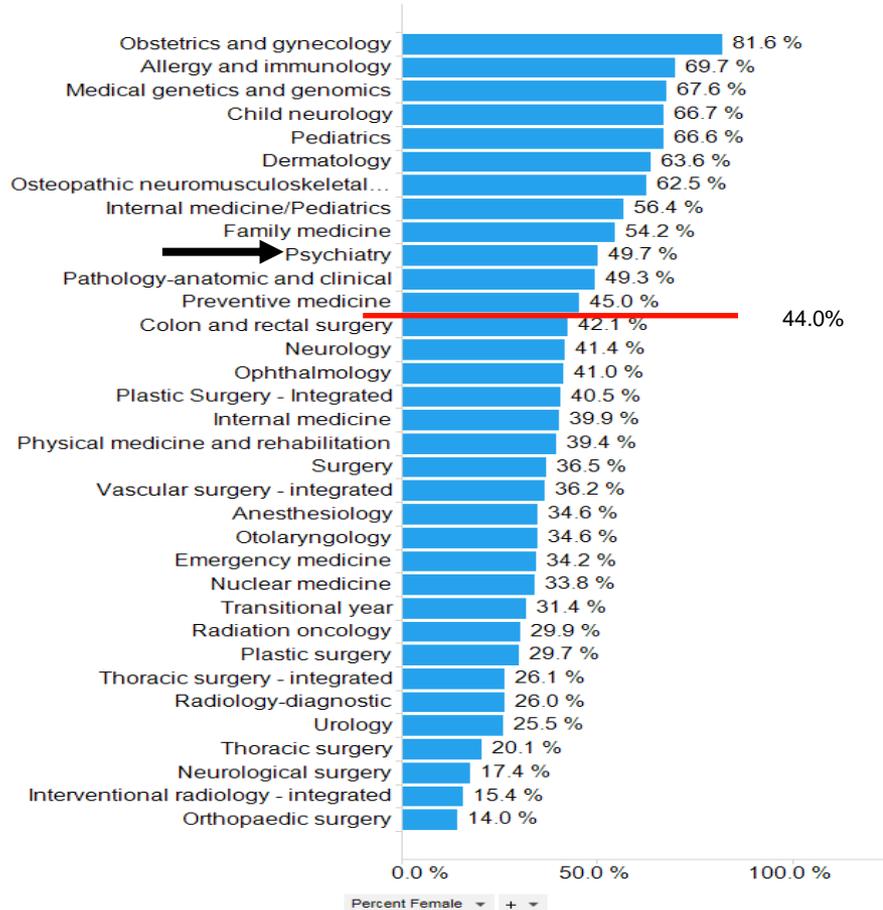
Males by Specialty

2016-2017 Academic Year

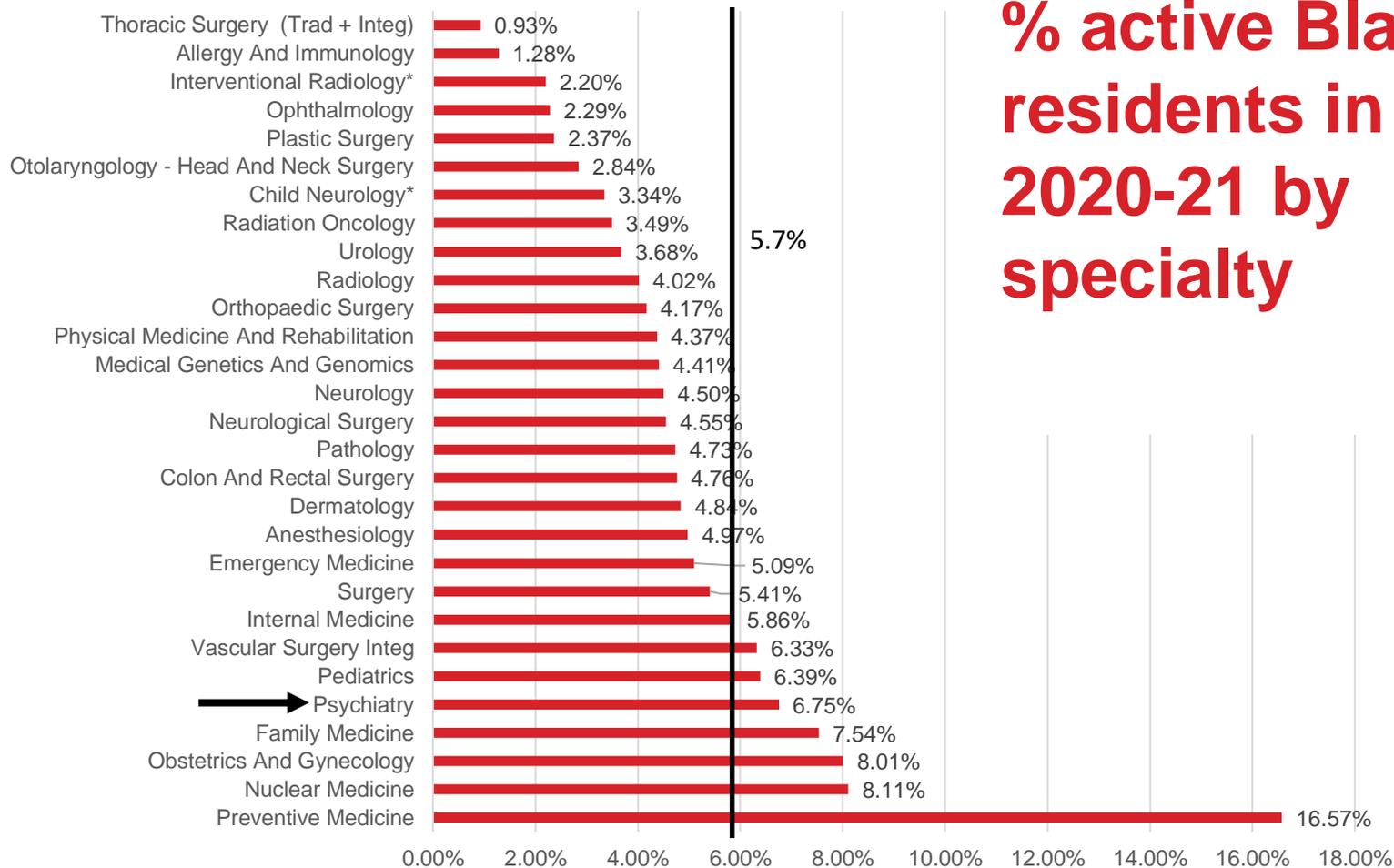


Females by Specialty

2016-2017 Academic Year



% active Black residents in 2020-21 by specialty



% active Black residents in 2021-21 by specialty

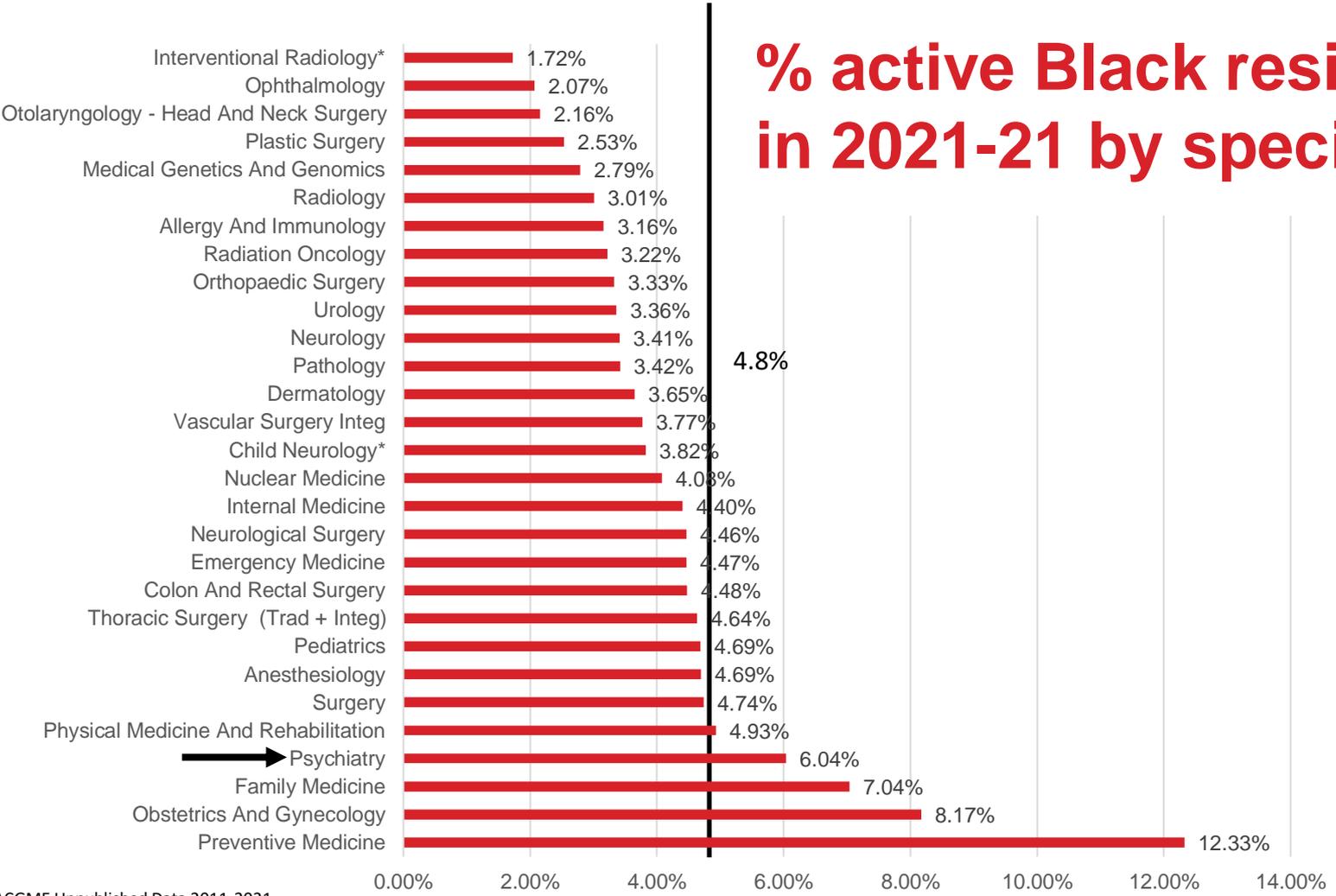


Table 2. Resident Physicians on Duty in ACGME-Accredited and in Combined Specialty GME Programs as of December 31, 2020 (continued)

	Total No. of programs ^a	Resident physicians, No. (%) ^b					
		Total	Female	USMDs	IMGs	Canadians	Osteopathic
Psychiatry	273	6745 (4.8)	3373 (50.0)	4298 (63.7)	1262 (18.7)	1 (<0.1)	1184 (17.6)
Addiction medicine	81	121 (0.1)	54 (44.6)	69 (57.0)	29 (24.0)	1 (0.8)	22 (18.2)
Addiction psychiatry	54	72 (0.1)	23 (31.9)	35 (48.6)	24 (33.3)	1 (1.4)	12 (16.7)
Child and adolescent psychiatry	141	874 (0.6)	487 (55.7)	467 (53.4)	248 (28.4)	1 (0.1)	158 (18.1)
Consultation-liaison psychiatry	63	67 (<0.1)	36 (53.7)	46 (68.7)	14 (20.9)	0	7 (10.4)
Forensic psychiatry	47	72 (0.1)	44 (61.1)	51 (70.8)	14 (19.4)	0	7 (9.7)
Geriatric psychiatry	62	42 (<0.1)	31 (73.8)	21 (50.0)	17 (40.5)	0	4 (9.5)

Table 3. Total Number of Resident Physicians in Program Year 1 Positions and in Postgraduate Year 1 (PGY-1) Positions on Duty as of December 31, 2020, in ACGME-Accredited Programs and in Combined Specialty Programs (continued)

	Total No. of residents ^a	No. of residents in program year 1 positions ^b	No. of residents in PGY-1 positions ^c	
			With prior US GME	Without prior US GME
Addiction psychiatry	72	69	0	0
Child and adolescent psychiatry	874	419	0	0
Consultation-liaison psychiatry	67	66	0	0
Forensic psychiatry	72	69	0	0
Geriatric psychiatry	42	38	0	0



Table 8. Race and Ethnicity of Resident Physicians in ACGME-Accredited and in Combined Specialty Graduate Medical Education (GME) Programs on Duty as of December 31, 2020, by Specialty (continued)

	No. of resident physicians ^{a,b}								
	American Indian/ Alaska Native	Asian	Black	Hispanic ethnicity	Native Hawaiian/ Pacific Islander	White	Multiracial	Other/ unknown	Total
Psychiatry	10	1789	499	637	6	3469	283	689	6745
Addiction medicine	1	23	8	4	0	49	0	40	121
Addiction psychiatry	1	13	4	8	0	38	1	15	72
Child and adolescent psychiatry	1	264	57	86	3	367	40	142	874
Consultation-liaison psychiatry	0	11	3	9	1	26	1	25	67
Forensic psychiatry	0	12	2	6	0	36	0	22	72
Geriatric psychiatry	0	11	3	5	0	14	2	12	42

Table 9. Resident Physicians Who Completed a Graduate Medical Education (GME) Program or Preliminary Year During 2019-2020^a (continued)

	No. completing a program	No. completing a preliminary year
Psychiatry	1277	1
Addiction medicine	66	0
Addiction psychiatry	78	0
Child and adolescent psychiatry	410	0
Consultation-liaison psychiatry	77	0
Forensic psychiatry	60	0
Geriatric psychiatry	41	0





Active psychiatry core residents and fellows 2011-2021 by race

Resident Ethnicity	2011-2012	2012-2013	2013-2014	2014-2015	2015-2016	2016-2017	2017-2018	2018-2019	2019-2020	2020-2021
American Indian or Alaskan Native	15	18	19	17	20	26	26	25	29	11
Asian									1,678	2,142
Asian or Pacific Islander	1,186	1,201	1,265	1,336	1,360	1,362	1,407	1,442		
Black or African American	373	374	371	398	430	414	443	444	513	570
Hispanic, Latino or of Spanish origin	380	392	405	405	383	411	430	431	537	459
Multiple Race/Ethnicity										704
Native Hawaiian or Pacific Islander									10	2
Other	397	401	387	364	347	346	347	379	522	209
Prefer not to report										1
Unknown	1,201	1,181	1,164	1,181	1,285	1,390	1,517	1,659	868	228
White	2,556	2,579	2,651	2,567	2,648	2,786	2,894	3,047	3,715	3,990
Total	6,108	6,146	6,262	6,268	6,473	6,735	7,064	7,427	7,872	8,316

ACGME Unpublished
Data 2011-2021



Active psychiatry core residents 2011-2021 by race

Resident Ethnicity	2011-2012	2012-2013	2013-2014	2014-2015	2015-2016	2016-2017	2017-2018	2018-2019	2019-2020	2020-2021
American Indian or Alaskan Native	11	14	19	16	17	19	22	23	25	11
Asian									1,396	1,767
Asian or Pacific Islander	974	972	1,040	1,076	1,057	1,056	1,072	1,158		
Black or African American	275	282	303	312	333	332	349	362	426	471
Hispanic, Latino or of Spanish origin	294	305	301	321	317	330	337	361	458	382
Multiple Race/Ethnicity										585
Native Hawaiian or Pacific Islander									9	2
Other	290	295	295	288	277	284	290	319	437	165
Unknown	1,034	1,048	1,037	1,087	1,191	1,278	1,377	1,436	710	212
White	2,119	2,118	2,133	2,076	2,166	2,320	2,460	2,588	3,157	3,381
Total	4,997	5,034	5,128	5,176	5,358	5,619	5,907	6,247	6,618	6,976



Active psychiatry fellows 2011-2021 by race

Resident Ethnicity	2011-2012	2012-2013	2013-2014	2014-2015	2015-2016	2016-2017	2017-2018	2018-2019	2019-2020	2020-2021
American Indian or Alaskan Native	4	4		1	3	7	4	2	4	
Asian									282	375
Asian or Pacific Islander	212	229	225	260	303	306	335	284		
Black or African American	98	92	68	86	97	82	94	82	87	99
Hispanic, Latino or of Spanish origin	86	87	104	84	66	81	93	70	79	77
Multiple Race/Ethnicity										119
Native Hawaiian or Pacific Islander									1	
Other	107	106	92	76	70	62	57	60	85	44
Prefer not to report										1
Unknown	167	133	127	94	94	112	140	223	158	16
White	437	461	518	491	482	466	434	459	558	609
Total	1,111	1,112	1,134	1,092	1,115	1,116	1,157	1,180	1,254	1,340

Active psych core residents M/F by race



Active UIM psych core residents M/F by race



Active psychiatry core resident trends by race/ethnicity/gender



Active psychiatry core residents by race %



Active UIM psych core residents by race %





Black active psychiatry core residents M/F 2011-21



LHS+ active psychiatry core residents M/F 2011-21



Program data active core psychiatry residents 2021-2022

There xxx Black residents across all 4 years of psychiatry core programs. xx programs (xxx%) account for 50% of all Black residents. xxx% of programs account for all Black residents. xx programs (xxx%) do not have a single Black resident in all 4 years

There xxx LHS+ residents across all 4 years of psychiatry core programs. xx programs (xxx%) account for 50% of all LHS+ residents. xxx% (xxx) of programs account for all LHS+ residents. xx programs (xxx%) do not have a single LHS+ resident in all 4 years



Getting the numbers right is imperative to understand phenomena with marginalized groups

Program A Psychiatry Core

	Female	Male	Non-binary	Gender Not Reported	Total Residents	White	Asian	Hispanic, Latino or of Spanish	Black or African American	American Indian or Alaskan Nat	Native Hawaii or Pacific	UIM Total	Multiple Race/Ethnicity	Other	Race/Ethnicity Unknown	Total Residents
Reported	71	26	0	55	152	49	19	13	11	0	0	24	2	2	56	152
Observed	111	41	0	0	152	75	35	19	17	1	0	37	0	5	0	152

Program B Psychiatry Core

	Female	Male	Non-binary	Gender Not Reported	Total Residents	White	Asian	Hispanic, Latino or of Spanish	Black or African American	American Indian or Alaskan Nat	Native Hawaii or Pacific	UIM Total	Multiple Race/Ethnicity	Other	Race/Ethnicity Unknown	Total Residents
Reported Initially	17	5	0	15	37	0	0	20	0	0	0	20	1	0	16	37
Reported Later	27	11	0	0	38	0	0	38	0	0	0	38	0	0	0	38



Active entering psychiatry core residents by race 2011-21

Resident Ethnicity	2011-2012	2012-2013	2013-2014	2014-2015	2015-2016	2016-2017	2017-2018	2018-2019	2019-2020	2020-2021
American Indian or Alaskan Native	2	5	4	4	4	6	6	6	9	2
Asian									391	484
Asian or Pacific Islander	297	256	299	275	247	254	324	360		
Black or African American	74	86	92	79	87	81	112	98	133	147
Hispanic, Latino or of Spanish origin	65	80	94	85	72	88	94	114	132	112
Multiple Race/Ethnicity										167
Native Hawaiian or Pacific Islander									7	
Other	75	95	72	66	71	95	74	90	103	40
Unknown	272	311	299	353	363	389	405	384	170	83
White	544	522	542	516	608	639	645	714	930	929
Total	1,329	1,355	1,402	1,378	1,452	1,552	1,660	1,766	1,875	1,964

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





Graduating core psychiatry residents by race 2010-20

Resident Ethnicity	2010-2011	2011-2012	2012-2013	2013-2014	2014-2015	2015-2016	2016-2017	2017-2018	2018-2019	2019-2020
American Indian or Alaskan Native	3	4		7	3	2	2	4	3	2
Asian									287	304
Asian or Pacific Islander	219	200	192	197	248	245	250	237		
Black or African American	70	60	65	62	58	71	78	65	77	70
Hispanic, Latino or of Spanish origin	53	69	82	62	67	70	75	74	61	80
Multiple Race/Ethnicity									92	117
Native Hawaiian or Pacific Islander										1
Other	62	68	60	57	57	71	52	66	38	33
Unknown	170	146	172	189	149	170	189	253	44	11
White	426	459	480	509	513	477	495	500	641	694
Total	1,003	1,006	1,051	1,083	1,095	1,106	1,141	1,199	1,243	1,312

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)



How common is, abuse and discrimination?

7409 residents (99.3% of the eligible residents) from all 262 surgical residency programs surveyed

31.9% reported gender discrimination, 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%).



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

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%



Yuce, Tarik K., et al. "National evaluation of racial/ethnic discrimination in US surgical residency programs." *JAMA surgery* 155.6 (2020): 526-528.

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 (Stata-Corp). 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. (%)						P value ^c	Most common source of discrimination ^d	
	All (N = 5679) ^b	White (n = 3455)	Black (n = 242)	Hispanic (n = 482)	Asian (n = 963)	Other/prefer not to say (n = 526)		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)

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

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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

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

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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, 2682/4440 [61%]) in the spring of 2009. The survey included the Maslach Burnout Inventory (MBI), the FRIME-100 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/dishonest 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 symptoms of depression, and QOL.

Results: Of the students who responded to all the MBI items, 18.54 of 2566 (5.8%) had burnout. Cheating/dishonest academic behavior was 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 (9.5/16% vs 21.9%, odds ratio [OR], 1.59; 95% confidence interval [CI], 1.59-2.24). Students with burnout were also less likely to report holding a strict view 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, 0.55-0.83). 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

www.jama.com

Author disclosures of potential conflicts of interest and author contributions are found at the end of this article. Address correspondence to Dr Dyrbye at the University of Wisconsin School of Medicine and Public Health, 800 Highland Drive, Madison, WI 53792 (ldyrbye@wisc.edu).
 See also pp 1181 and 1281.

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



Core psych residents leaving prematurely, all cause 2010-20

Resident Ethnicity	2010-2011	2011-2012	2012-2013	2013-2014	2014-2015	2015-2016	2016-2017	2017-2018	2018-2019	2019-2020
American Indian or Alaskan Native	2	1	3	2	1	5		1		1
Asian									119	112
Asian or Pacific Islander	105	114	102	110	94	112	129	90		
Black or African American	39	30	21	33	31	26	28	30	32	29
Hispanic, Latino or of Spanish origin	32	39	35	19	25	28	27	22	22	32
Multiple Race/Ethnicity									41	43
Native Hawaiian or Pacific Islander									1	
Other	28	34	34	29	34	23	24	21	14	15
Prefer not to report										1
Unknown	76	64	35	40	44	42	55	71	13	6
White	173	214	200	159	167	185	135	172	175	164
Total	455	496	430	392	396	421	398	407	417	403

10-yr B/W all cause leaving rate is x

10-yr LHS+/W all cause leaving rate is x



Core psychiatry residents dismissed, 2010-20

10-yr B/W dismissal rate is x

10-yr LHS+/W dismissal rate is x



Core psychiatry residents withdrawn 2010-20

10-yr B/W withdrawal rate is x

10-yr LHS+/W withdrawal rate is x



Core psychiatry residents transferred 2010-20

10-yr B/W transfer rate is x

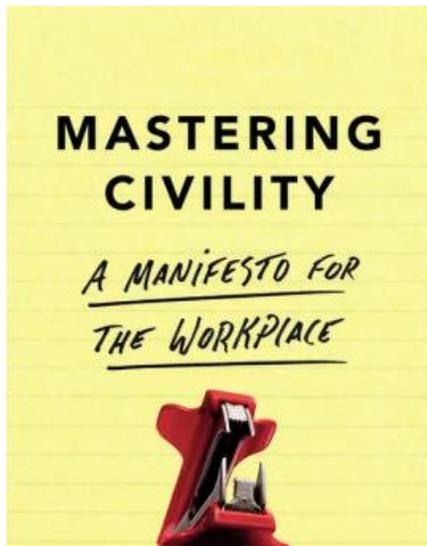
10-yr LHS+/W transfer rate is x

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



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 sidelines and back into the game. [#workhuman](#)





Active entering psychiatry fellows by race 2011-21

Resident Ethnicity	2011-2012	2012-2013	2013-2014	2014-2015	2015-2016	2016-2017	2017-2018	2018-2019	2019-2020	2020-2021
American Indian or Alaskan Native	4	1		1	2	5	1	2	3	
Asian									186	237
Asian or Pacific Islander	138	146	143	174	184	196	215	147		
Black or African American	67	53	42	64	55	50	60	43	60	67
Hispanic, Latino or of Spanish origin	52	50	72	41	46	50	59	38	56	59
Multiple Race/Ethnicity										79
Native Hawaiian or Pacific Islander									1	
Other	70	62	55	45	45	37	43	41	60	27
Prefer not to report										1
Unknown	100	88	71	62	59	74	104	162	99	11
White	273	307	324	298	328	307	276	320	379	427
Total	704	707	707	685	719	719	758	753	844	908



Active active psychiatry fellows by race 2011-21

Resident Ethnicity	2011-2012	2012-2013	2013-2014	2014-2015	2015-2016	2016-2017	2017-2018	2018-2019	2019-2020	2020-2021
American Indian or Alaskan Native	4	4		1	3	7	4	2	4	
Asian									282	375
Asian or Pacific Islander	212	229	225	260	303	306	335	284		
Black or African American	98	92	68	86	97	82	94	82	87	99
Hispanic, Latino or of Spanish origin	86	87	104	84	66	81	93	70	79	77
Multiple Race/Ethnicity										119
Native Hawaiian or Pacific Islander									1	
Other	107	106	92	76	70	62	57	60	85	44
Prefer not to report										1
Unknown	167	133	127	94	94	112	140	223	158	16
White	437	461	518	491	482	466	434	459	558	609
Total	1,111	1,112	1,134	1,092	1,115	1,116	1,157	1,180	1,254	1,340



Active graduating psychiatry fellows by race 2011-21

Resident Ethnicity	2010-2011	2011-2012	2012-2013	2013-2014	2014-2015	2015-2016	2016-2017	2017-2018	2018-2019	2019-2020
American Indian or Alaskan Native		1	4			1	1	5	1	
Asian									234	216
Asian or Pacific Islander	116	119	146	136	152	184	181	198		
Black or African American	57	53	62	48	42	65	54	52	55	60
Hispanic, Latino or of Spanish origin	42	46	58	61	61	37	45	63	39	51
Multiple Race/Ethnicity									50	62
Other	54	64	68	58	53	40	43	39	18	26
Unknown	97	116	73	89	50	51	67	79	28	5
White	284	264	269	322	326	307	298	294	325	391
Total	650	663	680	714	684	685	689	730	750	811



Psychiatry fellows leaving, all cause, by race 2011-21

Resident Ethnicity	2010-2011	2011-2012	2012-2013	2013-2014	2014-2015	2015-2016	2016-2017	2017-2018	2018-2019	2019-2020
Asian									7	9
Asian or Pacific Islander	6	8	3	8	6	6	9	6		
Black or African American	7	3	1	2	7	1	1	4	1	6
Hispanic, Latino or of Spanish origin	4	2	2	2	4	2	3	2		1
Multiple Race/Ethnicity									6	2
Other	3	5	1	5	3	1	4	2	1	1
Unknown	13	3	2	3	3	4	3	4		
White	18	17	10	10	13	15	11	11	15	16
Total	51	38	19	30	36	29	31	29	30	35

Black psych active fellows in past 10 years

Subspecialty	Male	Female	Total Black	Total Fellows in 10-yrs	% Black in 10-yrs	Black Graduates	Total graduates	% Black Graduates
Addiction Medicine Multispecialty								
Addiction Psychiatry								
Child and Adolescent Psychiatry								
Forensic Psychiatry								
Geriatric Psychiatry								
Consultation Liaison Psychiatry								



Latinx psych active fellows in past 10 years

Subspecialty	Male	Female	Total LHS+	Total Fellows in 10-yrs	% LHS+ in 10-yrs	LHS+ Graduates	Total graduates	% LHS+ Graduates
Addiction Medicine Multispecialty								
Addiction Psychiatry								
Child and Adolescent Psychiatry								
Forensic Psychiatry								
Geriatric Psychiatry								
Consultation Liaison Psychiatry								



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Thank you

ACGME EQUITY MATTERS

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



EQUITYMATTERS

ACGME Commitment to Equity

Assurance of the conditions for an optimal educational and practice environment for all learners, faculty, and staff requires:

- Valuing all individuals and populations equally
- Recognizing and rectifying historical injustices
- Providing resources according to need

Interconnectedness of levels to accomplish the mission

Leadership

- Establish or enhance infrastructure, policies, and procedures that will yield a diverse workforce and a culture of safety, equity, and inclusion in GME learning environments

Workforce

- Ensure that the diversity of the physician workforce reflects the demographics of the community

Workplace

- Create culture, climate, and educational experiences that build safety and trust providing consistent diversity, equity, and inclusion experiences for faculty and learners
Purposefully engage educators who understand and actively create a safe and equitable learning environment

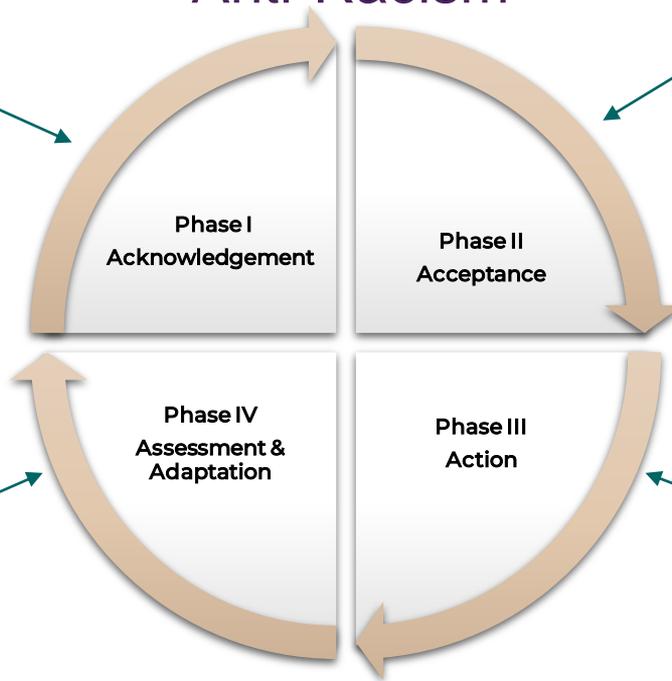
Patients/Populations

- Ensure that the diversity of the physician workforce reflects the intent to eliminate local health disparities/inequities to improve communication, trust, and outcomes

Equity Matters

Continuous Learning and Process Improvement in DEI & Anti-Racism

Goal:
Build a **fund of knowledge** in DEI, antiracism



Goal:
Acquire skills and training necessary to effect change without causing harm

Goal:
Assess the effectiveness of the intervention; share as a new resource for GME Community

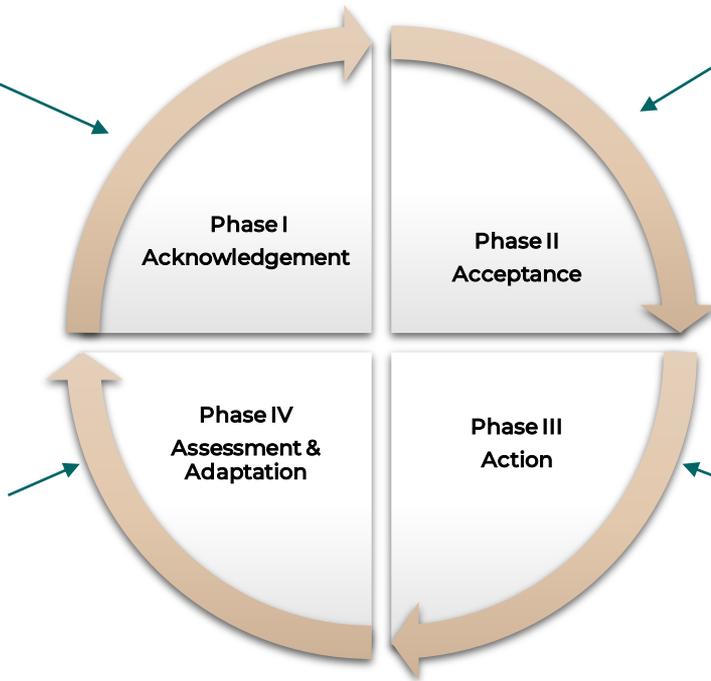
Goal:
Implement a current or innovate a new intervention

Equity Matters

Continuous Learning and Process Improvement in DEI & Anti-Racism

Activities:

- Fundamentals of DEI and Antiracism Modules
- Author Discussions



Activities:

- Dominant Cultural Norms
- Allyship
- Antiracism
- Holistic Review

Activities:

- Assess the effectiveness of the intervention
- Prepare final report

Activities:

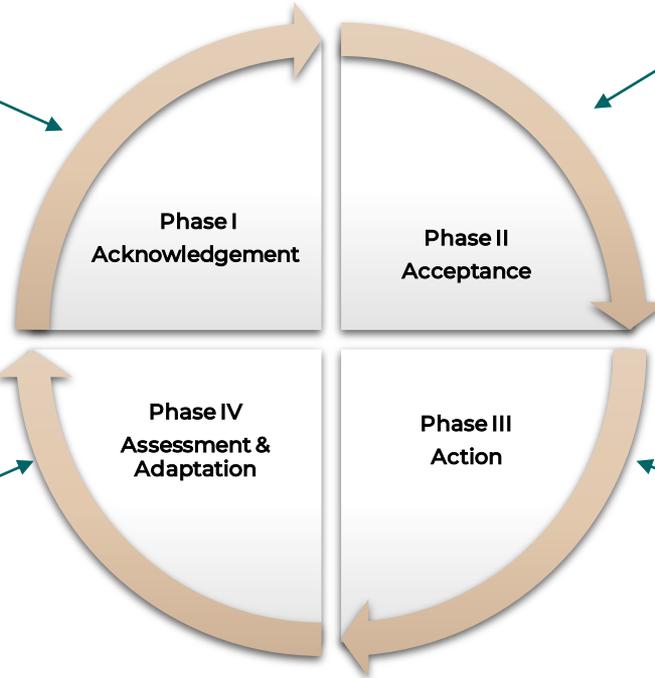
- Develop project plan
- Implement project

Equity Matters

Continuous Learning and Process Improvement in DEI & Anti-Racism

Deliverables:

- Review and reflect on monthly modules
- Completing knowledge assessment
- Track progress in Project Portfolio



Deliverables:

- Review and reflect on training modules
- Develop draft project plan
- Engage in peer project feedback

Deliverables:

- Identify success and areas for improvement
- Present at Capstone Event in December

Deliverables:

- Finalize and implement project plan
- Project coaching and peer feedback

Fundamentals of DEI and Antiracism Learning Modules

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



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Representative Learning Community Comments

These sessions have been so enlightening. I have loved and learned from each one. My only wish [is] for everyone to have access to these wonderful topics.

The resources are very useful and provide a credible and peer reviewed toolkit to help do this work, whether one is a newbie or a seasoned pro.

I am learning so much and appreciate the opportunity to participate. I do wonder why I don't see as many of the white, male CEOs. It is disappointing on one hand to see that most of us are women and BIPOC. Then on the other hand, it is amazing! Catch-22

I think this is critical for all organizations in healthcare.



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