Resident Perspectives on the Current State of Diversity in Graduate Medical Education

Nickalus R. Khan, MD
Charles M. Taylor II, MD
Kristy L. Rialon, MD

ABSTRACT

Background Diversity continues to be an important topic to physicians in training.

Objective We set out to define current issues related to diversity in graduate medical education; explore these topics with a multispecialty group of current residents and fellows; and identify programmatic, institutional, and Accreditation Council for Graduate Medical Education actions to support diversity in the medical profession.

Methods A 35-member, multispecialty council of residents and fellows used a World Café diversity and inclusion exercise to highlight current issues related to diversity.

Results Several common issues in diversity were identified, including microaggressions, team member relationships, underrepresentation of workplace discrimination, and tolerance of unacceptable behavior to conform to workplace norms. Suggestions and methods to improve these diversity issues were also proposed.

Conclusions As trainees, we must continue to implement strategies and policies that allow us to embrace diversity in our workplace and community for our patients and ourselves. Only with the continued support of residency and institutional leadership can we improve the state of diversity in our training programs.

Editor's Note: The ACGME News and Views section of JGME *includes data reports, updates, and perspectives from the ACGME and its review committees. The decision to publish the article is made by the ACGME.*

Introduction

The meaning of the word *diversity* has continued to evolve with time. Fundamentally, diversity means the acceptance of and respect for individuals while recognizing individual differences.[1] The concept of diversity is important in US health care. The health care system continues to provide more access to individuals, while US population demographics continue to rapidly change.[1] It is projected that by 2050 more than half of all Americans will belong to a minority group.[2] Minority patients have been shown to be more likely to have difficult physician-patient relationships, feel disrespected by the health care system, and experience barriers in obtaining health care.[1] Unfortunately, the same racial and ethnic minority groups that have poorer health status are also the most underrepresented in health professions.[3]

Embracing diversity can result in a number of positive benefits, such as increased care in underrepresented communities, improved familiarity with cultural differences in patients, and continued research into health care disparities.[4] A diverse health care workforce can improve patient relationships by understanding social and cultural norms and improving outreach for underserved populations.[5]

An important mechanism to address these issues is to promote diversity in the physician training process. The diversity of medical students has improved following the implementation of new accreditation standards in 2009 to attract and retain students from different backgrounds; however, large disparities in the physician workforce still persist.[6,7] For example, according to the American Association of Medical Colleges, only 4.4% of physicians identify themselves as being of Hispanic or Latino ancestry, and 4.1% identify themselves as being of African American ancestry.[2] Deville and colleagues[8] demonstrated that these percentages are similar in graduate medical education (GME).

The Accreditation Council for Graduate Medical Education (ACGME) Council of Review Committee Residents (CRCR) is a 35-member organization composed of residents from each medical specialty. The council meets twice a year to discuss pertinent resident topics.[9] Noting diversity issues faced by residents currently in training, the CRCR felt it was important to further explore this topic at its September 2018 meeting. At that meeting, the CRCR performed a diversity and inclusion exercise utilizing the World Café model.[10] The purpose of this project was to stimulate an open discussion about diversity

DOI: http://dx.doi.org/10.4300/JGME-D-19-00062.1

among residents across multiple specialties. Several open-ended questions were asked to identify diversity best practices, barriers to embracing diversity, and potential ideas to improve diversity and inclusion in the medical workplace.

The ACGME CRCR leadership subcommittee compiled the results of the larger CRCR focused topic discussion on diversity and identified common themes and perspectives.

Methods

The CRCR leadership formulated several questions to discuss at the diversity and inclusion exercise portion of the September 2018 CRCR meeting. These questions were based on CRCR member discussions with ACGME leadership at prior meetings. They were intentionally designed to be open ended to encourage robust group discussion. The following questions were discussed:

1. In relationship to diversity, what things are seldom if ever talked about openly that need to be discussed?
2. If you were in charge, what are 3 things you can identify that the ACGME or CRCR could do immediately to improve diversity in the medical workplace? Are there barriers that you foresee in accomplishing these?
3. What do you predict will be the main diversity and inclusion issues facing medical residents and physicians from now until 2030?
4. What are the best practices in your specialty or that you have seen to be successful in promoting diversity and inclusion? What best practices need to be created and what is the ACGME's role?

The World Café model was used to stimulate discussion among smaller groups of CRCR members. This model utilizes small groups of individuals having a discussion at a table and then moving to a new table after 15 to 20 minutes. Each table had a content expert (either ACGME board member or staff) as the table host. After a rotation, the new group would see the discussion of the former group and expand on it. The exercise included 4 stations and 5 rotations. The final rotation was used to summarize and rank feedback from all groups.

Results and Discussion

The World Café diversity and inclusion exercise resulted in an open and rich discussion about diversity as it relates to GME and physicians in training. The discussion fell into 2 general themes: (1) current issues related to diversity in GME and (2) ideas to improve diversity in GME.

Current Issues Related to Diversity in GME

The diversity and inclusion exercise uncovered several important topics that CRCR membership felt affected physicians in training. Some of these topics included dealing with microaggressions, improving relationships among team members, addressing underrepresentation of workplace discrimination, and addressing tolerance of unacceptable behavior to conform to workplace norms.

Dealing With Microaggressions: Several members of the group related that they experienced microaggressions on a regular basis either directly or as a bystander. These can be hard to address at the workplace. Examples include being mistaken as cleaning staff or being complimented for speaking "good English." Even with extensive residency training (mostly online modules), microaggressions continue to be a regular problem during training, coming not only from superiors but also peers and patients. Perhaps most worrying of all was the consistent theme in our conversations regarding a lack of intervention and reporting. Even among this group of resident leaders, there were numerous stories of "just not saying anything" and fear of "rocking the boat" when it came to calling out inappropriate comments and behavior.

Improving Relationships Among Team Members: The discussion revealed a need to improve relationships among diverse team members. The group response indicated that cultural competency training was felt to be inadequate and there needed to be more practical training instead of module-based training.

Addressing Underrepresentation of Workplace Discrimination: Participants felt that issues regarding workplace discrimination were underreported, either because of the fear of shame, authority, retaliation, or not advancing. The residents noted a need for processes to deal with problems related to diversity and inclusion at programmatic and institutional levels.

Addressing Tolerance of Unacceptable Behavior to Conform to Workplace Norms: This issue was reiterated by many participants in the exercise. A common scenario mentioned was tolerance of an older physician's unacceptable behavior due to his or her seniority at the institution.

Ideas to Improve Diversity in GME

Based on the World Café exercise and related discussions, we propose the following:

1. The ACGME could offer a course toolbox at the Annual Educational Conference to guide educators on how to remediate and identify residents at risk for withdrawal, or how to improve retention.
2. Institutions could designate a diversity official to act as an ombudsperson who could develop a grievance policy, review diversity issues in the annual program review, and create processes to adjudicate problems involving diversity and inclusion.
3. The ACGME could add a question about diversity to its annual Resident Survey to ensure that faculty set the tone for the program.
4. The ACGME could also create a diversity committee or contact, and should analyze national data to identify programs with problems.

Conclusion

It was obvious during the World Café exercise that problems related to diversity still exist in our current GME system and continue to undermine our profession. As educated, professional individuals we must continue to implement strategies, solutions, and policies that allow us to embrace diversity in our workplace and community for our patients and ourselves. Only with continued support of residency and institutional leadership, and residents as a whole, can we improve the state of diversity in our training programs.

References

1. ASGE Membership and Diversity Committee; Day LW, Gonzalez S, Ladd AM, Bucobo JC, Pickett-Blakely O, et al. Diversity in gastroenterology in the United States: where are we now? Where should we go? *Gastrointest Endosc*. 2016;83(4):679–683. doi:10.1016/j.gie.2015.12.001.
2. Van Voorhees AS, Enos CW. Diversity in dermatology residency programs. *J Investig Dermatol Symp Proc*. 2017;18(2):S46–S49. doi:10.1016/j.jisp.2017.07.001.
3. Freeman J. Diversity goals in medicine: it's time to stop talking and start walking. *Fam Med*. 2015;47(4):257–258.
4. Nivet MA. Commentary: diversity and inclusion in the 21st century: bridging the moral and excellence imperatives. *Acad Med*. 2012;87(11):1458–1460. doi:10.1097/ACM.0b013e31826d6ad8.
5. Komaromy M, Grumbach K, Drake M, Vranizan K, Lurie N, Keane D, et al. The role of black and Hispanic physicians in providing health care for underserved populations. *N Engl J Med*. 1996;334(20):1305–1310. doi:10.1056/NEJM199605163342006.
6. Boatright DH, Samuels EA, Cramer L, Cross J, Desai M, Latimore D, et al. Association between the Liaison Committee on Medical Education's diversity standards and changes in percentage of medical student sex, race, and ethnicity. *JAMA*. 2018;320(21):2267–2269. doi:10.1001/jama.2018.13705.
7. Chapman CH, Hwang WT, Deville C. Diversity based on race, ethnicity, and sex, of the US radiation oncology physician workforce. *Int J Radiat Oncol Biol Phys*. 2013;85(4):912–918. doi:10.1016/j.ijrobp.2012.08.020.
8. Deville C, Hwang WT, Burgos R, Chapman CH, Both S, Thomas CR Jr. Diversity in graduate medical education in the United States by race, ethnicity, and sex, 2012. *JAMA Intern Med*. 2015;175(10):1706–1708. doi:10.1001/jamainternmed.2015.4324.
9. Khan NR, Rialon KL, Buretta KJ, Deslauriers JR, Harwood JL, Jardine DA. Residents as mentors: the development of resident mentorship milestones. *J Grad Med Educ*. 2017;9(4):551–554. doi:10.4300/JGME-D-17-00415.1.
10. Brown J, Isaacs D, World Café Community, Senge P, Wheatley MJ. *The World Café: Shaping Our Futures Through Conversations That Matter*. San Francisco, CA: Berrett-Koehler Publishers; 2005.

Nickalus R. Khan, MD, is a Resident, Department of Neurosurgery, University of Tennessee Health Science Center, and Member and Vice-Chair, Council of Review Committee Residents (CRCR), Accreditation Council for Graduate Medical Education (ACGME); **Charles M. Taylor II, MD,** is a Resident, Department of Physical Medicine and Rehabilitation, University of Texas Southwestern Medical Center, and Member, CRCR, ACGME; and **Kristy L. Rialon, MD,** is an Assistant Professor, Department of Pediatric Surgery, Texas Children's Hospital, and Member and Chair, CRCR, ACGME.

The authors would like to thank the ACGME CRCR staff and other relevant stakeholders within the ACGME for organizing CRCR meetings and valuing the resident perspective in graduate medical education. We would also like to thank the facilitators who provided the sounding boards and guidance for our discussions: William McDade, MD; Edith Mitchell, MD; Timothy Brigham, MDiv, PhD; and Donald Brady, MD.

Corresponding author: Kristy L. Rialon, MD, Texas Children's Hospital, Department of Surgery, 12th Floor, 6701 Fannin Street, Houston, TX 77020, 832.822.3388, kristy.rialon@gmail.com