# Increasing Graduate Medical Education Diversity and Inclusion

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In February 2018, the Accreditation Council for Graduate Medical Education (ACGME) Board of Directors formed a planning committee to assess the state of diversity and inclusion in the graduate medical education (GME) space. The planning committee set the following as its charge:

- Consider current practices in US GME focused on enhancing the clinical learning environment as it pertains to diversity and inclusion.
- Consider demographic diversity data in residency and fellowship training with respect to specialty, and then determine where significant disparity presently exists so as to propose mechanisms to achieve more equitable access to training in those domains.
- Assess current data regarding the clinical learning environment as it pertains to experiences of diverse trainees to establish whether there are particular risks to learning and well-being for these individuals due to the nature of their treatment while in training.
- Assess how potential changes with respect to diversity in GME can be used to address health disparities in the United States.

After an extensive literature review of these subjects and an assessment of data on diversity with respect to admission, retention, and distribution among the various specialty training types of programs provided by the ACGME, the planning committee divided into subgroups to focus on 4 areas: (1) data categories; (2) pipeline and recruitment; (3) retention, well-being, and faculty development; and (4) role of the ACGME as a convener and partner.

## Data Categories

Data categories are inconsistent across the spectrum of medical education regulatory bodies from entry into medical education through clinical practice and will require alignment for meaningful assessment of the status of the medical workforce. Further, most entities that collect race, ethnicity, and gender data struggle with respondents selecting multiple categories, and each entity has a different way of funneling responses in these cases. Finally, nearly every regulator has approximately 20% of respondents in their database who do not identify race or ethnicity and get categorized as unknown. This is too large an unmeasured group to allow to go unclassified because it confounds estimation of the relatively small numbers of identified underrepresented minority individuals if there were overlap in classification. Because of the stigma of race and ethnicity for some groups and the fear of anti-affirmative action by others, it cannot be assumed that those who choose not to disclose this information are of any particular category. Therefore, using data to characterize the medical workforce requires significant effort to align categories and use the same schemes to funnel responses.

Additionally, the medical education community has to develop strategies that encourage the cooperation of individuals completing their demographic descriptions to do so fully and accurately. It was also noted that for some important work functions in GME, the ACGME does not currently collect data on race and ethnicity. Also, the ACGME does not currently collect demographic information for faculty, program directors, designated institutional officials, program and institutional coordinators, ACGME taskforce and committee volunteers, and its Board of Directors. New Common Program Requirement I.C. asserts that programs in partnership with their sponsoring institutions must address diversity and inclusion in their workforce,[1] and therefore, the ACGME will soon require demographic information to be included in its database.

## Pipeline and Recruitment

Pipeline and recruitment efforts are variable throughout GME, with some programs and sponsoring institutions doing an excellent job, and others putting forth little or no effort in diversity and inclusion activities. Medical schools have been driven by accreditation standards from the Liaison Committee on Medical Education to engage in diversity and

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inclusion work for the past several years, yet there was no equivalent accreditation guidance at the GME level. In fact, the general sentiment within the GME community has been that because nearly every medical school graduate obtains GME training, there is nothing that GME can do to affect the nature of the throughput of physicians-in-training into GME, and the domain of pipeline efforts is exclusively that of medical schools. The abdication of responsibility to work to develop younger learners for careers in medicine at the fountainhead of the pipeline can now be a focus of change for GME.

Programs and sponsoring institutions control considerable resources that can facilitate efforts of existing pipeline programs in significant ways (eg, access to clinical learning environments, role models and teachers, and exposure to research and service opportunities). Irrespective of whether there is a medical school partner, GME can also be the initiator of pipeline activity. Since half of the programs ACGME accredits do not have a medical school affiliate, assistance may be needed to help many programs identify community partners to help establish early learner programs at any number of levels (ie, elementary school, high school, junior college, college, postbaccalaureate, Master of Public Health, and medical school). Recruitment involves creative thinking at every level, but affords multiple opportunities for programs to consider innovative ways to market themselves, including using holistic admissions practices, altering the reliance on United States Medical Licensing Examination Step 1 examination scores, placing weight on the impact that diversity plays in educating the entire cohort of learners in a program, and providing a workforce that disproportionally serves underserved minority and disadvantaged communities.

## Retention, Well-Being, and Faculty Development

Retention, well-being, and faculty development all affect the clinical learning environment and inclusion. Considerable work associates burnout with poor performance and minority students who perceive themselves as the victims of discrimination unfavorably score as more burned out than those who have not perceived discrimination during training.[2] The clinical learning environment can include elements that reinforce the imposter syndrome, provoke stereotype threat, and subject the minority learner to implicit bias, microaggressions, microinsults, explicit discrimination, and harassment. However, mitigation of these hostile elements does not alone promote an inclusive environment. Inclusion is the sense of being accepted for who one is and not having to alter oneself in order to be accepted into a group. To make residents feel more included, having mentors or role models from underrepresented minority groups is helpful, so recruitment of minority individuals into faculty positions is essential. Grooming and viewing minority residents and fellows as future faculty members is necessary to convert them into colleagues and peers. Educational development to enhance the skills of existing faculty in cross-cultural mentoring and in recognizing implicit bias may be useful to improve efforts in this area.

Finally, increasing the numbers of pipeline candidates and recruiting diverse learners to a program are insufficient activities if there is no structure for retaining matriculated learners. Providing an inclusive environment is one essential element, but if specific resources are needed to ensure the success of a resident who may need support in other ways, programs and sponsoring institutions must be able to assess needs and provide access to resources to aid the learner. The ACGME provided the planning committee with retrospective data on withdrawn and dismissed residents as a function of race and ethnicity, and it is apparent that some mechanism to support minority residents is required to eliminate the loss of minority residents from our nation's programs.

## Role of Convener and Partner

The ACGME has a central role of convener and partner in GME and drives much of what takes place in medical education. It is centrally located geographically and tactically in GME so that its initiatives help to drive important initiatives in the GME community. We expect the initiative to drive diversity in GME to ignite the innovation and creativity of the United States, and ACGME will be a partner in helping programs, sponsoring institutions, and specialties to achieve their goals.

At the same time that the work was being done by the diversity and inclusion planning committee, the ACGME Board of Directors approved a new and modified set of Common Program Requirements that includes 3 components that directly impact diversity and inclusion[3]:

- Section I.C. states that 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 and inclusive workforce of residents, fellows (if present), faculty members, senior administrative staff, and other relevant members of its academic community.

- Section V changes the way in which board pass rates will be interpreted in program accreditation. If employed as intended, the changes will allow programs to establish a basic performance level consistent with success in acquiring knowledge in their specialty and completing certification. This will aid in selecting a more diverse class since test performance will be just one of many factors in appropriate selection. This should help to decrease the reliance upon standardized test performance as such a heavily rated measure of excellence and allow other strengths of the applicant to be appreciated more fully. Such changes will have the result of increasing the number of diverse learners in specialties that currently have very little diversity.
- Section VI.B.6 states that programs in partnership with their sponsoring institutions must provide a professional, equitable, respectful, and civil environment that is free from discrimination, sexual harassment, and other forms of harassment, mistreatment, abuse, or coercion of students, residents, faculty, and staff.

The planning committee recommended the creation of an Office of Diversity and Inclusion at ACGME and a chief officer to lead the initiative. They recommended that the office focus on achieving demographic data alignment across the medical education continuum, helping GME adapt holistic admissions processes for candidate selection, assisting in educating the GME community in ways to achieve compliance with the Common Program Requirements, conducting an in-depth assessment of dismissals and withdrawals of minority residents in order to devise ways to substantially reduce their occurrence, identifying effective means of making the medical education environment more inclusive for all learners, establishing a more effective means to approach complaints of discrimination and harassment in programs, and communicating the efforts of ACGME regarding diversity and inclusion to the entire GME community in order to amplify the results.

The ACGME Office of Diversity and Inclusion was established in March 2019 and looks forward to engaging with our colleagues nationally to further our shared diversity and inclusion goals. We welcome success stories that programs wish to share and see disseminated as well as opportunities to engage our community in further discussion. Please send all correspondence to diversity@acgme.org.

## References

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