

A Qualitative Study of Residency Faculty Motivations, Skills, and Preparedness to Facilitate Racial Affinity Caucusing

Molly Ormsby , MA

Amanda Weidner , MPH

Sarah D. Hohl , PhD

Tiffany Hou, MSIS

Grace Shih , MD, MAS

ABSTRACT

Background Racism pervades the medical system, contributing to health inequities, lack of Black, Indigenous, and people of color (BIPOC) entering medical education, and poor retention of BIPOC physicians. Racial affinity caucusing (RAC) is a tool to address and dismantle cultural and institutional racism by providing space for individuals with shared racial identities to engage in conversations about their racialized identities and experiences. Little is published on RAC facilitation and training.

Objective The authors aimed to evaluate an RAC facilitator training program.

Methods Program directors from 32 residency programs nominated 12 faculty for RAC facilitation training, and all participated in virtual trainings and RAC sessions from September 2021 to March 2022. Training consisted of foundational concepts of anti-racism and RAC, and practice co-leading an RAC session. All 12 participated in semistructured interviews. Interview transcripts were evaluated for identified themes. This qualitative study used directed content analysis to discern patterns and cross-walked code categories with constructs from social cognitive theory.

Results Interview transcripts for all 12 participants, who included 7 BIPOC faculty and 5 White faculty, were reviewed to discern patterns. Patterns were coded revealing themes for participants' motivations and perceived benefits of facilitator training, critical skills needed for successful facilitation, and resources necessary to implement RAC at home institutions.

Conclusions In addition to identifying motivations for participation in training, key skills and resources for successful facilitation were identified, including small group facilitation, managing one's own emotions, understanding principles of anti-racism, and practice and debrief of RAC facilitation.

Introduction

Racial affinity caucusing (RAC) is increasingly recognized as a powerful tool to address the needs of Black, Indigenous, and people of color (BIPOC) medical residents and as a key component of anti-racist and diversity, equity, and inclusion (DEI) curricula.¹ Despite growing attention to the need, including the Accreditation Council for Graduate Medical Education's (ACGME's) 2020 requirement for all residency programs to address and report their efforts in DEI,² many residency programs struggle with implementation. As evidence, a 2020 survey from the Association of Family Medicine Residency Directors (AFMRD) Diversity and Health Equity Committee indicated 50% of family medicine program directors lacked confidence in implementing the common program requirement change pertaining to diversity.³ Similarly, internal medicine program directors indicated concerns

related to their limited scope of influence and lack of institutional commitment.⁴

RAC offers structured spaces where individuals, grouped by racial identity, can engage in discussions that address racism and white supremacy.^{1,5} It has been implemented across academic and community settings to foster environments of healing and belonging, especially for BIPOC individuals.⁵⁻⁷ RAC creates opportunities for participants to reflect on their identities and contributions to institutional racism, making it an important tool in addressing disparities in medical education and clinical practice.^{1,5,8}

To understand how RAC facilitator training and subsequent RAC sessions may contribute to creating an anti-racist culture in medicine, we generated a logic model (FIGURE). The faculty training part of the logic model, which this project addresses, was designed to map against principles of social cognitive theory (SCT) to explain the possible relationship between training and preparedness to facilitate successful RAC. SCT posits that learning occurs in a social context and that subsequent behaviors (ie, successful RAC facilitation) are a result of dynamic interplay of individual experiences,

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Editor' Note: The online supplementary data contains the interview guide and final code book used in the study, and a visual abstract.

interpersonal interactions, and the environment.⁹ The theory describes 6 constructs that influence the process of learning: (1) reciprocal determinism: the interaction of an individual, environment, and behavior; (2) behavioral capability: having the skill to perform a behavior; (3) observational learning: observing outcomes of others modeling the behavior; (4) reinforcements: responses to a person's behavior that affect the likelihood of continuing that behavior; (5) expectations: determining outcomes of behavior change; and (6) self-efficacy¹⁰: belief that an individual can successfully perform a behavior.¹¹

The need for addressing racism and including DEI curricula in residency training is well-established, and RAC implementation may meet this need.¹²⁻¹⁵

Few, if any, theory-based curricula or tools exist to prepare medical educators to facilitate RAC.⁸ The perspectives and experiences of faculty who have been trained to do so may be particularly valuable for designing effective training programs that build capacity to dismantle racism in medicine.⁶

This study aims to understand how RAC facilitator training influences faculty readiness to implement RAC, with an emphasis on motivations and key skills and resources necessary for successful facilitation.

Methods

In this exploratory qualitative study, we utilized a constructivist paradigm to put emphasis on the participants' own lived experiences,¹¹ in which an understanding of

KEY POINTS

What Is Known

Racial affinity caucusing (RAC) is a tool designed to address and dismantle cultural and institutional racism, but program directors must understand the skills required and training programs needed for RAC facilitation.

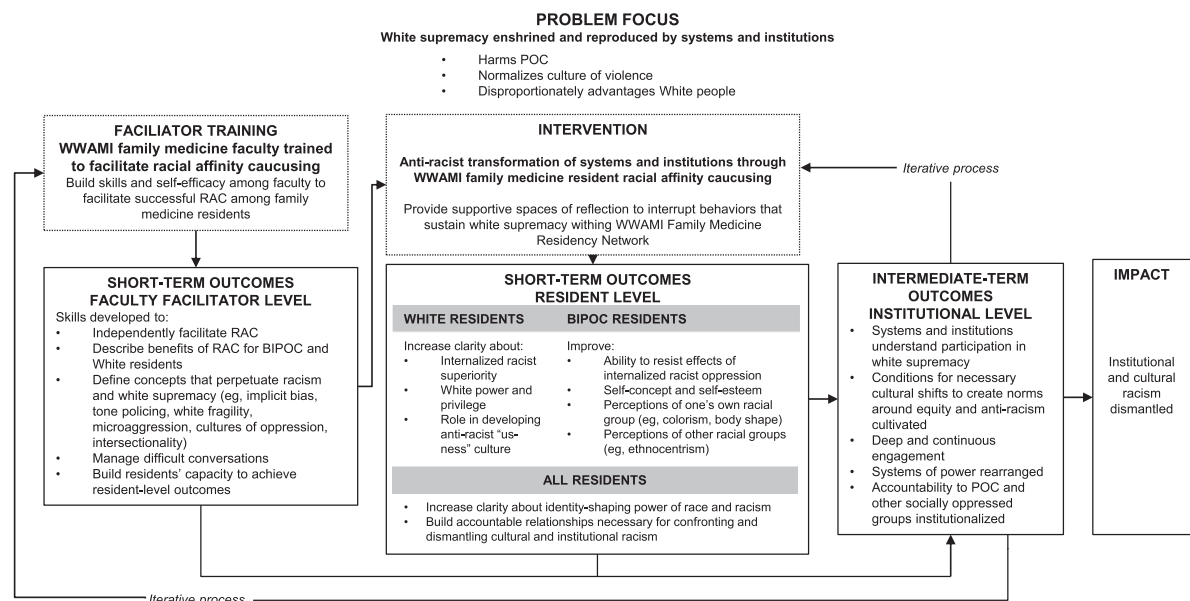
What Is New

An RAC facilitator training program was developed and evaluated, involving 12 family medicine faculty members from diverse backgrounds

Bottom Line

Successful RAC facilitation requires comprehensive training that integrates anti-racism knowledge, emotional regulation, and practical facilitation skills.

RAC facilitators' individual experiences and perceptions were sought using semistructured interviews. We then applied a directed content analysis approach¹⁶ to interview transcripts to discern patterns across facilitators' experiences. An established Crossroads' theory of change posits that, "antiracist transformation of institutions and systems can begin through understanding how they participate in and are integral to white supremacy, and providing spaces of reflection for individuals to interrupt behaviors that sustain white supremacy culture."⁶ Building on this theory, we integrated SCT constructs with lived experiences of residency faculty to identify and describe the faculty's motivation to participate in RAC facilitator training, as well as the skills and resources they perceive are necessary to facilitate RAC.



FIGURE

Logic Model for Racial Affinity Caucusing as a Tool in Dismantling Institutional and Cultural Racism

Abbreviations: POC, people of color; WWAMI, Washington, Wyoming, Alaska, Montana, and Idaho (states served by the University of Washington School of Medicine's multi-state medical education program); RAC, racial affinity caucusing; BIPOC, Black, Indigenous, and people of color.

Note: Adapted by Sarah D. Hohl from Crossroads Antiracism Organizing and Training. <https://crossroadsantiracism.org/theory-of-change>

Setting and Participants

Housed at the University of Washington, the Family Medicine Residency Network (FMRN) comprises 32 family medicine residency programs and 10 rural training programs across the 5-state region of Washington, Wyoming, Alaska, Montana, and Idaho. In June 2021, all FMRN program directors were invited to nominate faculty to participate in RAC facilitator training. Twelve faculty were nominated, and all were accepted to participate in the training. The faculty included 7 (58%) BIPOC and 5 (42%) White. Nine (75%) were MDs and 3 (25%) PhDs. Their level of experience ranged from 4 to 10 years as residency faculty with an average of 6 years. Seven (58%) were trained in the Northwest, 2 (17%) in the West, 1 (12%) in the Midwest, and 1 (12%) in the Northeast. A brief overview of our RAC facilitator training is provided in TABLE 1. Faculty participants attended 20 hours of training spanning 6 months (September 2021 to March 2022). Part of the training included co-facilitating RAC sessions for regional residents with experienced facilitators. After completing training and facilitation of these RAC sessions, all faculty participants were invited to participate in a brief semistructured interview. Interviews took place March through May 2022. The study team members (M.O., A.W., P.E., T.H., G.S.) received formal training from an experienced qualitative researcher (S.D.H.) and then together developed a semistructured interview guide (provided as online supplementary data) with input from S.D.H. The final guide included 11 questions and probes that aimed to identify (1) motivations for RAC facilitation, (2) skills that faculty facilitators

perceived as important to successful facilitation of RAC among residents, and (3) faculty preparedness and ability to implement RAC within their own institutions. The study team cross-walked interview questions and code categories with SCT constructs to help ensure that interview findings could inform theory-guided learning interventions in the future.¹⁷

Three team members (T.H., M.O., G.S.) conducted audio-recorded interviews with faculty participants via Zoom, which generated transcripts for each interview. Interviews ranged from 13 to 44 minutes in length, with an average of 20 minutes. To promote trust and safety, BIPOC team members (T.H., G.S.) conducted interviews with BIPOC faculty and a White team member (M.O.) conducted interviews with White faculty participants. M.O. and T.H. subsequently cleaned and deidentified transcripts.

Data Analysis

Transcripts were entered into Dedoose qualitative data management and analysis software version 9.0.62 (SocioCultural Research Consultants LLC). The study team developed a start list of deductive codes representative of study aims and inductive codes representing constructs of SCT. The start list was applied to a subset of interviews; additional codes were added as appropriate and refined. Through an iterative process, codes were grouped under higher order headings representative of the study aims,¹⁸ and a final codebook was agreed upon by all team members. Each interview was independently coded by 2 members of the team using the final codebook

TABLE 1
RAC Facilitator Training Schedule

RAC Activity	Date	Duration	Topics Covered
Facilitator training #1	September 2, 2021	2 hours	Introduction to RAC, foundational facilitation skills
Facilitator training #2	September 8, 2021	2 hours	Developing a practice of anti-racism, internalized racist oppression, ladder of empowerment
RAC #1	September 14, 2021	1.5 hours + 30-minute debrief	Co-lead by faculty participants paired with an experienced facilitator
RAC #2	November 10, 2021	1.5 hours + 30-minute debrief	Co-lead by faculty participants paired with an experienced facilitator
Facilitator training #3	November 17, 2021	2 hours	Interrupting bias, elicitive questions, facilitator practice
RAC #3	January 20, 2022	1.5 hours + 30-minute debrief	Co-lead by faculty participants paired with an experienced facilitator
RAC #4	March 8, 2022	1.5 hours + 30-minute debrief	Co-lead by faculty participants paired with an experienced facilitator
Facilitator training #4	March 9, 2022	2 hours	Continuum on becoming an anti-racist, interpersonal anti-racism

Abbreviation: RAC, racial affinity caucusing.

(provided as online supplementary data); coders were blinded to others' codes. Intercooder reliability was evaluated subjectively. Discrepancies were discussed and resolved during study team meetings.

The study team included 2 family physicians (G.S., P.E.), a public health researcher (A.W.), 2 staff members (T.H., M.O.), and a mixed methods researcher (S.D.H.). Study team members represented diverse educational backgrounds and varied racial and ethnic identities. The intersectional identities of team members aimed to ensure that multiple interpretations of the data were considered, that credibility was promoted throughout study phases, and that perspectives described by participants were authentically reported.¹⁹

The study was determined to be exempt from institutional review board review by the University of Washington Human Subjects Division.

Results

All 12 faculty participants were interviewed. We organized 15 identified codes and corresponding quotes into 2 overarching categories representative of the study aims (TABLE 2): (1) motivations for and perceived benefits of obtaining RAC facilitator training, and (2) critical skills for successful RAC facilitation. Representative quotes were chosen for their succinct characterization of corresponding theoretical constructs. Within each of the higher-order headings, we included codes and corresponding illustrative quotes and constructs of the SCT. Quotes represent a range of participants, but to maintain confidentiality of this small sample, participants were identified by their racial group (BIPOC or White) only. The final column lists corresponding SCT constructs to situate our findings in the context of SCT constructs that appeared to influence RAC facilitator learning.

Motivation for and Perceived Benefits of Obtaining RAC Facilitator Training

The dynamic interplay between individual faculty participants and their residency program environment (reciprocal determinism) was a core driver of participation in RAC training. All but one respondent indicated that they were motivated to learn RAC facilitation because they saw a need for anti-racism training in their program. Participants also expressed that the individual expectation of personal growth was a key motivating factor.

While the concept of creating a "safe space" was both a motivator and a benefit noted across both groups of faculty, BIPOC and White faculty described nuanced differences in how RAC was a unique space. BIPOC faculty described RAC as "one of the only

places that you can build community ... you talk about those specific things that affect BIPOC folks in training like imposter syndrome and code switching, and that sort of thing which we don't talk about as a residency, which is really important piece of healing trauma" (BIPOC faculty #1). In contrast, White faculty noted the RAC space as one where they could discuss institutional racism without burdening BIPOC colleagues. One White faculty stated, "I really believe that White caucusing creates space for addressing institutionalized racism ... without putting that burden on Black and Indigenous [people]" (White faculty #1). Several White faculty also referenced RAC as a space where people could feel discomfort together with one faculty saying, "Where else are you going to be challenged to reflect on what it means to be White and to be White in a racist world? ... There's something really valuable ... to sit with some of the discomfort and be able to be supported by other White folks, and doing that uncomfortable work. I don't think that there's any spaces that are really comparable" (White faculty #1).

Critical Skills for Successful RAC Facilitation

Observational learning/modeling was identified as playing a central role in the faculty training, with all participants recognizing key elements, such as facilitation practice, debrief sessions, or modeling their own learning, as critical to their facilitation skillset. In particular, all faculty identified RAC facilitation practice as being a key component of training, stating that "the real learning was actually the practice" (BIPOC faculty #1). Most faculty also shared the importance of modeling the learning process, with one faculty explaining "I don't have to get it right and in fact, not getting it right is maybe even a great opportunity to just sort of model, some of that [is] what RAC is supposed to be about" (BIPOC faculty #2).

The majority of faculty, especially BIPOC faculty, also identified that having skills to manage their own emotions was critical in RAC facilitation. One BIPOC faculty described "learning how to handle your own emotions ... even things that could come up for yourself as part of a trauma response" (BIPOC faculty #6) as an important skill. A White faculty described learning that "when posing questions, discussion, questions to the group, [it] really started with some self-disclosure. And answering the questions for myself in a way models for the group. Reflecting on my own stuff, watching my own whiteness to my privilege" (White faculty #1).

Several faculty, mostly White, identified that acquiring foundational knowledge of race and racism was important, and that understanding the "why" of RAC and receiving training on general

TABLE 2

Illustrative Quotes and Corresponding Theoretical Constructs for FMRN RAC Facilitator Training

Motivations for and Benefits of Obtaining RAC Facilitator Training	Illustrative Quotes	SCT Construct
Respond to leadership request	"That's something I've been charged with here." (White faculty #4)	Reciprocal determinism
Meet a need	"I felt like it would be beneficial for our program to have this training." (BIPOC faculty #3)	Reciprocal determinism; behavioral capacity
Build community	"When we talk about justice, equity, diversity, inclusion, and belonging within medical training, you essentially have to talk about race and anti-racism, white supremacy of culture and those are things that are really hard to talk about... RAC is one of the only places to have those conversations safely without tokenizing your BIPOC groups." (BIPOC faculty #3)	Expectations
Grow personally	"... a step forward and my own personal growth." (White faculty #2)	Expectations
Shift culture	"I think it's a really important piece to share and get out there, so that you can change those environments for the next generation." (BIPOC faculty #1)	Reciprocal determinism; reinforcements
Sit with discomfort	"thinking about the White caucus [a successful RAC is] sitting in a place of some discomfort, and reflecting on pieces of being White that feel more uncomfortable." (White faculty #1)	Expectations; reinforcements
Create brave spaces	"... wanting to make sure it was a space that people felt comfortable and supported within to talk openly and honestly with one another and because we hadn't had anything like this in the past." (BIPOC faculty #4)	Expectations
Critical Skills for Successful RAC Facilitation		
Facilitating effectively	"One [skill] was leading a meeting and learning how to manage potentially sensitive subjects." (BIPOC faculty #5)	Behavioral capability
Structuring a caucus	"What was particularly helpful is that our RAC faculty gave us some various topics to consider to bring up to RAC, because as a novice, I wouldn't have really considered those particular topics as an overall theme." (BIPOC faculty #6)	Behavioral capability
Articulating caucusing goals	"Maybe our aim or goal is to allow spaces where people can be among one another who have similar self-identities and race to talk about, and work on anti-racist work, or work towards those goals." (BIPOC faculty #4)	Expectations
Communicating context and principles of anti-racism	"I think having [a] framework and understanding of race as a social construct, and how it interfaces with medicine. Privilege and oppression—we're having an understanding of those things helps talk about issues that come up in RAC or issues that should be covered in RAC." (White faculty #3)	Behavioral capability; self-efficacy
Practicing self-awareness	"You have to be kind of self-aware of what you're bringing in the group. ... we are all bringing our own bias and emotions into this group, and not letting those control as a facilitator, not letting those control the group dynamics." (BIPOC faculty #1)	Reciprocal determinism; observational learning
Modeling learning	"[I] tell myself that it's okay if things aren't perfect, because I'm learning and that's a good thing to model for learners as well." (White faculty #1)	Observational learning (modeling)

TABLE 2

Illustrative Quotes and Corresponding Theoretical Constructs for FMRN RAC Facilitator Training (continued)

Motivations for and Benefits of Obtaining RAC Facilitator Training	Illustrative Quotes	SCT Construct
Managing conflict	"... learning how to handle your emotions during very emotionally charged discussions or situations. You know even things that could come up for yourself as part of a trauma response. You know that certainly overlays some of the anxiety that you have as a facilitator, because a lot of that stuff is internal in terms of what you have to process yourself." (BIPOC faculty #6)	Behavioral capability
Debriefing caucuses	"... the debriefs that we did after the different sessions were the most impactful, just because it kind of gave a framework of how to facilitate, and then helped reflect." (White faculty #3)	Behavioral capability; observational learning (modeling)

Abbreviations: FMRN, Family Medicine Residency Network; RAC, racial affinity caucusing; SCT, social cognitive theory; BIPOC, Black, Indigenous, and people of color.

facilitation skills were core foundational knowledge and skills gained from the training. They also identified other skills desired that were not covered in our training, such as mindfulness, conflict management, how to run group therapy, and differences between facilitating in-person and virtual RACs.

Resources Necessary to Implement RAC at Home Institutions

Faculty described a variety of factors influencing whether they could facilitate RAC in the future, including those over which they had individual control (self-efficacy) and those at the interpersonal, institutional, and community levels (reciprocal determinism and reinforcement). All respondents mentioned the importance of interpersonal influences, like co-facilitators, for conflict management during a

RAC session and as personal support; several participants also expressed a desire for a support network among RAC facilitators or ongoing resources through FMRN. Many participants emphasized that crucial structural factors—such as institutional and leadership buy-in and support, protected time, and money—influenced their ability to implement RAC. These are summarized in TABLE 3.

Discussion

Our findings suggest that a brief, 20-hour training program for RAC facilitation may be sufficient for physician faculty, given that many of the core facilitation skills overlap with existing clinical competencies such as counseling and small group facilitation. However, certain skills, such as managing emotions during discussions and understanding anti-racism

TABLE 3

Tips for Successful RAC: Necessary Resources and Facilitator Skills

Category	Recommendation
Leadership and support	Secure leadership buy-in, including financial support. Identify potential opposition or barriers for implementation.
Facilitator preparation	Ensure facilitators understand the purpose and goals of RAC at their institution. Provide comprehensive training that includes: • Small group facilitation skills (eg, conflict management, fostering reflection, establishing community agreements) • Emotional self-management during facilitation • Core anti-racism principles • RAC facilitation practice • Post-session debriefing with fellow facilitators
RAC structure	Organize sessions with a clear structure: • Work with a co-facilitator • Select relevant topics for each caucus • Collaborate with other residency programs or networks to expand impact
Time commitment	Allocate dedicated time and resources to support RAC activities and ensure their success.

Abbreviation: RAC, racial affinity caucusing.

concepts like microaggressions, implicit bias, privilege, and White fragility, were unique to RAC facilitation and may require additional focus in future training sessions.

For organizations looking to get started, we identified several key structural factors for implementing RAC (TABLES 2 and 3); these findings expand on what has been suggested in previous literature, specifically offering RACs in conjunction with other anti-racism curricula and needing explicit support from program leadership and involvement of leadership and learners from the start of the process.¹ In our study, participants identified the importance of leadership support and highlighted the importance of understanding their institution's motivation and goals for implementing RAC. Participants also reported the importance of a co-facilitator within their same racial affinity group as well as having the facilitator capacity to run both a BIPOC and White RAC. Having co-facilitators helps provide psychological safety for a successful RAC and distributes the emotional labor of facilitation among several people.

We found that our faculty described nuances in training needs for BIPOC and White facilitators, which aligns with the different needs and experiences of BIPOC and White RAC participants and trainees.^{1,12} Specifically, BIPOC faculty emphasized the need to have skills to simultaneously recognize and manage their own racial trauma during facilitation, while White faculty shared more desire for training on foundational racism/anti-racism concepts. We hypothesize that these differences in facilitator training needs exist because of the different experiences and goals for RAC for White and BIPOC groups.⁶ As described by Just Lead Washington, BIPOC RAC “is a place to work with their peers on their experiences of internalized racism, for healing and to work on liberation.”⁵ For White people, “a caucus provides time and space to work explicitly and intentionally on understanding white culture and white privilege and to increase one’s critical analysis around these concepts.”⁵ As noted in our logic model (FIGURE), the impact of faculty facilitator training is different for BIPOC and White participants. As such, future training sessions should be tailored to the different needs of BIPOC and White facilitators.

Our study has several limitations. First, all training and caucusing were conducted virtually. This was necessary because our faculty participants were located at 8 different residency programs in 2 states with caucusing open to participants in 5 states. While this geographic diversity represents a strength of the study, it is possible that different skills are needed to facilitate RAC virtually compared to in-person. In our study, faculty noted the importance of having co-facilitators

who had the ability to text and chat with each other directly to discuss concerns during the RAC. This would be more difficult in an in-person session. Second, in our observation, RAC is often performed within one residency program or organization rather than among many residency programs or organizations. If conducted within one program, caucus participants are likely to have already established relationships and rapport with one another.

Future research is needed to explore the experiences of residents participating in RAC and to investigate if caucuses in which participants are largely unknown to one another have significantly different discussions, conflicts, or outcomes compared to caucuses in which participants have pre-formed relationships. Though the regional and virtual nature of our project may limit the generalizability of our study findings, it provides an example by which programs can collaborate with one another to provide RAC. Our program was developed, in part, because several individual residency programs did not have any or a significant number of BIPOC residents/faculty to form a caucus. Although ideally, faculty and residents in residency programs would equally represent the diversity of the United States, creating environments that actively foster anti-racism and support inclusion and belonging represents an early step toward achieving that representation. In the meantime, working collaboratively with other programs may increase the number of BIPOC residents/faculty that can caucus together.

Conclusions

This study uncovered faculty motivations for participating in the training and identified essential skills and resources necessary for successful RAC facilitation. Key skills included effective small group facilitation, emotional regulation during discussions, a solid understanding of anti-racism principles, and the importance of both practice and post-session debriefing.

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Molly Ormsby, MA, is Regional Communications Manager, Family Medicine Residency Network, University of Washington, Seattle, Washington, USA; **Amanda Weidner, MPH**, is an Associate Teaching Professor and Associate Director of Strategic Planning, Family Medicine Residency Network, Department of Family Medicine, University of Washington, Seattle, Washington, USA, and Executive Director, Association of Departments of Family Medicine, Leawood, Kansas, USA; **Sarah D. Hohl, PhD**, is Lead Scientist, Office of Community Health, Department of Family Medicine and Community Health, University of Wisconsin in Madison, Wisconsin, USA; **Tiffany Hou, MSIS**, is Technology Strategist, Family Medicine Residency Network, Department of Family Medicine, University of Washington, Seattle, Washington, USA; and **Grace Shih, MD, MAS**, is an Associate Professor, Department of Family Medicine, and Director, Family Medicine Residency Network, University of Washington in Seattle, Washington, USA.

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Corresponding author: Molly Ormsby, MA, University of Washington, Seattle, Washington, USA, mormsby@uw.edu

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