Current State of Underrepresented in Medicine Groups in GME

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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

ACGME's path to Diversity in GME

- Formed taskforce in 2018
- Formed office in 2019
- Set strategic areas for the work of the office:
  - Data
  - Accreditation
  - Education
  - Learning environment safety

Why in the collection of demographic identity information from residents important?

Is there a societal benefit?

- Attempt to demonstrate fairness in the process of allocating a scarce, high demand resource
- Recognition of the role diversity plays in improving the quality of education for all learners
- Attempt to build a physician workforce that better reflects the population that is to be served: Access and outcomes
- An attempt to obtain broader input from potential contributors to solve problems: Advocacy, clinical care, and scholarship
- Intentional effort to promote an inclusive clinical environment improves work and care conditions

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

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

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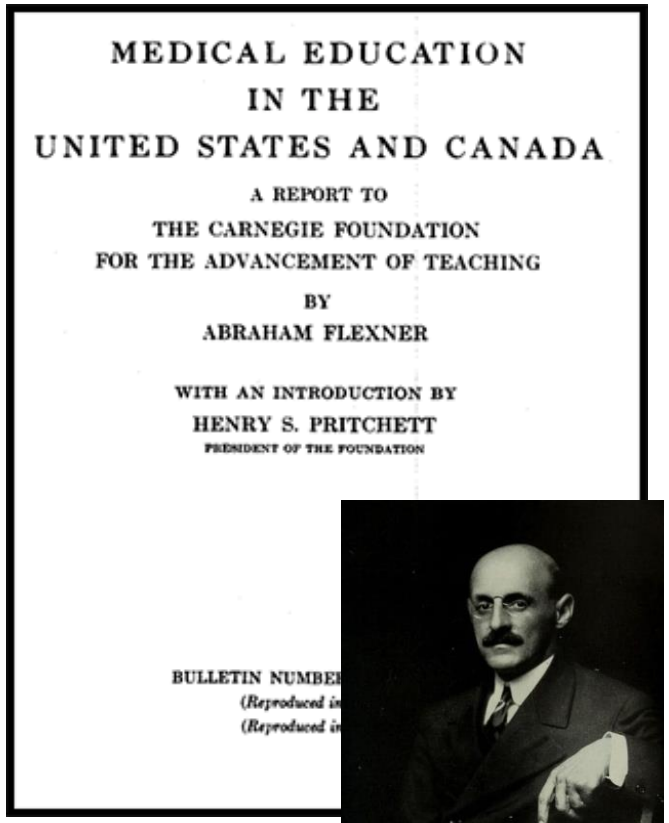
Workforce diversity matters to the elimination of health disparities

Stems from the Flexner report in 1910 that stated the reason to leave the two Black medical schools in place, after recommending closure of the other five at the time, was to ensure a supply of negro physicians to serve the black population to prevent spread of disease to the overall population.


MEDICAL EDUCATION
IN THE
UNITED STATES AND CANADA

A REPORT TO
THE CARNEGIE FOUNDATION
FOR THE ADVANCEMENT OF TEACHING

BY
ABRAHAM FLEXNER

WITH AN INTRODUCTION BY
HENRY S. PRITCHETT
PRESIDENT OF THE FOUNDATION

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CHAPTER XIV

THE MEDICAL EDUCATION OF THE NEGRO

THE medical care of the negro race will never be wholly left to negro physicians. Nevertheless, if the negro can be brought to feel a sharp responsibility for the physical integrity of his people, the outlook for their mental and moral improvement will be distinctly brightened. The practice of the negro doctor will be limited to his own race, which in its turn will be cared for better by good negro physicians than by poor white ones. But the physical well-being of the negro is not only of moment to the negro himself. Ten million of them live in close contact with sixty million whites. Not only does the negro himself suffer from hookworm and tuberculosis; he communicates them to his white neighbors, precisely as the ignorant and unfortunate white contaminates him. Self-protection not less than humanity offers weighty counsel in this matter; self-interest seconds philanthropy. The negro must be educated not only for his sake, but for ours. He is, as far as human eye can see, a permanent factor in the nation. He has his rights and due and value as an individual; but he has, besides, the tremendous importance that belongs to a potential source of infection and contagion.

The pioneer work in educating the race to know and to practise fundamental hygienic principles must be done largely by the negro doctor and the negro nurse. It is important that they both be sensibly and effectively trained at the level at which their services are now important. The negro is perhaps more easily "taken in" than the white; and as his means of extricating himself from a blunder are limited, it is all the more cruel to abuse his ignorance through any sort of pretense. A well-taught negro sanitarian will be immensely useful; an essentially untrained negro wearing an M.D. degree is dangerous.

Make-believe in the matter of negro medical schools is therefore intolerable. Even good intention helps but little to change their aspect. The negro needs good schools rather than many schools,— schools to which the more promising of the race can be sent to receive a substantial education in which hygiene rather than surgery, for example, is strongly accentuated. If at the same time these men can be imbued with the missionary spirit so that they will look upon the diploma as a commission to serve their people humbly and devotedly, they may play an important part in the sanitation and civilization of the whole nation. Their duty calls them away from large cities to the village and the plantation, upon which light has hardly as yet begun to break.

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 inequities[1]

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 racism[2]

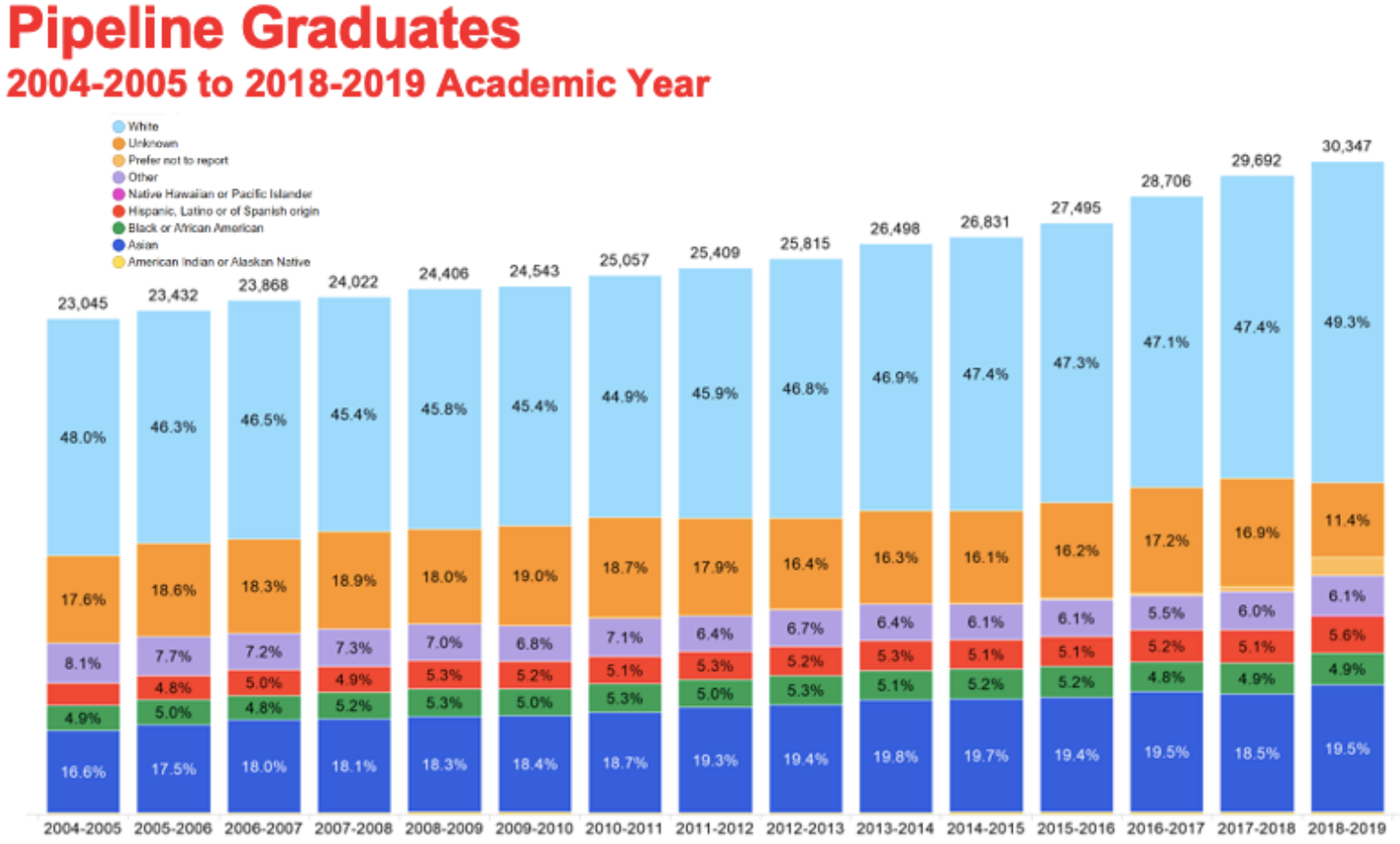
[1]Dawes, D.E., 2020. *The political determinants of health*. Johns Hopkins University Press.

[2]Pronk, 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[1] to improve the care they give to patients from historically marginalized groups

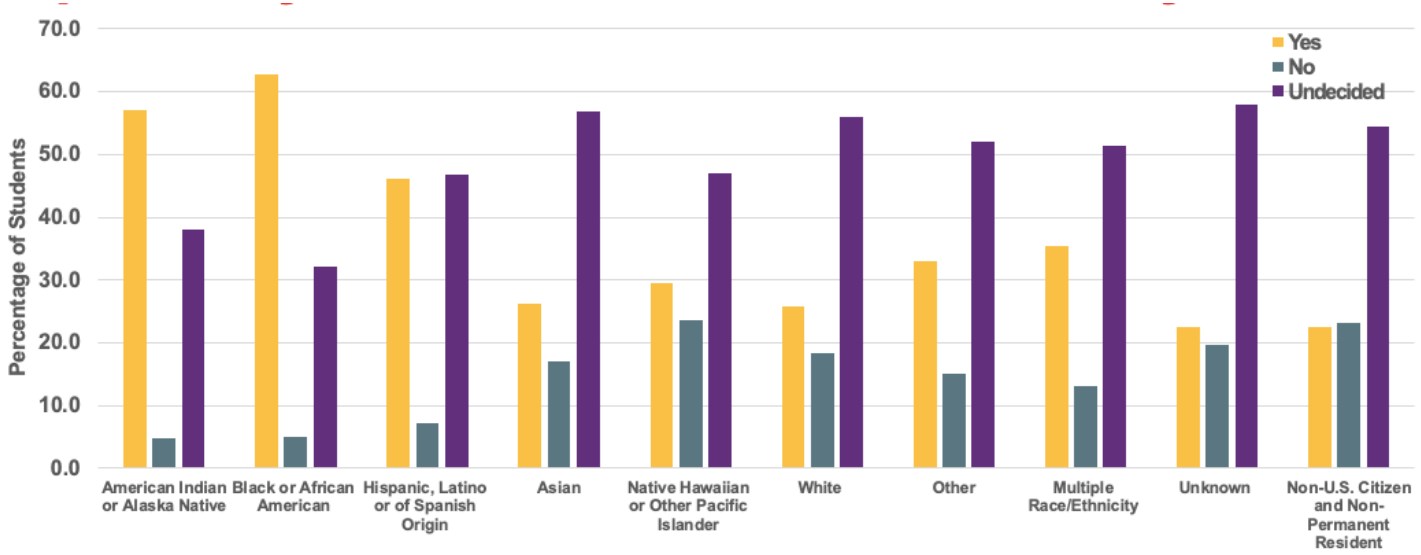


ACGME Data Resource Book Academic Years 2004-2019

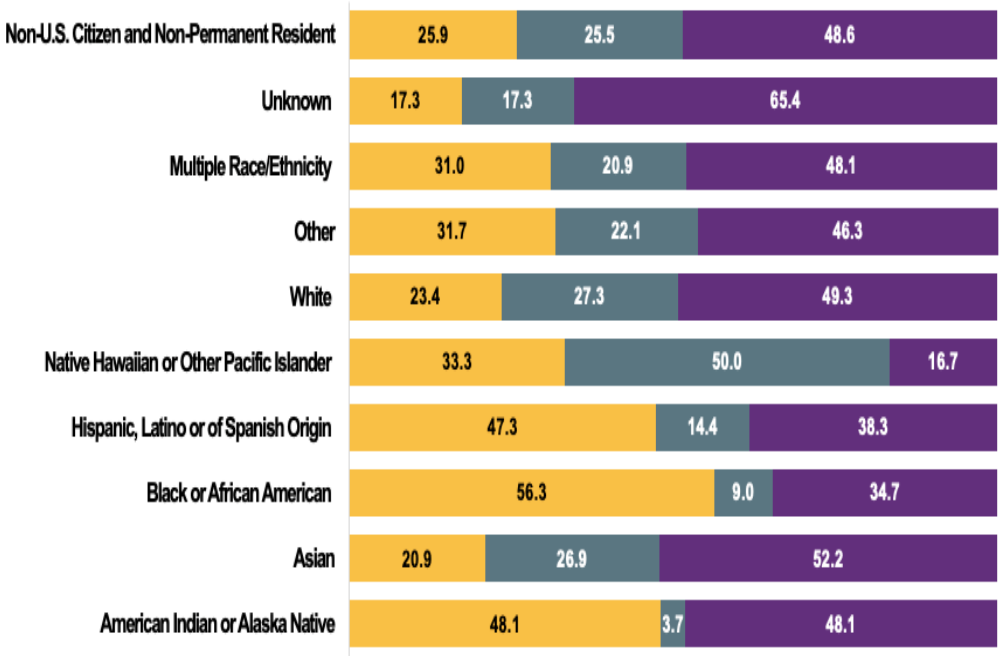
[1]Tervalon M, Murray-Garcia J. Cultural humility versus cultural competence: a critical distinction in defining physician training outcomes in multicultural education. J Health Care Poor Underserved. 1998;9:117–25.

Can you predict who is more likely to serve underserved and marginalized communities?

AAMC Matriculating Student Questionnaire

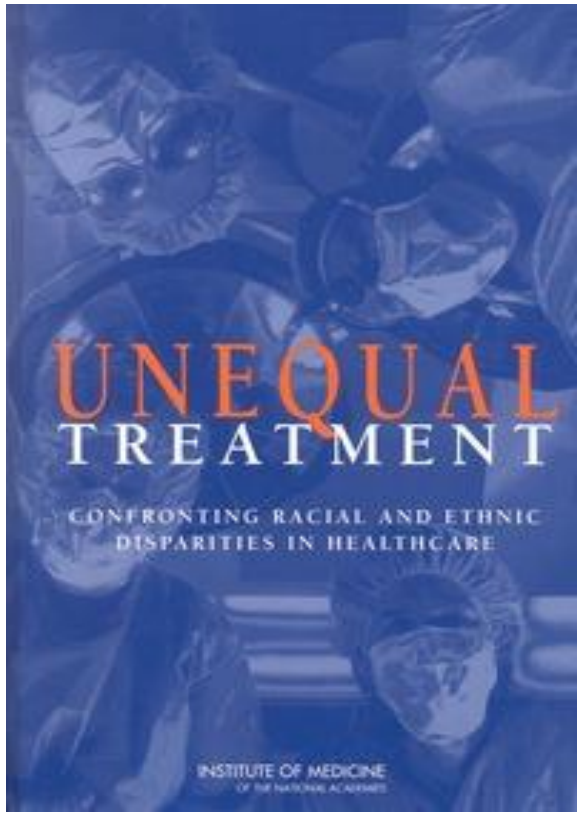


AAMC Graduating Student Questionnaire



AAMC: Data Warehouse, MSQ_R, GQ_R, and IND_IDENT_R tables as of December 30, 2020. MSQ_R last updated 1/9/2020. GQ_R last updated 8/26/2020. IND_IDENT_R last updated 12/3/2020.

Evidence of racial and ethnic disparities in healthcare



Nat Academy Press 2002
http://www.nap.edu/catalog/10260.html

- 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)

ACGME foundational principles in DEI

- Society must view health care disparities as a deficiency in health care quality
- Health equity is a means to achieve elimination of health care disparities
- Increasing workforce diversity is a means to achieve health equity
- Inclusion is a tool to ensure that diversity is successful

ACGME action steps

Changed its mission to address the formative piece that programs typically lack experience and expertise in DEI

Changed its vision to explicitly add diversity and inclusion as key elements

Modified common program requirements to address DEI

Developed new tools to assess programs and institutions for compliance as support the work of the review committees

Developed learning communities to continuously improve DEI practices – ACGME Equity Matters™

Extracting data on DEI practices from the Annual Program Update and expanding them for use for the entire GME community - ACGME Equity Matters Resource Collection (Q1 2023)

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

https://acgme.org/About-Us/Overview/Mission-Vision-and-Values Adopted by ACGME Board of Directors September 2020

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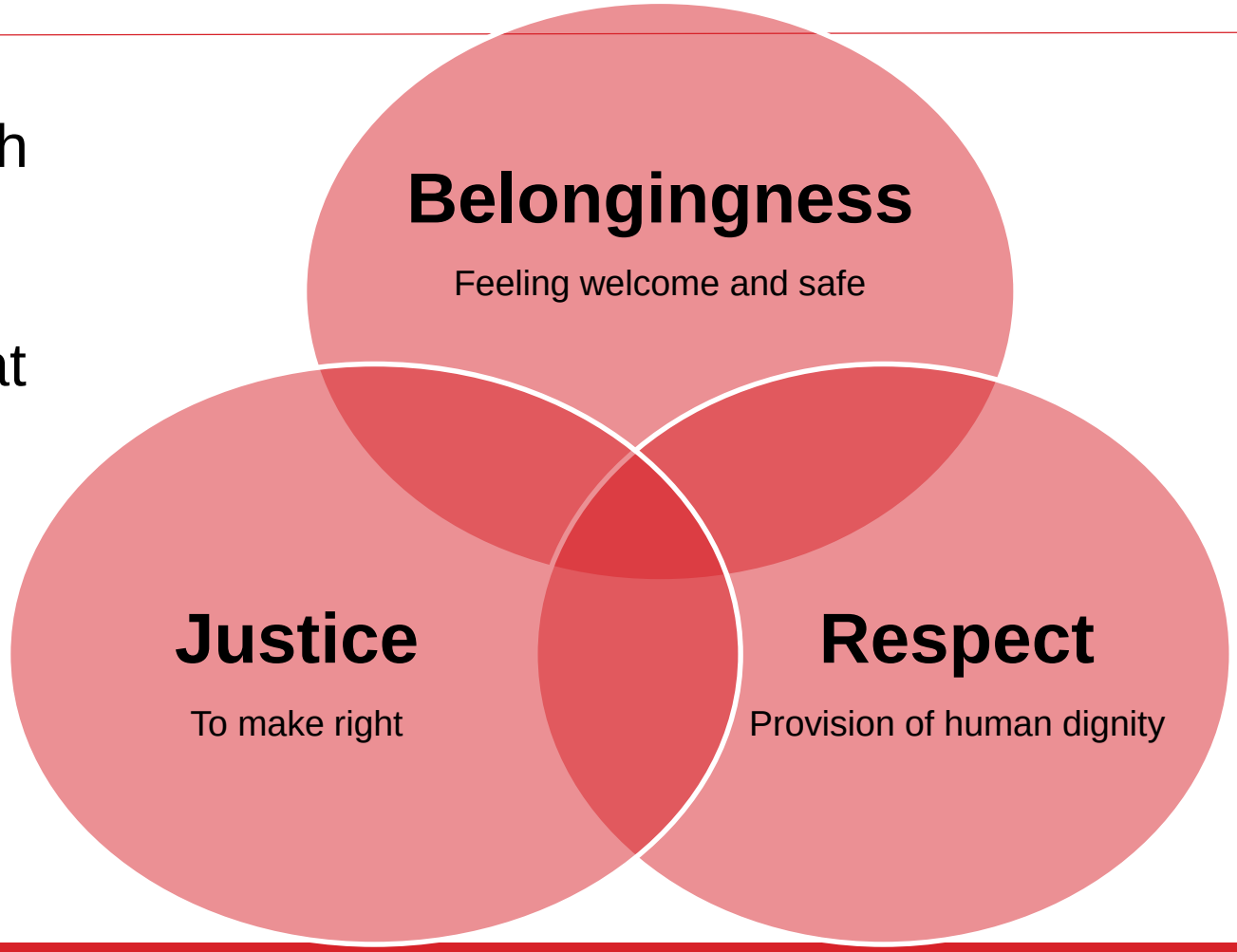
Common Program Requirement I.C.

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)

Common 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)



Common Program Requirement on nonretaliation and psychological safety

II.A.4.a).(10)

A program director must provide a learning and working environment in which residents have the opportunity to raise concerns and provide feedback in a confidential manner as appropriate, without fear of intimidation or retaliation; (Core)

Program Requirement Changes to Section V: Board Certification

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

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

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

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

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

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ACGME EQUITYMATTERS™

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

ACGME EQUITYMATTERS™

Overview of *ACGME Equity Matters*™ Program

AIM

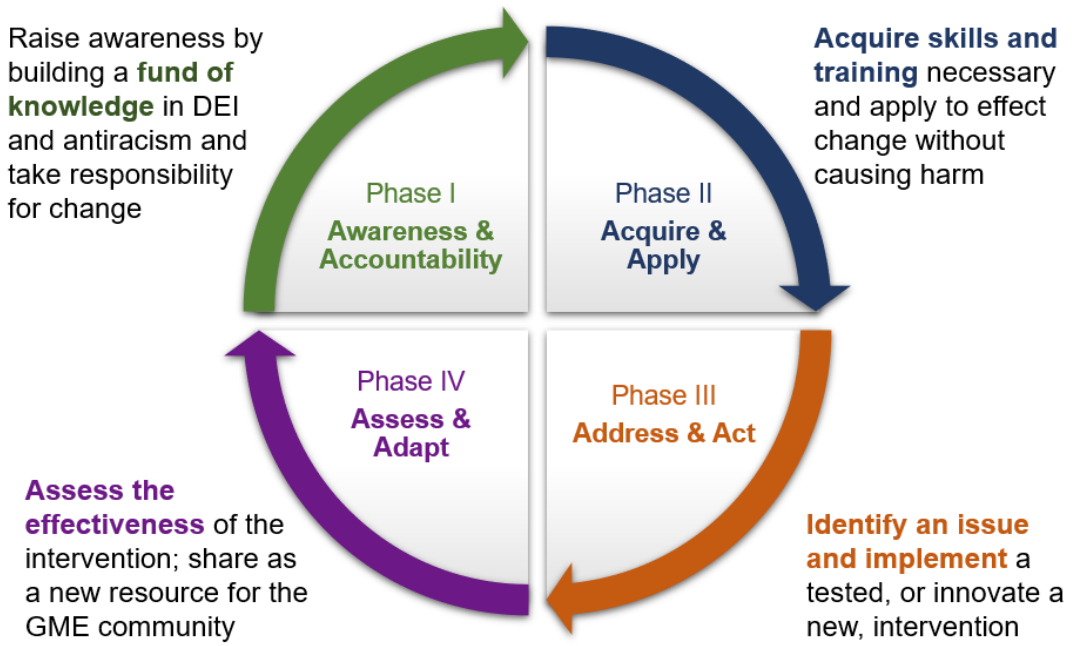
To achieve the goal of health equity by:

- Increasing physician workforce diversity
- Building physician learning environments that are safe, inclusive, and equitable to support diversity

APPROACH

- Engage with experts and gain **access to resources** to enhance understanding of current DEI and anti-racism practice
- Provide and customize proven educational and professional development tools **to enact change in clinical learning environments**
- Guide and assist the facilitation of change through the **peer-advisory model in Learning Communities,** to create a safe and brave space

PROGRAM FORMAT



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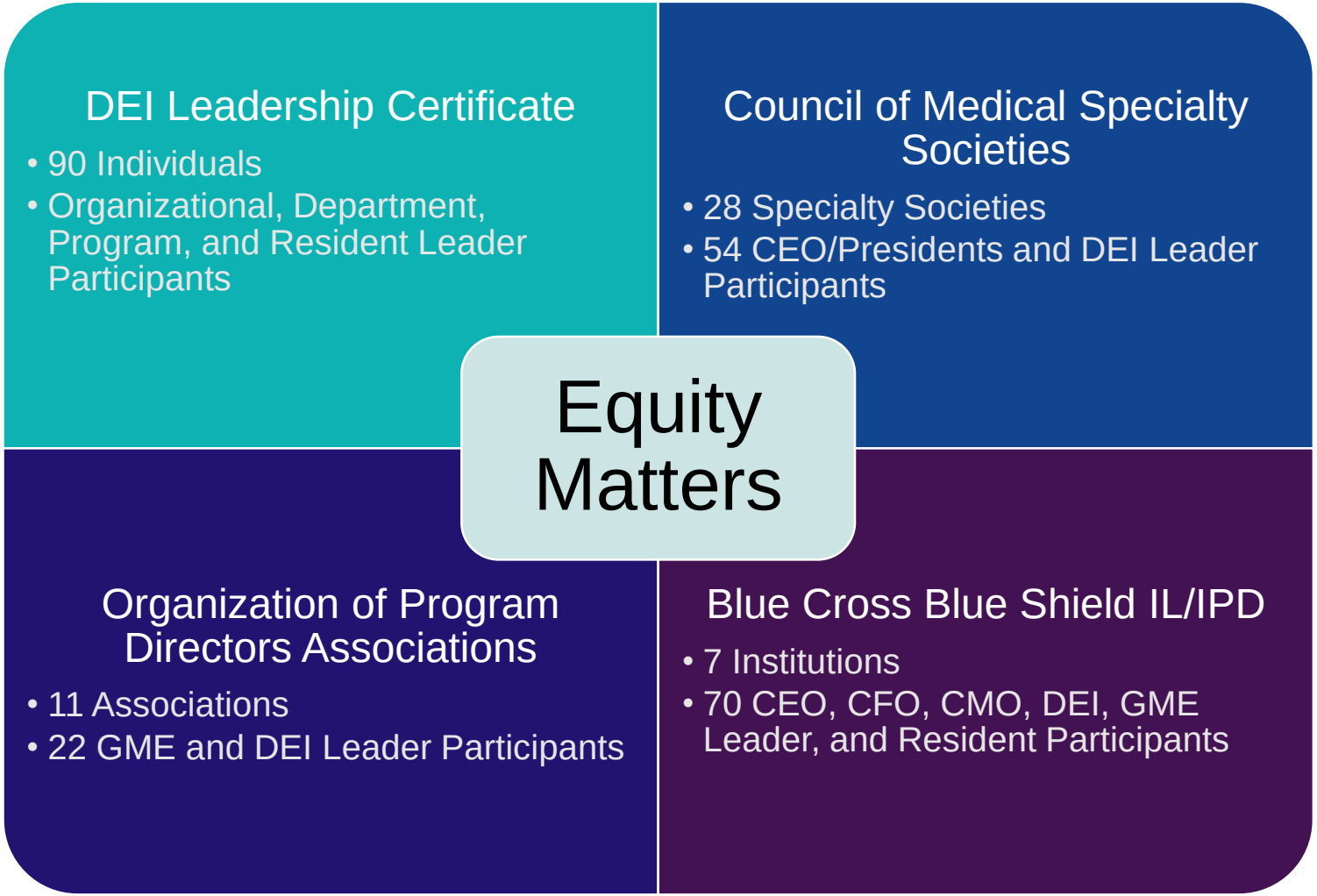
4 Learning Communities 2021-2022



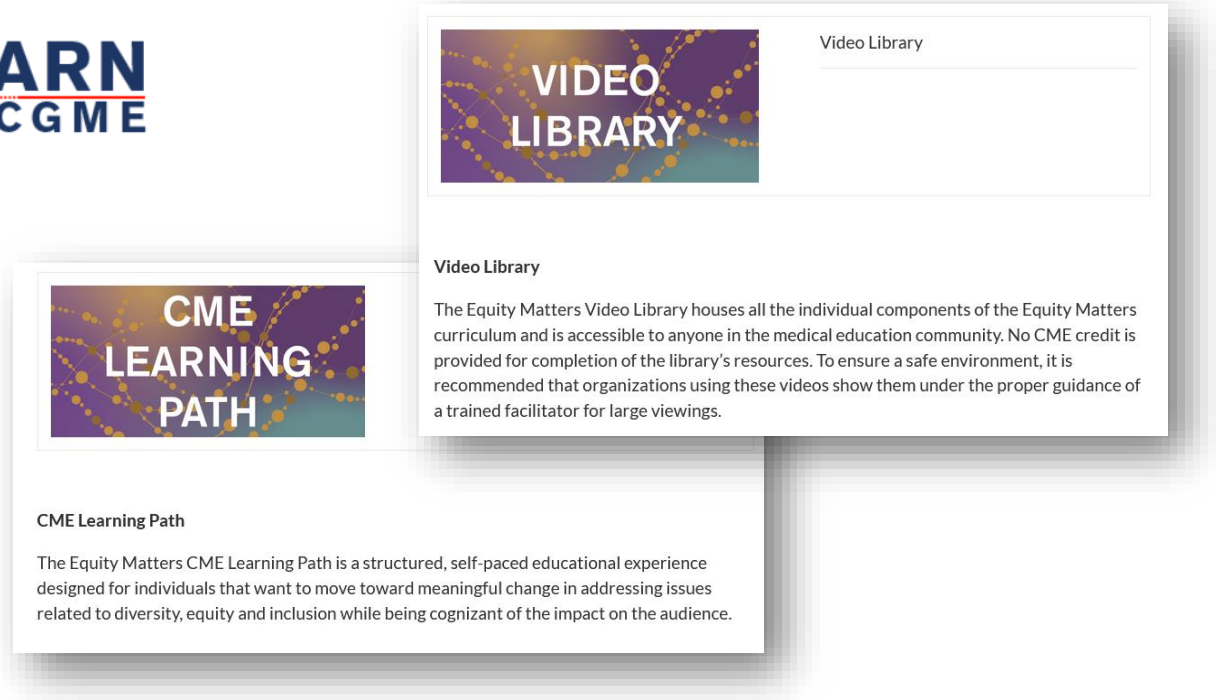
ACGME EQUITYMATTERS™

Fundamentals of DEI and antiracism learning modules

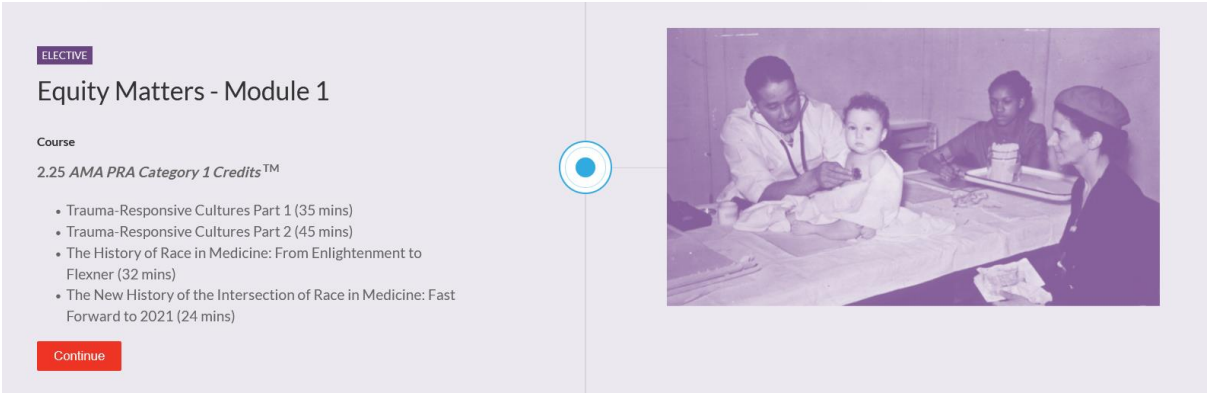
1. Trauma-Responsive Cultures Part 1 & 2
2. The History of Race in Medicine: From the Enlightenment to Flexner
3. The New History of the Intersection of Race in Medicine: Fast Forward to 2021
4. Building Safe and Courageous Spaces in GME
5. Steps Leaders Can Take to Increase Diversity, Enhance Inclusion, 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

ACGME EQUITYMATTERS™

LEARN at ACGME



- 35+ DEI foundational video topic presentations packaged into 13 modules as part of a structured, self-paced educational experience.
- 18 AMA PRA Category 1 Credits™ currently available. Registration to Learn at ACGME required, no cost
- To access, register through the link below. Please allow up to 24 hours for confirmation.



https://dl.acgme.org/pages/equity-matters

ACGME Equity Matters Capstone Projects

Sample Topics	
Cross programs use of Holistic Review (BCBSIL)	Develop Competency based GME DEI Curriculum (Leaders)
Establish URM Visiting Rotation (BCBSIL)	Develop Longitudinal Leadership and Mentor Program (Leaders)
Develop Resident Mentorship Program (CMSS/OPDA)	Identify Barriers of Standardized Tests (Leaders)
Establish Equity Scholars Program (CMSS/OPDA)	Assess Impact of Second Look (Leaders)
Identify and address gaps in DEI data collection (CMSS/OPDA)	Design and Test Simulation Based DEI Curriculum (Leaders)
Expand Summer Research Internship (CMSS/OPDA)	Implement TVUs for Teaching Time (BCBSIL)
Map UIM Mentorship Programs (CMSS/OPDA)	Create DEI Toolkit for Faculty (CMSS/OPDA)
Incorporate DEI Perspective in Lectures (CMSS/OPDA)	Improve Access to Leadership for Women Toolkit (CMSS/OPDA)
Review Mentorship Program for Bias (CMSS/OPDA)	Build Intentional Pathways to Faculty and Leadership (CMSS/OPDA)
Incorporate Supplemental ERAS application (Leaders)	Develop Faculty Mentorship Program (CMSS/OPDA)
Plan Equity Advocacy Certificate Program (Leaders)	Create JEDI M&M that Examines Racism (Leaders)
Expand Wellness Curriculum to Include DEI (Leaders)	Assess and Address Workplace Culture (BSBSIL)

Impact Areas	Projects
Workforce-Resident	33
Workforce-Faculty	14
Workplace	12
Patients and Populations	2

ACGME

Equity Matters Resource Collection

Converting data into information

ACGME EQUITYMATTERS™

ACGME Equity Matters™ Goal resource provision for GME

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

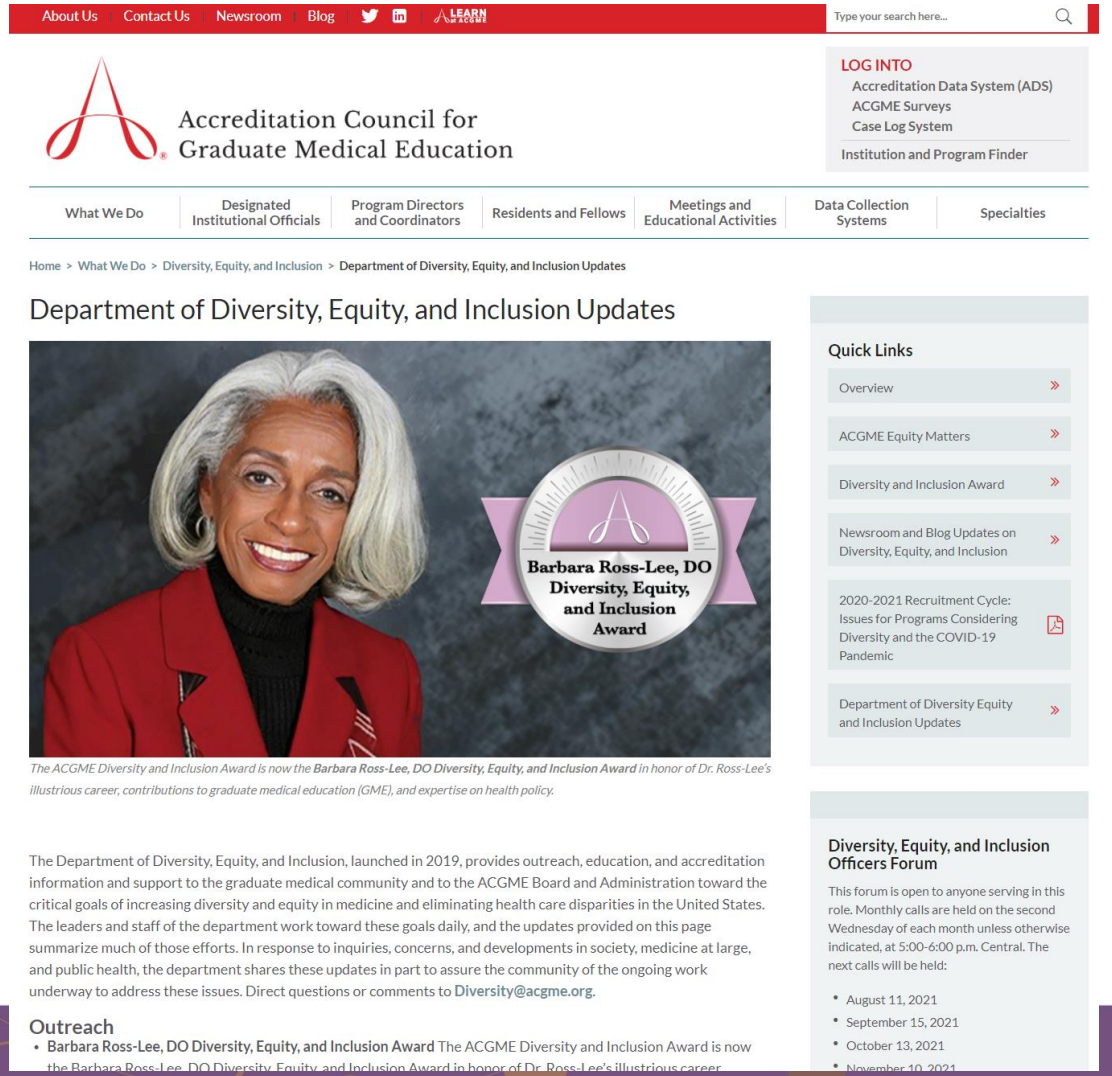
- Online tool that helps programs identify measures they can take to increase workforce diversity and to establish and enhance inclusive learning environments

Putting the Annual Program Update to use

- ACGME Equity Matters™ Resource Collection
- Compilation and categorization of APU responses that comprehensively detail the strategies GME is using to increase diversity in recruitment and retention
  - Attempt to pair with literature evidence
  - Seeking the best examples of strategies that adapted, implemented and ported to other programs and specialties
- 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
- Innovations created by the ACGME Equity Matters™ learning communities

Barbara Ross Lee, DO Diversity, Equity and Inclusion Award

- Started in 2020 to honor Dr. Barbara Ross Lee, the first African American woman to serve as Dean of an US medical school AND excellence in innovation to foster a diverse workforce and/or to provide for inclusiveness within the GME learning environment
- Application goes live in January 2023 and will close a week following the Annual Educational Conference
- Up to four awards are given each year
- Applications can come from Sponsoring Institutions, programs or specialty societies
- Winners are celebrated at AEC and representatives attend the Awards Retreat
- All entries can be used to support the Equity Matters Resource Collection



ACGME EQUITYMATTERS™

The tool will be organized into six focused strategies

EQUITY MATTERS (EM) RESOURCE COLLECTION

PATHWAY INITIATIVES > RECRUITMENT > RETENTION > DIVERSE WORKFORCE > DECREASE HEALTHCARE DISPARITIES

Resource Collection Entry

Title of approach

What: A description of the approach

Why: The rationale as to why a program would engage in this effort

Variants: Various ways in which the general concept has been undertaken in different GME settings

How: Steps involved in how a program might go about putting this innovation into play – example from another institution

Who: Individuals at programs who have agreed to be helpful to colleagues wishing to understand the approach at a more granular level

References: Any literature that we can identify that describes the method, outcomes or value of the approach

Comments: Experiences from users who will describe their own characteristics and the satisfaction they had in implementing the approach

Pathway Initiatives

K-12 Summer Research Opportunities

Solution: Summer research opportunities for pre-college learners.

Problem: Few opportunities for young learners to develop skills in medical education and research.

What: Summer research opportunities for pre-college learners include arrays of fully funded research immersion programs targeting young learners from underrepresented backgrounds. Faculty members, post-doctoral researchers, and advanced students from host institutions provide research training and mentorships as participants work on short-term research projects in these programs. Summer research opportunities aim to increase biomedical science and medical education interests among underrepresented high school learners to develop and foster pathways for future diverse biomedical scientists and physicians. These programs also equip participants with research experience to help them transition into college and further medical education and biomedical research.

Learn More

Why: To train future GME candidates from underrepresented backgrounds in scientific research in medical education settings. Young learners from the underrepresented population may have limited exposure to medicine (Rao & Flores, 2007) and research environments (Rashied-Henry et al., 2007). Summer research programs expose them to immersive research training, mentorship, and research collaboration.

Variation: Sophie Davis Biomedical Education Program at the CUNY (City University of NY) School of Medicine offers a two-year program for rising high school juniors, Health Professions Mentorship Program (HPMP), that includes summer research activities. The HPMP requires a two-year commitment and includes two four-week summer sessions following learners' sophomore and junior years of high school and monthly Saturday sessions. Learners will conduct a community-based research project in which they will take part in recognizing challenges and developing solutions to health care problems in New York City. During this summer research session, learners observe and discuss the social and economic determinants of health and disease and explore how different health care professionals address these issues to improve the health of communities. Mentorship sessions include presentations, group seminars, and problem-solving experiences led by CUNY School of Medicine faculty and students. Topics include current health challenges as well as an overview of the specific career paths designed to address them. During the Fall, Winter, and Spring seminars, medical students mentor and help high school learners build the knowledge and skills needed to become successful college students

Main topic content for each level. (This information will be the content of each approach).

Resident Recruitment

Holistic Review

Solution: Holistic Review

Problem: Resident Recruitment

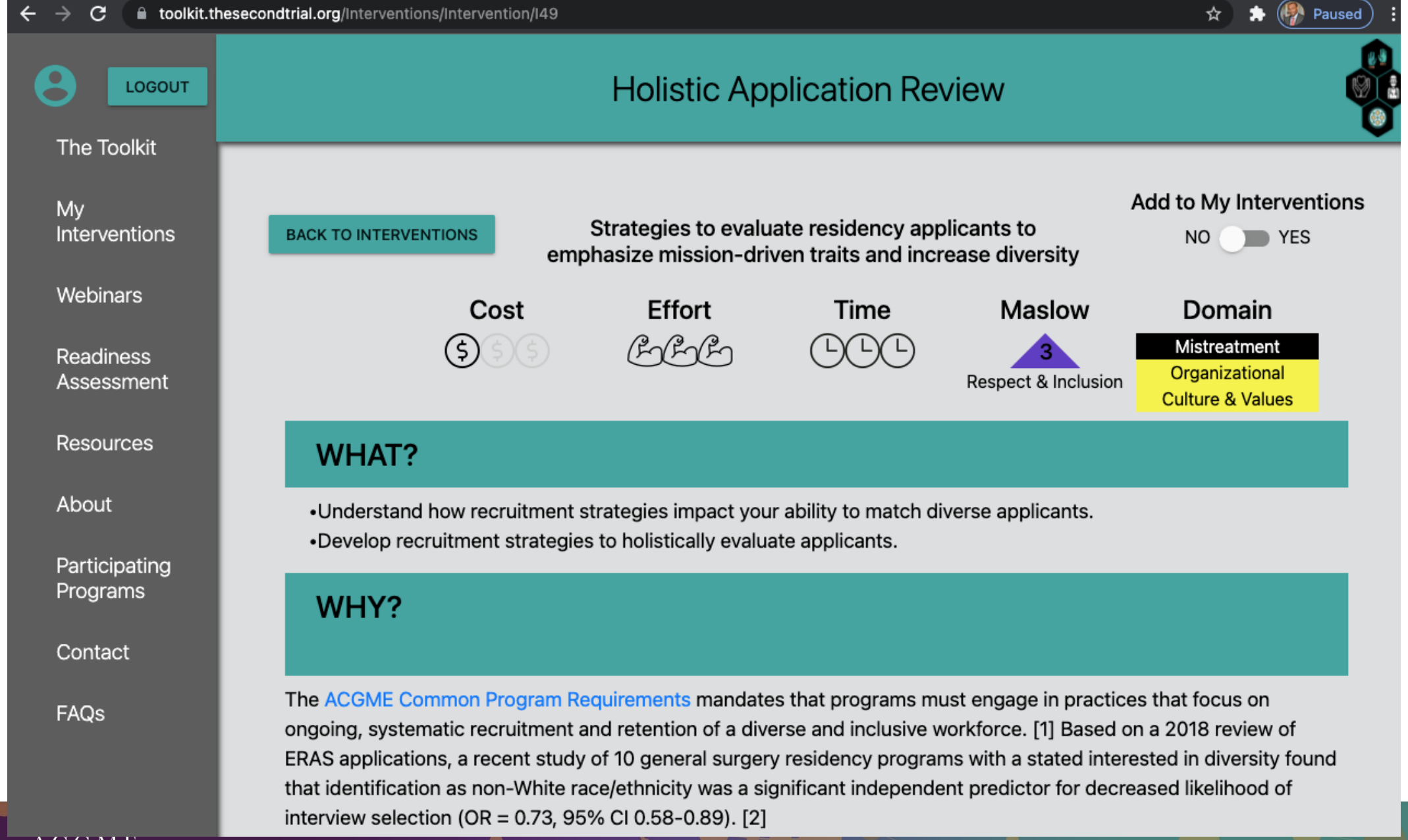
What: Holistic review is a process for reviewing applicants that take into consideration their experiences, academic achievements, and attributes, as well as the value that the applicant would contribute to the learning, practice, and teaching environment of the institution. In the recruitment process, selection committees place a lower emphasis on USMLE cut scores and assign a higher weight to selection criteria of concern to the institution. Examples include civic engagement, community service, personal essays, personal interests that display leadership skills, or unique experiences. The selection criteria are broad and are based on the mission of the institution. Additionally, these criteria must be applied universally across the entire applicant pool. (Conrad et al., 2016)

Learn More

Why: Test scores do not tell the entire story of an applicant's potential for success or what they can contribute to a program by admission. The holistic review process is tailored to the mission and needs of each program that adopts the approach. Including these additional criteria allows programs to assess an applicant as an individual and gain a greater sense of institutional fit as the new recruitment process allows committees to align application requirements to the institution's mission and goals. For example, institutions that have missions oriented around social justice or desire to see more physicians engaged in social justice work in the profession at large can make social justice work a selection criterion for prospective graduate medical trainees. (Garrick JF et al. 2019)

Variation:
A Neurosurgery department requires resident recruitment committee members to undergo implicit bias training as well as training on microaggressions before they are allowed to work on the committee to review application materials or interview residents. Faculty are also equipped and trained with the tools of the holistic review process, assessment rubrics, interview questions, review of applications by more than one reviewer.

Example of the Resident Recruitment Strategy Subtopic – Holistic Review Approach



ACGME EQUITYMATTERS™

SECOND Trial website shown with permission from Dr. Bilimoria

ACGME sources of DEI data

- Annual Program Update
  - Two narrative questions on recruitment and retention of residents/fellows and of faculty
  - Mission statement
- Resident Roster
  - Demographic data (Race/ethnicity/gender)
  - Related program data
- Resident/Faculty Surveys
  - Mistreatment questions (witnessed/observed)
  - Involvement in recruitment activities
- Complaints and concerns process
- Dismissal, withdrawal, transfer, unsuccessful completion, death
  - Cause categories only
- Milestones evaluations
- Board certification rate

Data collection and reporting

ACGME has demographic data for approximately 75-80% of residents on R/E and nearly 100% by gender through secondhand program director reports on ADS

Missing data are important

Nonuniform method of collection/reporting

ACGME currently collects no data on faculty and GME staff (CCC, GMECs, PD, DIO, coordinators, CEOs, CAO, etc.) – Inconsistent with current CPR I.C. - accreditation data missing element

We can't know what happens to our graduates and their impact on health care without better data.

AAMC Association of American Medical Colleges

AMA AMERICAN MEDICAL ASSOCIATION

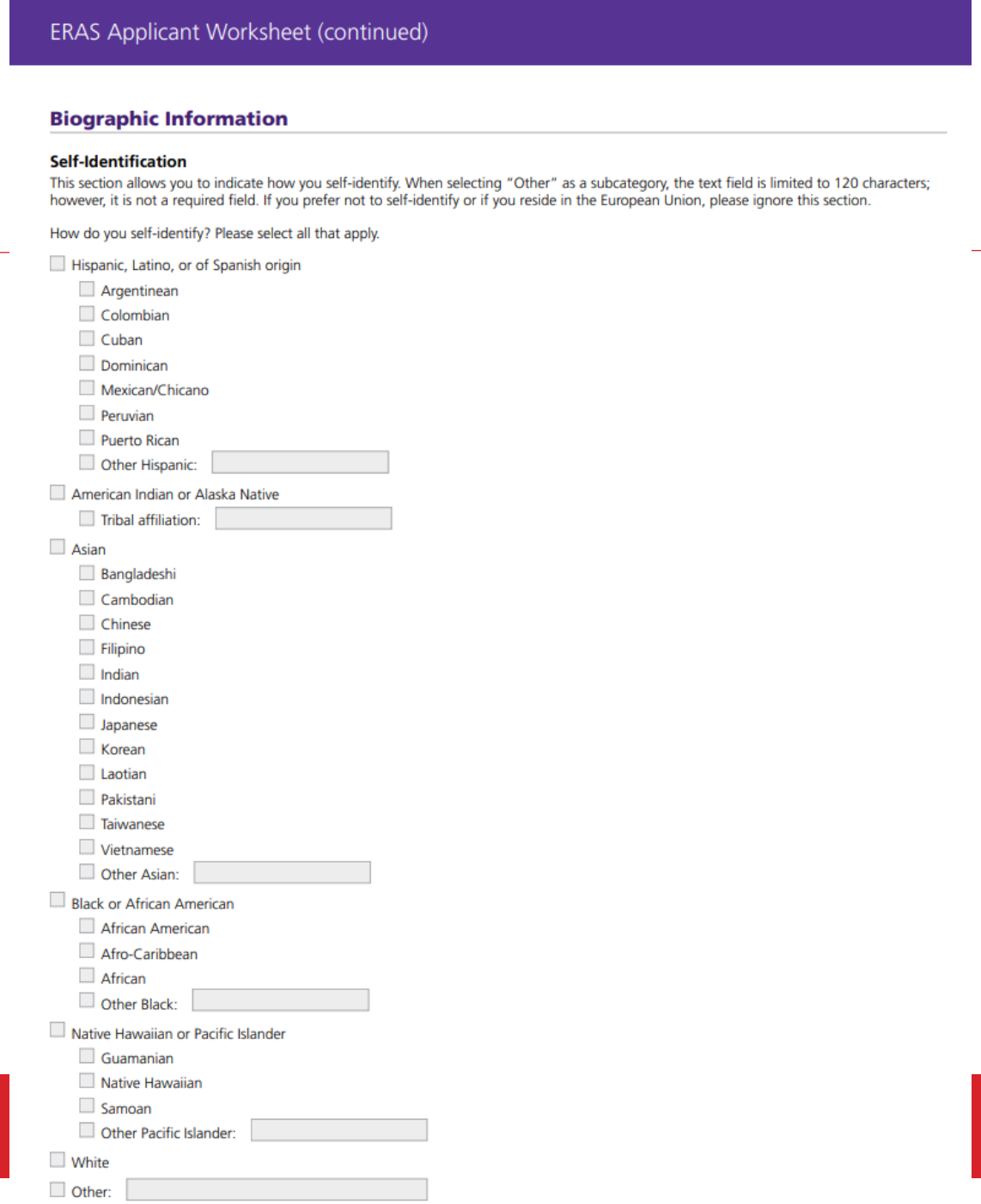
Accreditation Council for Graduate Medical Education

Physician Data Collaborative

First meeting to align categories for collecting and reporting occurred in August 2019. At the time, there were three different instruments the organizations employed to collect data and three different ways they used to report it.

AAMC data collection

- LHS+ identities are listed alongside with racial categories
- Lends itself to the choice of ethnicity only for LHS+ identifying individuals (Mexican Americans, who may not choose to consider themselves any particular race
- Doesn't distinguish race from ethnicity for LHS+ selection and offer the dichotomy of ethnicity and race



ERAS Applicant Worksheet (continued)

Biographic Information

Self-Identification

This section allows you to indicate how you self-identify. When selecting "Other" as a subcategory, the text field is limited to 120 characters; however, it is not a required field. If you prefer not to self-identify or if you reside in the European Union, please ignore this section.

How do you self-identify? Please select all that apply.

- ☐ Hispanic, Latino, or of Spanish origin
  - ☐ Argentinean
  - ☐ Colombian
  - ☐ Cuban
  - ☐ Dominican
  - ☐ Mexican/Chicano
  - ☐ Peruvian
  - ☐ Puerto Rican
  - ☐ Other Hispanic:
- ☐ American Indian or Alaska Native
  - ☐ Tribal affiliation:
- ☐ Asian
  - ☐ Bangladeshi
  - ☐ Cambodian
  - ☐ Chinese
  - ☐ Filipino
  - ☐ Indian
  - ☐ Indonesian
  - ☐ Japanese
  - ☐ Korean
  - ☐ Laotian
  - ☐ Pakistani
  - ☐ Taiwanese
  - ☐ Vietnamese
  - ☐ Other Asian:
- ☐ Black or African American
  - ☐ African American
  - ☐ Afro-Caribbean
  - ☐ African
  - ☐ Other Black:
- ☐ Native Hawaiian or Pacific Islander
  - ☐ Guamanian
  - ☐ Native Hawaiian
  - ☐ Samoan
  - ☐ Other Pacific Islander:
- ☐ White
- ☐ Other:

Demographic reporting

Using a multiple race mutually exclusive group to categorize individuals who choose more than one value in separate categories (e.g., Asian and Black = multiple race)

Using the IPEDS methodology that defaults to Hispanic as a mutually exclusive category in any combination when it is chosen and discounts other selections (e.g., Hispanic and Black = Hispanic)

Using the AAMC methodology of alone and in combination, which separates individuals who have only chosen a single category from those who have chosen that and another category and then adds each group's total number of counts (e.g., Asians who also chose Black get added to the Black Alone or in combination group to show all Black respondents). This results in overcounting.

Hispanic

Table 6. Race and Hispanic Ethnicity of Resident Physicians on Duty as of December 31, 2020, by Type of Medical School From Which They Graduated[a]

	No. (%)			
	US and Canadian allopathic	US osteopathic	Non-US	Total
Race[b]				
American Indian/Alaska Native	171 (66.8)	38 (14.8)	47 (18.4)	256
Asian	19 833 (52.2)	4967 (13.1)	13 204 (34.7)	38 004
Black	5430 (63.9)	577 (6.8)	2485 (29.3)	8492
Native Hawaiian/Pacific Islander	79 (57.2)	23 (16.7)	36 (26.1)	138
White	51 267 (68.2)	14 418 (19.2)	9432 (12.6)	75 117
Multiracial	3121 (66.9)	690 (14.8)	856 (18.3)	4667
Other/unknown	8180 (45.8)	2777 (15.5)	6912 (38.7)	17 869
Ethnicity[b]				
Hispanic	7761 (60.7)	1128 (8.8)	3905 (30.5)	12 794
Non-Hispanic	80 320 (61.0)	22 362 (17.0)	29 067 (22.1)	131 749
Total[c]	**88 081**	**23 490**	**32 972**	**144 543**

Abbreviation: GME, graduate medical education.

[a] Includes resident physicians on duty as of December 31, 2020, reported through the 2020 National GME Census. A total of 55 programs (0.4%) did not provide updated information on residents by March 1, 2021. For these nonresponding programs, resident physicians reported from the last received survey were moved into their next year in the program or graduated.

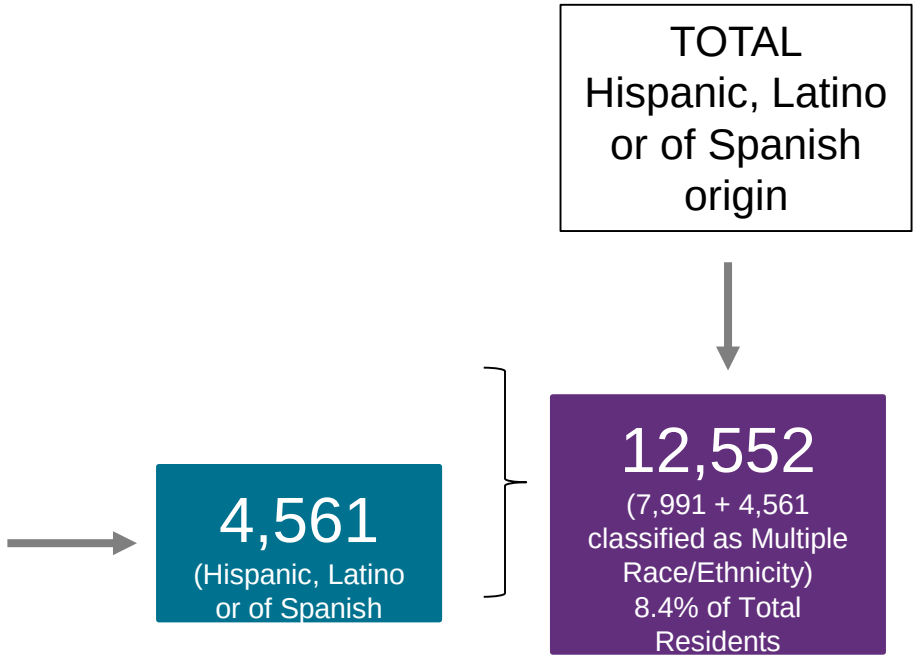
[b] The 2020 National GME Census imported self-designated race and ethnicity from Association of American Medical Colleges databases where available. "Multiracial" refers to residents who have self-identified as more than 1 race. A person of Hispanic ethnicity may be of any race. Race and Hispanic ethnicity were imputed for residents with missing values for race and Hispanic ethnicity for 2202 (1.5%) and 311 (0.2%) residents, respectively, using birth country and the US 2010 Census Surname Table, using names of 80% or greater known race or Hispanic ethnicity.

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

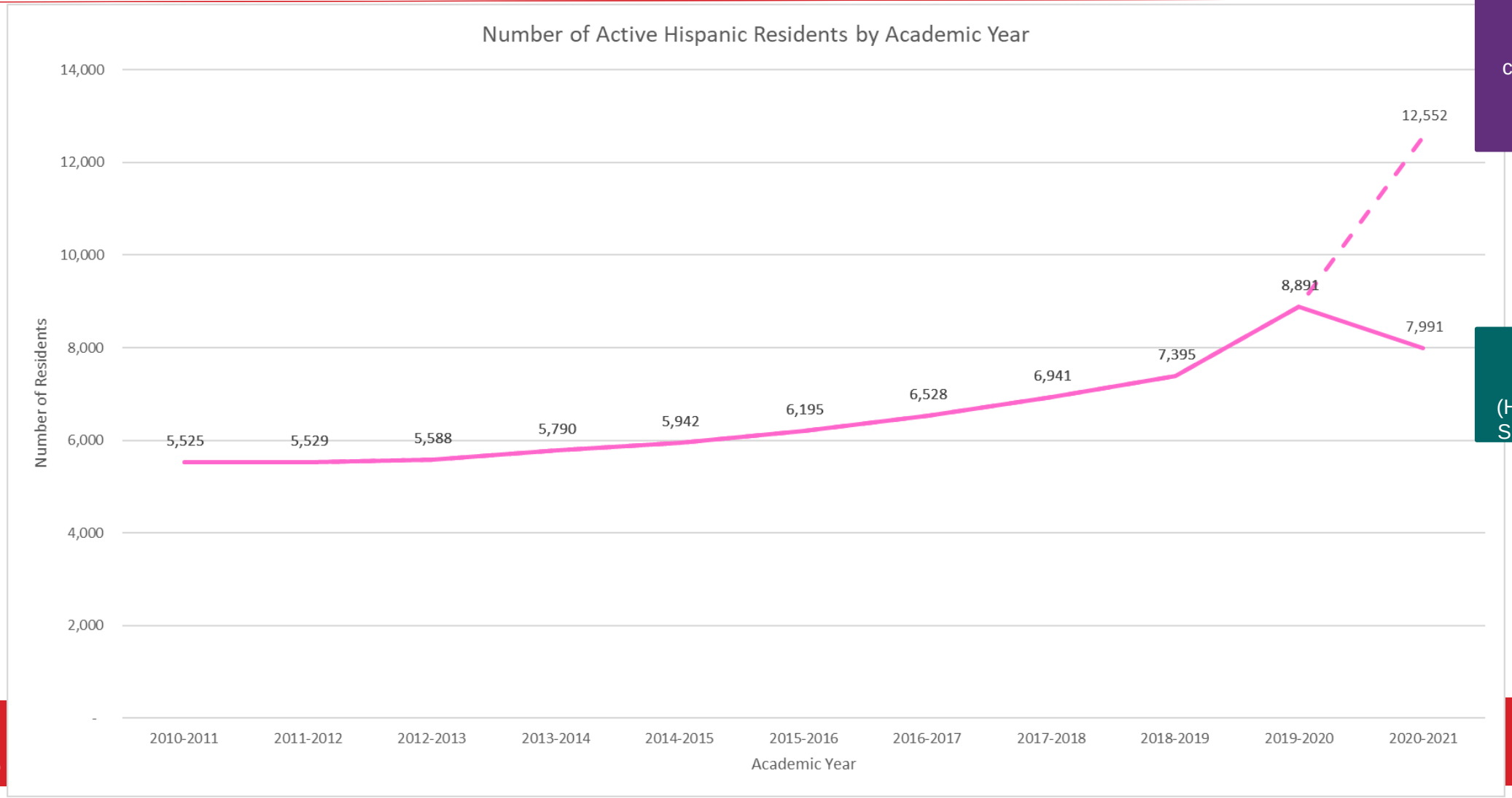
Number of Active Residents by Race/Ethnicity (AAMC Self-Reported) 2020-2021

(Hispanic, Latino or of Spanish origin Breakdown)

Race/Ethnicity	N	%
White	74,025	49.6%
Asian	38,394	25.7%
Hispanic, Latino or of Spanish origin	7,991	5.4%
Black or African American	8,305	5.6%
American Indian or Alaskan Native	152	0.1%
Native Hawaiian or Pacific Islander	61	0.0%
Multiple Race/Ethnicity	10,263	6.9%
Other	4,050	2.7%
Prefer not to report	5,959	4.0%
OVERALL	149,200	100.0%



Number of Active Residents by Race/Ethnicity and Academic Year
(Hispanic, Latino or of Spanish origin Breakdown)



12,552
(7,991 + 4,561 classified as Multiple Race/Ethnicity)
8.4% of Total Residents

7,991
(Hispanic, Latino or of Spanish origin ONLY)

Table A-14.3: Race/Ethnicity Responses (Alone and In Combination) of Matriculants to U.S. MD-Granting Medical Schools, 2017-2018 through 2021-2022

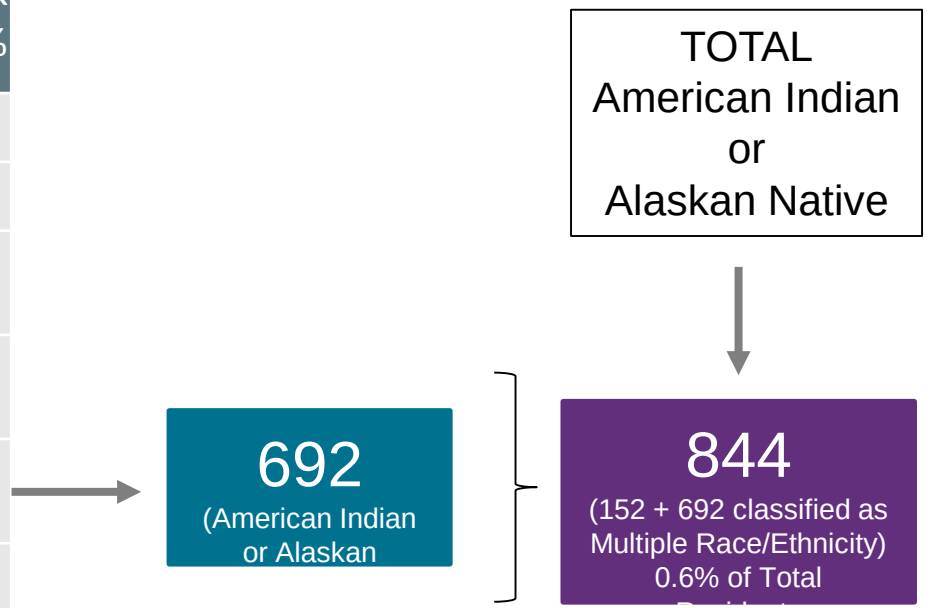
The table below displays the self-identified racial and ethnic characteristics of matriculants to U.S. MD-granting medical schools from 2017-2018 through 2021-2022. "Alone" indicates those who selected only one race/ethnicity response. "In Combination" indicates those who selected more than one race/ethnicity response. Please email datarequest@aamc.org if you need further assistance or have additional inquiries.

Matriculant Race/Ethnicity Responses		2017-2018	2018-2019	2019-2020	2020-2021	2021-2022
American Indian or Alaska Native	Alone	42	39	44	36	40
	In Combination	163	179	186	212	187
	Alone or In Combination	205	218	230	248	227
Asian	Alone	4,481	4,787	4,687	4,803	5,153
	In Combination	685	699	744	740	851
	Alone or In Combination	5,166	5,486	5,431	5,543	6,004
Black or African American	Alone	1,505	1,540	1,627	1,767	2,124
	In Combination	270	316	289	350	438
	Alone or In Combination	1,775	1,856	1,916	2,117	2,562
Hispanic, Latino, or of Spanish Origin	Alone	1,383	1,350	1,412	1,524	1,575
	In Combination	912	969	1,054	1,154	1,294
	Alone or In Combination	2,295	2,319	2,466	2,678	2,869
Native Hawaiian or Other Pacific Islander	Alone	14	23	13	14	13
	In Combination	54	52	82	66	72
	Alone or In Combination	68	75	95	80	85
White	Alone	10,585	10,783	10,184	9,944	9,580
	In Combination	1,553	1,698	1,858	1,930	2,102
	Alone or In Combination	12,138	12,481	12,042	11,874	11,682
Other	Alone	388	381	379	470	480
	In Combination	309	346	338	380	404
	Alone or In Combination	697	727	717	850	884
Unknown Race/Ethnicity		765	394	1,073	1,094	798
Non-U.S. Citizen and Non-Permanent Resident		275	280	272	276	328
Unduplicated Total Matriculants		***21,338***	***21,622***	***21,869***	***22,239***	***22,666***

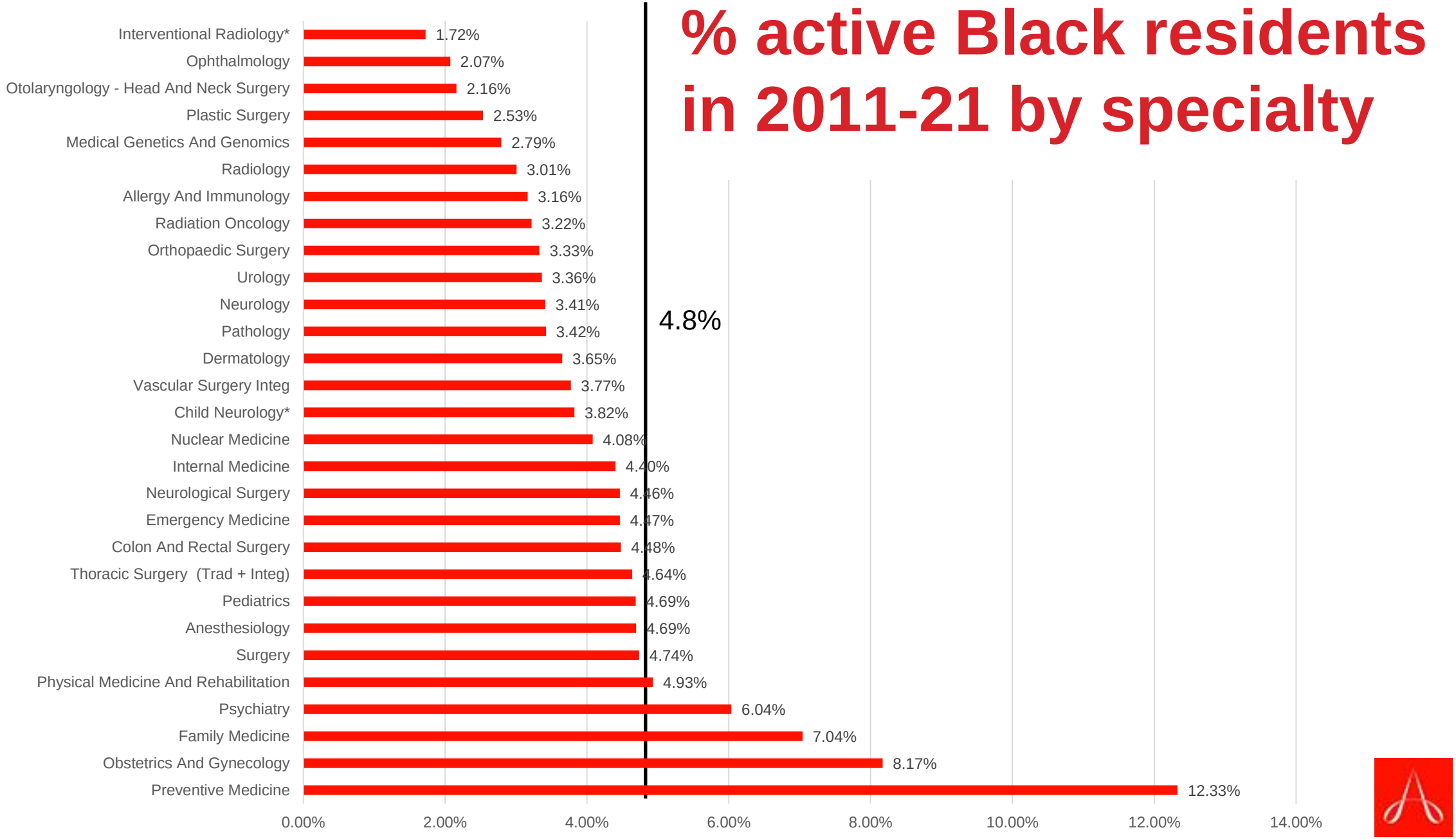
Number of Active Residents by Race/Ethnicity (AAMC Self-Reported) 2020-2021

(American Indian or Alaskan Native Breakdown)

Race/Ethnicity	2019-20	2020-21	%2020-21	GME Track 2020-21	GME Track 2020-21 %
White	68,835	74,025	49.6%	75,117	52.0%
Asian	29,256	38,394	25.7%	38,004	26.3%
Hispanic, Latino or of Spanish origin	8,891	7,991	5.4%	12,794	8.8%
Black or African American	7,376	8,305	5.6%	8,492	5.9%
American Indian or Alaskan Native	428	152	0.10%	256	0.18%
Native Hawaiian or Pacific Islander	231	61	0.041%	138	0.10%
Multiple Race/Ethnicity	-	10,263	6.9%	4,667	3.2%
Other	9,615	4,050	2.7%	-	-
Unknown	20,356	5,845	3.9%	17,869	12.4%
Prefer not to report	-	114	0.076%	-	-
OVERALL	144,988	149,200	100.0%	144,543*	100%*

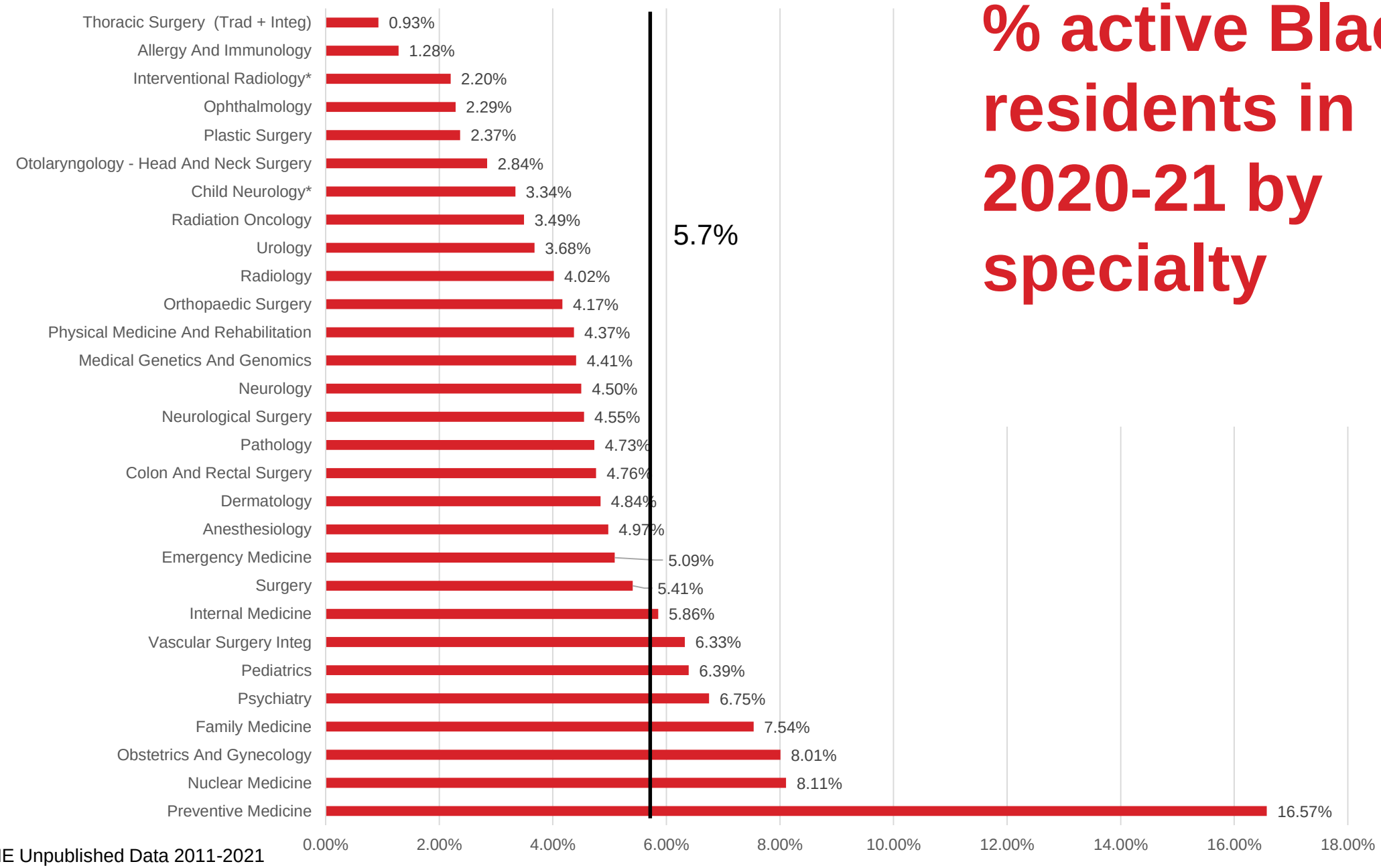


% active Black residents in 2011-21 by specialty



ACGME Unpublished Data 2011-2021

% active Black residents in 2020-21 by specialty



ACGME Unpublished Data 2011-2021

Program data active core urology residents 2021-2022

There are 84 Black residents across all 5 years of the 145 urology core programs. 16 programs (11.0%) account for 50% of all Black residents. 41.2% (60) of programs account for all Black residents. 92 programs (63.4%) do not have a single Black resident in all 5 years

There are 161 LHS+ residents across all 5 years of the 145 urology core programs. 24 programs (16.6%) account for 50% of all LHS+ residents. 60.0% (87) of programs account for all LHS+ residents. 58 programs (40.0%) do not have a single LHS+ resident in all 5 years

Number of programs reporting residents of this number	Number of Hispanic, Latino or of Spanish urology residents per program	Total LHS+ urology residents	Number of programs reporting residents of this number	Number of Black or African American urology residents per program	Total Black urology residents	Number of programs reporting residents of this number	Number of UIM urology residents per program	Total UIM in urology residents
1	11	11	2	4	8	1	11	11
0	10	0	6	3	18	0	10	0
0	9	0	13	2	26	1	9	9
0	8	0	32	1	32	0	8	0
0	7	0	92	0	0	1	7	7
0	6	0	145		84	4	6	24
4	5	20				3	5	15
3	4	12				6	4	24
6	3	18				17	3	51
27	2	54				35	2	70
46	1	46				36	1	36
58	0	0				41	0	0
145		161				145		247

ACGME unpublished data 2020-2021

Program data active core anesthesiology residents 2021-2022

There are 314 Black residents across all 4 years of the 161 anesthesiology core programs. 23 programs (14.3%) account for 50% of all Black residents. 65.8% (106) of programs account for all Black residents. 56 programs (34.8%) do not have a single Black resident in all 4 years

There are 263 LHS+ residents across all 4 years of the 161 anesthesiology core programs. 27 programs (16.8%) account for 50% of all LHS+ residents. 66.4% (107) of programs account for all LHS+ residents. 54 programs (33.5%) do not have a single LHS+ resident in all 4 years

Number of programs reporting residents of this number	Number of Hispanic, Latino or of Spanish residents per program	Total LHS+ anesthesiology residents
1	11	11
0	10	0
0	9	0
2	8	16
1	7	7
2	6	12
6	5	30
11	4	44
13	3	39
34	2	68
37	1	37
54	0	0
161		264

Number of programs reporting residents of this number	Number of Black or African American residents per program	Total Black anesthesiology residents
3	10	30
1	9	9
3	8	24
3	7	21
6	6	36
5	5	25
9	4	36
17	3	51
24	2	48
34	1	34
56	0	0
161		314

Number of programs reporting residents of this number	Number of UIM Emergency Med residents per program	Total UIM in anesthesiology residents
1	18	18
0	17	0
0	16	0
1	15	15
1	14	14
0	13	0
3	12	36
3	11	33
4	10	40
2	9	18
8	8	64
6	7	42
12	6	72
9	5	45
19	4	76
15	3	45
21	2	42
32	1	32
24	0	0
161		592

ACGME unpublished data 2020-2021

Program data active core general surgery residents 2021-2022

There are 365 Black residents across all 5 years of the 340 gen surgery core programs. 47 programs (13.8%) account for 50% of all Black residents. 52.9% (180) of programs account for all Black residents. 160 programs (47.1%) do not have a single Black resident in all 5 years

There are 422 LHS+ residents across all 5 years of the 340 gen surgery core programs. 44 programs (12.9%) account for 50% of all LHS+ residents. 58.5% (199) of programs account for all LHS+ residents. 141 programs (41.5%) do not have a single LHS+ resident in all 5 years

Number of programs reporting residents of this number	Number of Hispanic, Latino or of Spanish residents per program	Total LHS+ gen surg residents
1	24	24
1	13	13
1	10	10
1	9	9
0	8	0
2	7	14
1	6	6
6	5	30
11	4	44
25	3	75
47	2	94
103	1	103
141	0	0
340		422

Number of programs reporting residents of this number	Number of Black or African American residents per program	Total Black gen surg residents
1	15	15
0	14	0
0	13	0
0	12	0
0	11	0
0	10	0
0	9	0
0	8	0
2	7	14
1	6	6
6	5	30
10	4	40
24	3	72
52	2	104
84	1	84
160	0	0
340		365

Number of programs reporting residents of this number	Number of UIM Emergency Med residents per program	Total UIM in gen surg residents
1	24	24
1	15	15
1	13	13
3	10	30
1	9	9
4	8	32
10	7	70
12	6	72
19	5	95
26	4	104
49	3	147
59	2	118
71	1	71
83	0	0
340		800

ACGME unpublished data 2020-2021

Program data active core EM residents 2021-2022

There are 330 Black residents across all 4 years of emergency medicine in 350 core programs. 29 programs (8.8%) account for half of all Black residents. 41.1% (144) of programs account for all Black residents. 206 programs (58.9%) do not have a single Black resident in all 4 years

There are 303 LHS+ residents across all 4 years of emergency medicine in 350 core programs. 29 programs (8.8%) account for 50% of all LHS+ residents. 40.0% (140) of programs account for all LHS+ residents. 210 programs (60.0%) do not have a single LHS+ resident in

Number of programs reporting residents of this number	Number of Hispanic, Latino or of Spanish residents per program	Total LHS+ Emergency Med residents	Number of programs reporting residents of this number	Number of Black or African American residents per program	Total Black Emergency Med residents	Number of programs reporting residents of this number	Number of UIM Emergency Med residents per program	Total UIM in Emergency Med
1	14	14	1	15	15	3	15	45
0	13	0	0	14	0	2	14	28
1	12	12	0	13	0	0	13	0
0	11	0	0	12	0	2	12	24
1	10	10	1	11	11	5	11	55
0	9	0	1	10	10	2	10	20
2	8	16	1	9	9	2	9	18
1	7	7	0	8	0	1	8	8
3	6	18	4	7	28	0	7	0
3	5	15	3	6	18	10	6	60
6	4	24	6	5	30	14	5	70
18	3	54	8	4	32	15	4	60
29	2	58	12	3	36	31	3	93
75	1	75	34	2	68	45	2	90
210	0	0	73	1	73	75	1	75
350		303	206	0	0	143	0	0
			350		330	350		646

ACGME unpublished data 2020-2021

Program data active core psychiatry residents 2021-2022

There are 302 LHS+ residents across all 4 years of the 285 psychiatry core programs. 30 programs (9.9%) account for 50% of all LHS+ residents. 48.4% (138) of programs account for all LHS+ residents. 147 programs (51.6%) do not have a single LHS+ resident in all 4 years

There are 374 Black residents across all 4 years in the 285 psychiatry core programs. 32 programs (11.2%) account for 50% of all Black residents. 52.3% (149) of programs account for all Black residents. 136 programs (47.7%) do not have a single Black resident in all 4 years

Number of programs reporting residents of this number	Number of Hispanic, Latino or of Spanish residents per program	Total LHS+ psychiatry residents
1	13	13
0	12	0
1	11	11
0	10	0
2	9	18
1	8	8
3	7	21
1	6	6
2	5	10
5	4	20
18	3	54
37	2	74
67	1	67
147	0	0
285		302

Number of programs reporting residents of this number	Number of Black or African American residents per program	Total Black psychiatry residents
2	11	22
1	10	10
2	9	18
2	8	16
3	7	21
2	6	12
8	5	40
13	4	52
19	3	57
29	2	58
68	1	68
136	0	0
285		374

Number of programs reporting residents of this number	Number of UIM Emergency Med residents per program	Total UIM in psychiatry residents
1	14	14
2	13	26
4	12	48
3	11	33
2	10	20
3	9	27
7	8	56
5	7	35
9	6	54
17	5	85
8	4	32
34	3	102
48	2	96
60	1	60
82	0	0
285		688

ACGME unpublished data 2020-2021

Program data active core pediatrics residents 2021-2022

There are 414 Black residents across all 3 years of the 209 pediatric core programs. 34 programs (16.3%) account for 50% of all Black residents. 72.2% (151) of programs account for all Black residents. 58 programs (27.8%) do not have a single Black resident in all 3 years

There are 446 LHS+ residents across all 3 years of pediatric core programs. 28 programs (13.4%) account for 50% of all LHS+ residents. 71.3% (149) of programs account for all LHS+ residents. 60 programs (28.7%) do not have a single LHS+ resident in all 3 years

Number of programs reporting residents of this number	Number of Hispanic, Latino or of Spanish residents per program	Total LHS+ pediatrics residents
1	23	23
1	20	20
1	13	13
2	11	22
2	10	20
1	9	9
4	8	32
3	7	21
3	6	18
5	5	25
10	4	40
26	3	78
35	2	70
55	1	55
60	0	0
209		446

Number of programs reporting residents of this number	Number of Black or African American residents per program	Total Black pediatrics residents
1	11	11
1	10	10
1	9	9
3	8	24
5	7	35
9	6	54
7	5	35
13	4	52
19	3	57
35	2	70
57	1	57
58	0	0
209		414

Number of programs reporting residents of this number	Number of UIM Emergency Med residents per program	Total UIM in pediatrics residents
2	24	48
1	20	20
1	18	18
1	14	14
2	13	26
4	12	48
2	11	22
5	10	50
6	9	54
7	8	56
10	7	70
11	6	66
15	5	75
26	4	104
31	3	93
34	2	68
32	1	32
19	0	0
209		864

ACGME unpublished data 2020-2021

Historically Black Medical Schools

Howard University

Meharry Medical School

Moreshouse School of Medicine

Charles Drew University of Medicine and Science

Harlem Hospital Center*

*Historically Black teaching hospital

Residency programs at HBCUs

Howard University Programs

Dermatology
Family medicine
Internal medicine
Cardiovascular disease
Endocrinology, diabetes, and metabolism
Gastroenterology
Infectious disease
Pulmonary disease
Neurology
Obstetrics and gynecology
Ophthalmology
Orthopaedic surgery
Pathology-anatomic and clinical
Psychiatry
Addiction medicine (multidisciplinary)
Surgery

Morehouse School of Medicine Programs

Family medicine
Internal medicine
Cardiovascular disease
Pulmonary disease and critical care medicine
Obstetrics and gynecology
Pediatrics
Psychiatry Child and adolescent psychiatry
Surgery
Preventive medicine

Residency programs at HBCUs

Charles Drew University Programs

Internal medicine
Psychiatry

Meharry Medical School Programs

Preventive medicine (Occupational Medicine)
Family medicine
Sports medicine (Family medicine)
Internal medicine
Obstetrics and gynecology
Psychiatry
Preventive medicine (Preventive Medicine)

Harlem Hospital Center Programs

Internal Medicine
Gastroenterology
Infectious Disease
Nephrology
Pediatrics
Psychiatry
Pulmonary Disease
Radiology -Diagnostic
Surgery

Underperforming specialties relative to presence in HBCUs

Specialty	Howard	Meharry	Morehouse	Drew	Harlem
Thoracic Surgery (Trad + Integ)					
Allergy And Immunology					
Interventional Radiology*					
Ophthalmology	x				
Plastic Surgery					
Otolaryngology - Head And Neck Surgery					
Child Neurology*					
Radiation Oncology					
Urology					
Radiology					x
Orthopaedic Surgery	x				
Medical Genetics and Genomics					
Vascular Surgery Integ					
Dermatology	x				
Pathology	x				
Neurology	x				

Outsized effect of HBCUs

For those relatively underrepresented core specialties at HBCUs, typically there is an outsized effect on the number of Black residents who are trained in the discipline (ophthalmology, orthopedic surgery, dermatology, and to a lesser extent, pathology).

There are exceptions (neurology and radiology) where the HBCU effect is not present and in fact the HBCUs do not contribute significantly to the diversity of that specialty.

With the propensity to impact national totals of physicians in undersubscribed specialties, starting new programs or expanding existing ones at HBCU-associated medical residencies represents an important strategy to address workforce numbers of Black specialist physicians.

Need for UIM specialists as well

The risk to HBCU-associated residency training programs represents a formidable risk to the production of a diverse workforce and there must be extreme intention applied to these institutions to ensure their continued success.

The distribution of Black residents at predominantly White residency programs is typically a small fraction of the available programs (44-77% of specialties in particular disciplines lack a single Black resident in all years of training). Thus, there is room for growth, if all programs make intentional efforts to expand their diversity.

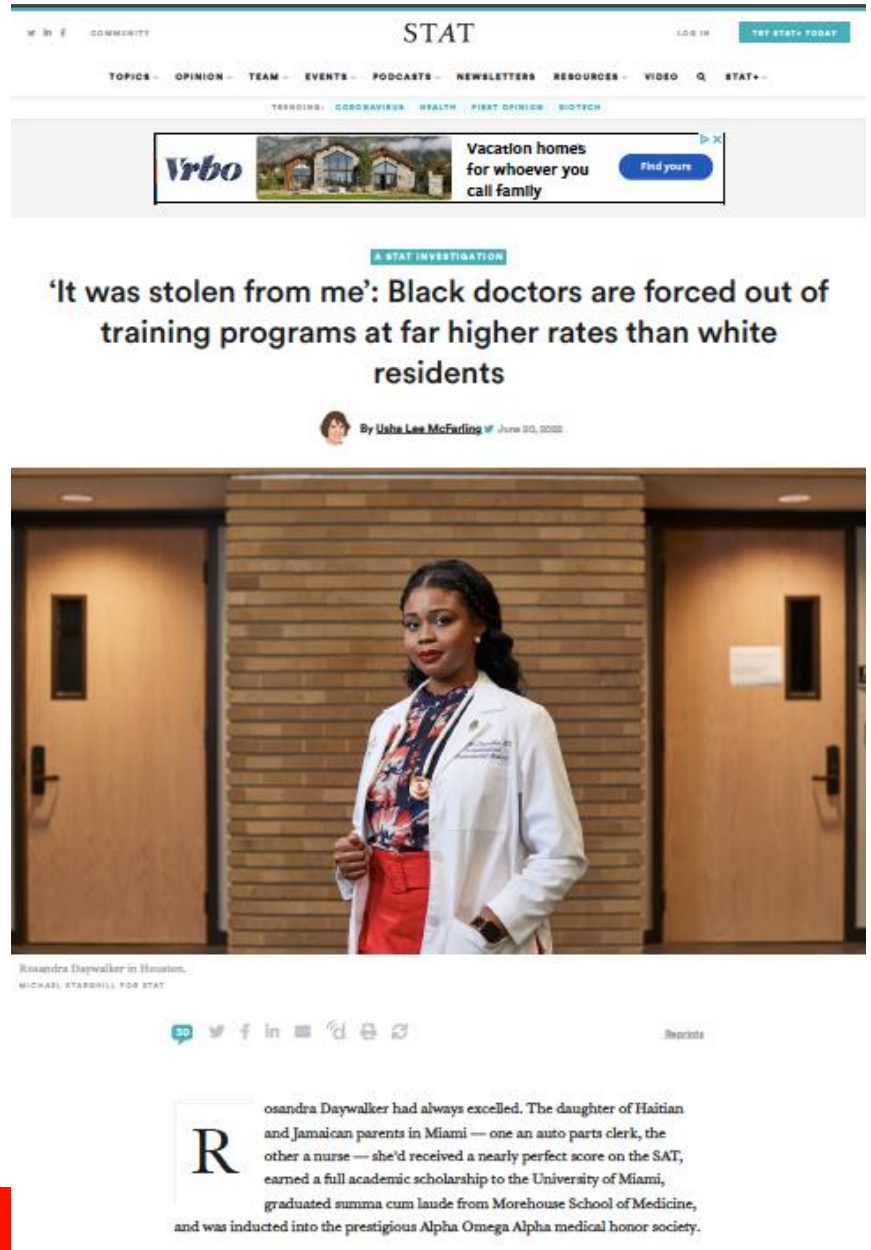
The need for Black specialists continues to be controversial with emphasis placed on primary care by many contributors. However, having access to specialty care is a frequent problem experienced by primary care physicians, and so workforce development in specialty care should remain a priority as well.

Premature departure of UIM residents makes headlines

Very few Black residents are dismissed annually (n =17- 47) and represent 0.2-0.8% of Black residents in training

Blacks are disproportionately dismissed relative to their numbers in GME compared to their White counterparts that varies by specialty

Blacks withdraw at a disproportionate rate



Need for better clarity around decision to separate from training

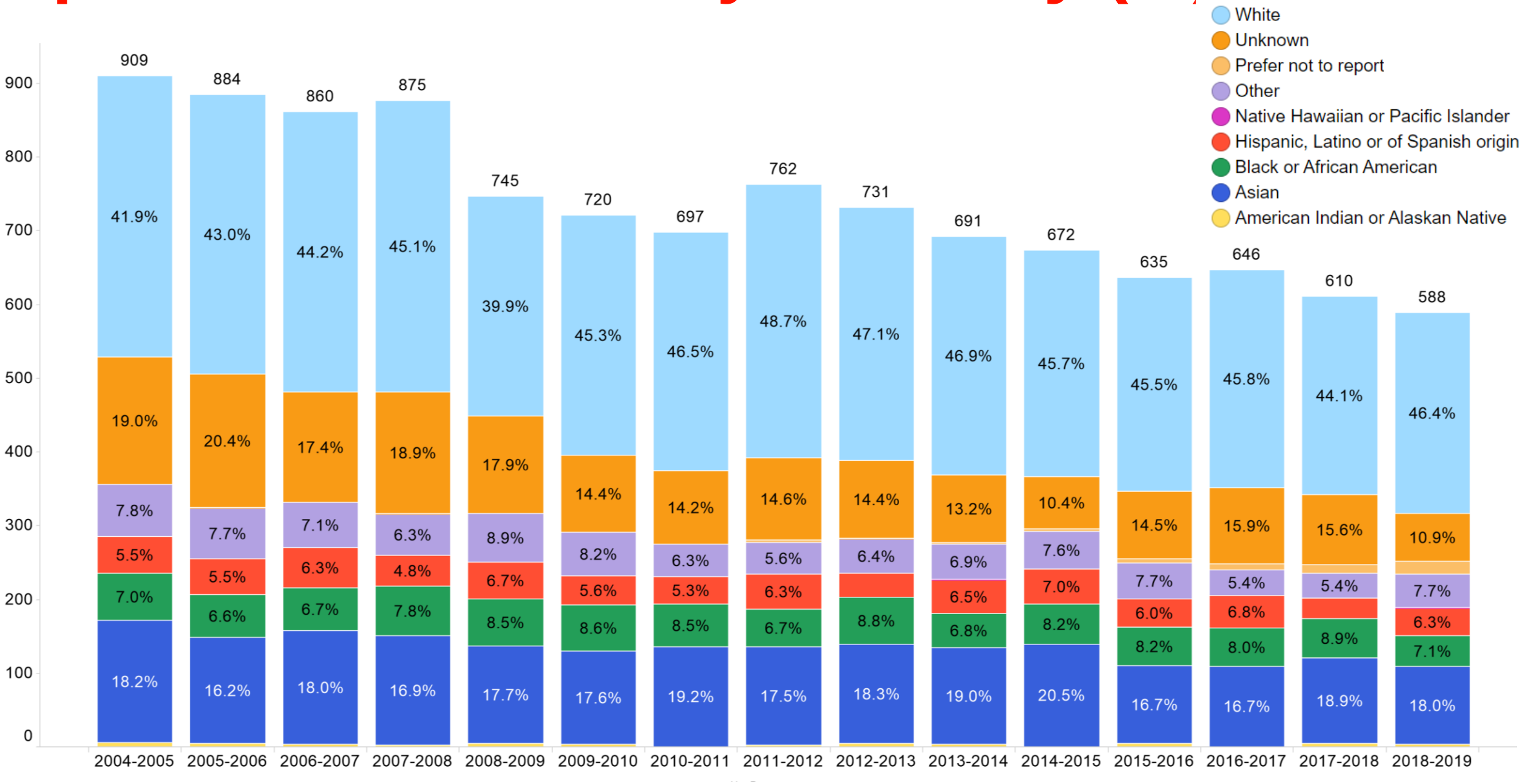
- Withdrawal (Undifferentiated):
  - Voluntary, in good standing, resident choice
  - Voluntary, in good standing, but poor program fit
  - Involuntary- incentivized or coerced
- Dismissal/Non-renewal – Involuntary prior to contract term or at end of current contract
- Transfer – identified same specialty move
- Unsuccessfully completed program
- Death: Accident, Medical, Suicide, unknown

ACGME collects no data on probation or metadata on status change

2011-2012 to 2015-2016	Dismissed	
Category	N	%
Academic/Performance Deficiency	546	48.23%
Terminated	195	17.23%
Professionalism	171	15.11%
Medical Reasons	27	2.39%
Personal Reasons	16	1.41%
Visa/Work Permit Issues	10	0.88%
Other	167	14.75%
Grand Total	1,132	100.00%

2011-2012 to 2015-2016	Withdrew from Program	
Category	N	%
Pursuing Another Specialty/Career Change	1,045	30.05%
Resigned	713	20.50%
Personal Reasons	494	14.20%
Medical Reasons	287	8.25%
Family Reasons	258	7.42%
Academic/Performance Deficiency	170	4.89%
Military Commitment	64	1.84%
Professionalism	48	1.38%
Visa/Work Permit Issues	11	0.32%
Other	388	11.16%
Grand Total	3,478	100.00%

Pipeline Withdrawn by Ethnicity (%)



Residents Dismissed 2010-2020

Academic Year Range	2010-2011	2011-2012	2012-2013	2013-2014	2014-2015	2015-2016	2016-2017	2017-2018	2018-2019	2019-2020	
Resident Ethnicity											
American Indian or Alaskan Native	2		1	1					1	1	**6**
Asian	0								47	53	**100**
Asian or Pacific Islander	42	58	54	56	35	43	36	47			**371**
Black or African American	40	39	31	35	36	47	23	44	32	19	**346**
Hispanic, Latino or of Spanish origin	13	14	7	13	10	18	14	15	12	16	**132**
Multiple Race/Ethnicity									21	16	**37**
Other	27	19	26	20	25	18	19	27	7	11	**199**
Prefer not to report									1		**1**
Unknown	53	49	36	47	50	48	38	61	11	5	**398**
White	77	83	96	74	62	75	81	80	98	82	**808**
Total	**254**	**262**	**251**	**246**	**218**	**249**	**211**	**274**	**230**	**203**	**2,398**

Dismissed Black residents 2015-2020 by specialty

Core SpecialtyName	2015-16	2016-17	2017-18	2018-19	2019-20	5-yr Total
Allergy and immunology	0	0	0	0	0	0
Anesthesiology	4	0	2	1	3	10
Colon and rectal surgery	0	0	0	0	0	0
Dermatology	0	0	2	1	0	3
Emergency medicine	0	0	1	3	0	4
Family medicine	5	7	9	5	7	33
Internal medicine	13	5	7	7	1	33
Medical genetics and genomics	0	0	0	0	0	0
Neurological surgery	0	0	0	1	0	1
Neurology	0	0	0	0	0	0
Nuclear medicine	0	0	0	0	0	0
Obstetrics and gynecology	3	3	4	2	0	12
Ophthalmology	0	0	0	0	0	0
Orthopaedic surgery	3	0	2	2	2	9
Osteopathic neuromusculoskeletal medicine	0	0	0	0	0	0
Otolaryngology - Head and Neck Surgery	0	0	0	0	0	0
Pathology-anatomic and clinical	2	0	1	1	0	4
Pediatrics	3	1	2	2	0	8
Physical medicine and rehabilitation	0	0	1	0	0	1
Plastic surgery	0	0	0	0	0	0
Plastic Surgery - Integrated	0	0	0	0	0	0
Preventive medicine	0	1	2	0	0	3
Psychiatry	3	0	3	2	2	10
Radiation oncology	0	0	0	0	0	0
Radiology-diagnostic	1	1	0	1	1	4
Surgery	8	3	3	3	1	18
Thoracic surgery	0	0	0	0	0	0
Thoracic surgery - integrated	0	0	0	0	0	0
Transitional year	0	1	1	0	0	2
Urology	1	0	0	0	0	1
Total Dismissed	46	22	40	31	17	
Total Blacks in training	5714	5811	5981	6184	7376	

Why is ACGME not transparent with dismissal data?

The numbers are so small that they permit the identification of individuals and the protection ACGME extends to individuals' data would be breeched.

Because of the concentration of UIM residents in a small number of programs, these programs would be seen to cause a greater burden of dismissals from training. The real issue is that not enough programs have UIM trainees in their ranks and if you don't have trainees, you aren't dismissing any.

By reporting programs that have dismissed UIM residents, it may cause UIM residents to avoid those programs, even when reforms have occurred to improve learning conditions.

By identifying individual programs, it may cause them to decrease efforts to select UIM trainees holistically, relying on norms that are biased against UIM candidate.

Challenges to diversity in GME

There is currently too little diversity within the leadership and faculty in GME programs. The result is a lack of experience and expertise in addressing barriers faced by diverse residents.

There is too little effective effort to enhance number of UIM individuals on the pathway to medicine (e.g., Improved educational equity, increased outreach to younger learners, provision of opportunities to be exposed and stimulated in biomedical science careers, support for postbaccalaureate programs, etc.)

Use of standards in selection that are grounded in dominant cultural norms or structured in racism, both historical and current, exclude minoritized learners disproportionately and result in a decreased likelihood of transition from medical school into graduate medical education compared with their White peers

Challenges to diversity in GME

Concentration of training of UIMs in a few select residency programs instead of widespread training distribution (e.g., Overreliance on residency programs affiliated with HBCUs)

Disproportionate dismissal and withdrawal of UIM residents once in training that may be grounded in ineffective efforts to: Eliminate unconscious bias in evaluation; redress harmful behaviors towards them, including microaggressions and other burnout and depression inducing acts; embrace antiracism in learning environments as it impacts the learning space and the patient care space; and, provide resources according to need holistically for all learners in the environment.

Uniform method of data collection/reporting that permits a cleaner picture of the status of diversity in across the continuum of the medical worforce.

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Thank you