

# Creating greater diversity in medical schools and residencies

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## Featured topic and speakers

AMA Chief Experience Officer Todd Unger speaks with physicians about how the COVID-19 pandemic has amplified the lack of diversity in the physician workforce, and how to create a more diverse health care workforce beginning with medical school admissions and residency selection.

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## Speakers

- Kimberly Lomis, MD, vice president, UME Innovations, AMA
- William McDade, MD, MPH, chief diversity and inclusion officer, ACGME
- Tanya Fancher, MD, MPH, director, Center for a Diverse Healthcare Workforce, UC Davis Health

## Transcript

**Unger:** This is the American Medical Association's COVID-19 update. Today, we're talking about creating a more diverse health care workforce beginning with medical school admissions and residency selection. I'm joined today by Dr. William McDade, chief diversity and inclusion officer at the Accreditation Council for Graduate Medical Education, or ACGME, in Chicago. Dr. Tonya Fancher, associate dean and director of the Center for a Diverse Healthcare Workforce at the University of California Davis Health in Sacramento, California. And Dr. Kimberly Lomis AMA's vice president of UME innovations in Nashville. I'm Todd Unger, AMA's chief experience officer in Chicago.

Lack of diversity in the physician workforce is not new but, like so many things, the COVID-19 pandemic has really amplified this along with other health equity issues. Dr. McDade, why don't you

start by telling us how can a more diverse workforce help address some of the inequities that we're seeing during the pandemic?

**Dr. McDade:** Well, thanks Todd. One of the things that COVID showed is that there are underlying health disparities. And so, one of the focuses of the work that we're doing at ACGME is to try to figure out how we can reduce the deficit in health outcomes for minority populations. What we've noticed is that when African-American students are first years in medical school, about 60% of them suggest that they want to be working in an environment where they can help to eliminate health disparities in an underserved minority population. The same thing is true for Native Americans. And when you ask them as fourth year medical students, about the same numbers represent wanting to work in those fields.

And then, data from the Cambridge Health Alliance has really suggested that when in practice African-American physicians, in particular, focus on trying to take care of African-American patients to a relationship or the ratio, at least, of seeing a minority patient, if you are a minority physician for African-Americans, it's about 23 and a half or so to 1 compared to a white physician seeing a minority patient. Same thing is true for Latinx physicians seeing Latinx patients. And language also plays a role in those relationships. And for Asian physicians, it's about 26 times greater that an Asian physician will see an Asian patient relative to a white physician.

The idea that minority patients, once they choose a physician choose that physician not just because of location, or geography, but because there are additional preferences that are involved is also true. Greater trust is developed because of a same race relationship. And racial congruence, racial concordance is important in establishing better communication, better attendance to medical advice. And in a recent paper from Owen Garrick and Marcella Alsan, the suggestion that outcomes may even be improved for minority patients who see minority physicians.

**Unger:** That's a huge impact. Dr. Fancher, anything to add there?

**Dr. Fancher:** Yeah, I would add just that when we think about the need in medical education, we also think about the need for more physicians who have disabilities. So, it's not just race-related it's related to physicians with disabilities, it's really related to where they practice, as Dr. McDade suggested, we need to think about rural communities, about inner city communities, about service in tribal communities. And, also, about just different backgrounds and experiences. So, I really want us to also think about the LGBTQ physicians and what we can do to really recruit those communities as well.

**Dr. Lomis:** Yeah, so I would just concur that, obviously, diverse physicians bring so much to the care of patients. And, Todd, we have been having a really difficult conversation in our country over the last several weeks about structural racism. And, as Dr. Fancher points out, this issue is beyond just race and ethnicity, but also including lower socioeconomic status, and other groups that have been marginalized. But, essentially, the messages that medicine has not been exempt or protected from these structural processes. There are a lot of barriers to entry for diverse physicians to come and be

part of the workforce.

**Dr. Lomis:** And the AMA itself has admitted to some role in that in the past issuing of a public apology in 2008. And, as you know, most recently establishing the Center for Health Equity, where Dr. Aletha Maybank is giving us terrific guidance about how we can do better moving forward in the future. And so, what can happen is the current workforce is predominantly white, and predominantly privileged. And despite our best intentions, as physicians, we just have blind spots to the lived reality of our patients' experiences, so we can't anticipate their needs, and we can't do a good job in working with them to come up with viable options for their care.

**Unger:** Well, getting a more diverse workforce, obviously, starts with building diversity in medical school admissions and in residency selections. Dr. Fancher, can you talk about that?

**Dr. Fancher:** Yeah, absolutely. So, medical schools, we're sort of the gatekeepers right to a career in medicine. And so, the burden is really on us to develop partnerships that recruit the right physicians into our field. So, we need to partner with K through 12 programs with community colleges, and rethink the process of getting into medical school. So, traditionally, we were very much metrically driven. That's not enough, right? It's a much more complicated process to be a physician. So yes, metrics is one part of it, but it really is about what you bring to the table, what those experiences are, what your background is. That's really the connection that patients are looking for.

**Dr. Lomis:** And AMA's really invested in trying to help medical schools do a better job in this space. And, to be honest, we're entering that work with a great deal of humility. There are a lot of organizations and individuals who have been working for years to improve the diversity of entering medical school classes. And so, we're in a learning phase right now, meeting with those organizations, talking to those individuals. We're fortunate that in our Accelerating Change for Medical Education Consortium, we have a cadre of experts, including Dr. Fancher and others from across the country, who are helping us think through how we can optimize the use of holistic tools and admissions, and use the AMA's influence to propagate those practices, and extend them more fully. We have been doing some work with schools to look at bias in the educational process. And so, trying to learn from that and bring it back into the processes of admissions and selection, and really unpack that and raise awareness, is where we can see ourselves contributing

**Unger:** Dr. McDade, why don't you talk about the work at the ACGME?

**Dr. McDade:** Well, the ACGME is really focused on the resident level, the graduate medical education level. And for years graduate medical education really didn't see itself as having a role in changing the influx of physicians into a physician pathway. Instead, they felt themselves as the recipients and not able to impact early learners or pre-residency learners. We'd like to try to just diffuse the GME community of that and have them join with the UME community to try to work to establish those early learners in considering careers in medicine.

We passed a new common program requirement last summer, 1C, that says that the program in partnership with the sponsoring institution must engage in practices that focus on a mission driven, ongoing systematic recruitment, and retention of a diverse workforce. That includes faculty, fellows, residents, and senior administrative GME staff, as well as other relevant members of the community. In interpreting this, it means that every program has to try to figure out how to increase its diversity.

So, what we don't want to do is to cause competition between programs vying for the same small group of folks, right now, who are available to come to residency training. But instead we wish you to then work with those early learners, whether it's in high school or grade school, whether it's in college, developing programs for medical students, ensuring that your institution is structured, so that you can actually bring people into the institution without restriction. So, one of the things that we really like to do is to go out and talk to the GME community about what they could do in order to try to enhance this pathway of physicians into the practice of medicine.

**Unger:** Well, that's a good ... go ahead.

**Dr. Fancher:** Oh, sorry, Todd. I was going to say, I love that message, and that message at the medical school level too, to look towards those GME programs for partnership. Again, I think that we should think about our commitment to the community as a joint commitment from the medical school, as well as the GME community, the fellowship community; to create and train the physicians that are really needed. So, it has to be done in partnership.

**Unger:** Attracting and admitting more diverse candidates, obviously, an area of key focus. Dr. Lomis, how do we ensure we create an inclusive environment that allows candidates to be successful once they are admitted?

**Dr. Lomis:** That's such an important consideration. When we bring them on board, we need to make sure they feel like they belong, and are connected with the community that they're going to add so much to as they embark on their own career paths. And in the current environment, Todd, you and I have had the opportunity over the last several months to talk a lot about disruptions to medical education that are happening because of the COVID pandemic. So, we're very concerned about the potential that some of those learners may be more vulnerable than others in these changes and disruption. Anytime the system is shaken up those with kind of the least entrenchment, and least stability long-term might feel those impacts the greatest. So, changes such as converting to online learning, for some students, technology limitations, access to bandwidth, a different living situation that may have a more demanding circumstance around it. Those are impacting some of the learners that are going through these transitions.

As we look ahead to selection processes, both for medical school and residency, those two are being disrupted. So, changes to things like not having in-person interviews could limit the opportunities for some candidates to really show the depths and dimensions that they would bring to a given program

or a given school. And so, we really want to amplify those concerns right now, and ask all of our colleagues to remain very vigilant that our investment in diversity and inclusion be carried forth, even during these strange times.

**Unger:** Dr. McDade?

**Dr. McDade:** Well, the environment is really, really an important aspect of what it is because I see admission of a diverse workforce into training and residency programs, or medical school as being the first step. But, in order to ensure their success, the environment has to be primed so that they can actually be able to complete the program. And so, what happens when you increase diversity in an environment that's unaccustomed to it? Well, these matriculating residents have to somehow be able to navigate a system as being the other, which is one of the complaints that residents have. So, you have to try to make the environment inclusive, give them a sense of belonging, mitigate cultural underexposure and indifference. See stereotypical projections that would otherwise taint them, reduce environmental triggers that could feed the imposter syndrome, effectively address uncivil behavior. And do it in a way that allows privacy, of course, but at the same time sends the message that you will not tolerate behavior that's ineffective.

We think that implicit bias training can be very helpful, both for the learners, as well as the learners' peers, and the faculty as well. Evaluation of residents is very important to be fair and equitable in how you assess them. And it's very hard to take your hat off in a structurally racist environment when you walk into the hospital, and somehow be untainted by that. And so, having some insights in how to mitigate implicit bias is important. And then, also, you have to figure out how to give this information in a way that doesn't engender resistance and resentment on the part of those who feel that they may not need it. Robin DiAngelo in her book, "White Fragility," gave a really strong argument as to why whites sometimes have a difficult time of trying to process and deal with some of the culpability that they may have in benefiting from structures that exist right now, understanding privilege, and then understanding how to dismantle that.

**Unger:** Dr. Fancher, any final thoughts on creating a more inclusive environment?

**Dr. Fancher:** Yeah, I think Dr. McDade hit on many of those. But I do think, particularly, for young learners, as they're coming into medical school, that that's incredibly important. So, it's important that they see role models, who are doing what they want to do, who look like them, who have traits like them. It's important that they're in a small community that they're developing these skill sets, right, to really go into an environment that can be very, very challenging. I would say that we have not yet figured it out, but that it's on us to look at our policies, to look at how we teach, to look at the language that we use, to look at our recruitment strategies, our advancement strategies, all of those pieces with a really critical eye to try to understand how do we undo some of the structural racism, and really make improvements going forward.

**Unger:** Well, thank you so much, Dr. Lomis, Dr. Fancher, Dr. McDade for being here today and



sharing your perspectives, and for your efforts and those of your organizations to build a more diverse physician workforce.

**Unger:** That's it for today's COVID-19 update. We'll be back tomorrow with another segment. For updated resources on COVID-19 visit [ama-assn.org/covid-19](https://ama-assn.org/covid-19). Thanks for joining us, and take care.

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