Strategy for Improving Diversity Within Anesthesiology Residencies Panel

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When you think of what a doctor looks like…

What comes to mind?

What do you think of when you think of a doctor?

Dr. Tamika Cross
Meharry 2013
UT Houston PGY3 OB/GYN Resident

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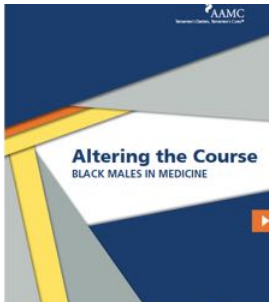
Who's Missing?



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Minimal Growth in Black Candidates

AAMC Data Book

AAMC

B3. Archive of U.S. Medical School Applicants and Accepted Applicants by Race and Ethnicity, 2002-03 Through 2012-13

	Race Alone or in Combination, Non-Hispanic											
	American Indian or Alaska Native		Asian		Black/ African American		Native Hawaiian or OPI		White		U.S. Non-Hispanic*	
Year	Apps	Accepted	Apps	Accepted	Apps	Accepted	Apps	Accepted	Apps	Accepted	Apps	Accepted
2002-03	344	163	6,500	3,511	2,858	1,284	95	37	20,446	11,152	30,202	16,124
2003-04	342	168	6,834	3,562	2,963	1,228	98	38	21,330	11,332	31,342	16,132
2004-05	383	176	7,464	3,585	3,004	1,264	103	37	22,007	11,443	32,163	16,148
2005-06	383	171	8,089	3,862	3,013	1,228	102	41	22,801	11,471	33,454	16,330
2006-07	332	149	8,257	3,830	3,073	1,280	180	67	23,567	11,672	34,852	16,716
2007-08	349	148	9,134	4,113	3,322	1,282	182	58	25,071	11,755	37,502	17,105
2008-09	333	154	8,971	4,089	3,168	1,265	187	57	24,717	11,715	37,343	17,274
2009-10	312	140	9,219	4,226	3,313	1,293	180	62	24,426	11,709	37,569	17,527
2010-11	362	178	9,473	4,322	3,264	1,319	164	56	24,408	11,704	37,764	17,651
2011-12	308	135	9,818	4,472	3,407	1,332	139	48	25,074	12,145	38,813	18,165
2012-13	340	150	10,373	4,704	3,551	1,347	149	50	25,556	12,135	39,852	18,334

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There were only 556 Black men who matriculated nationally

Table A-9: Matriculants to U.S. Medical Schools by Race, Selected Combinations of Race/Ethnicity and Sex, 2013-2014 through 2015-2016

Matriculants	2013-2014			2014-2015			2015-2016		
Selected Combinations of Race/Ethnicity	Women	Men	Total	Women	Men	Total	Women	Men	Total
American Indian or Alaska Native Only	17	26	43	23	30	53	24	31	55
American Indian or Alaska Native, Black or African American	4	3	7	9	3	12	4	4	8
American Indian or Alaska Native, White	46	41	87	49	53	102	48	50	98
Asian Only	1,845	1,868	3,713	1,918	1,899	3,817	2,029	2,066	4,095
Asian, Black or African American	9	10	19	16	14	30	13	14	27
Asian, White	151	152	303	184	151	335	195	153	348
Black or African American Only	734	500	1,234	712	515	1,227	793	556	1,349
Black or African American, White	24	28	52	28	25	53	35	32	67
Hispanic or Latino Only	583	667	1,250	574	656	1,230	625	695	1,320
Hispanic or Latino, Black or African American	26	22	48	25	20	45	39	26	65
Hispanic or Latino, White	193	206	399	222	244	466	222	248	470
Native Hawaiian or Other Pacific Islander Only	15	14	29	12	15	27	7	10	17
White Only	4,645	5,729	10,374	4,831	5,778	10,609	4,793	5,775	10,568
White, Other	49	62	111	47	80	127	56	62	118
Other	239	283	522	238	285	523	232	265	497
Multiple Race/Ethnicity Not Listed Above	119	98	217	127	109	236	140	119	259
Unknown Race/Ethnicity	656	727	1,383	550	601	1,151	438	499	937
Non-U.S. Citizen and Non-Permanent Resident	112	152	264	153	147	300	165	164	329
Total Matriculants	*9,467*	*10,588*	*20,055*	*9,718*	*10,625*	*20,343*	*9,861*	*10,766*	*20,627*

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What difference does it make if we don't accept the challenge to increase diversity in medicine?

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Underrepresented Minority Population

- Producing a physician workforce that reflects the diversity of the American population has been a goal of medical schools, teaching hospitals, policy makers, and the health care professions for many years
- Strong evidence exists to show that racial, ethnic, and linguistic diversity among health care providers is correlated with better access to and quality of care for underserved populations

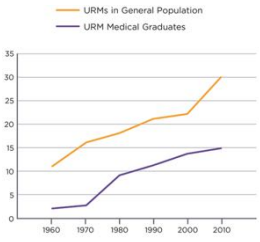

FIGURE 2-2 Trends in the proportion of underrepresented racial minorities (URMs) among medical school graduates and the U.S. general population

SOURCE: Sullivan, 2010 (AAMC).

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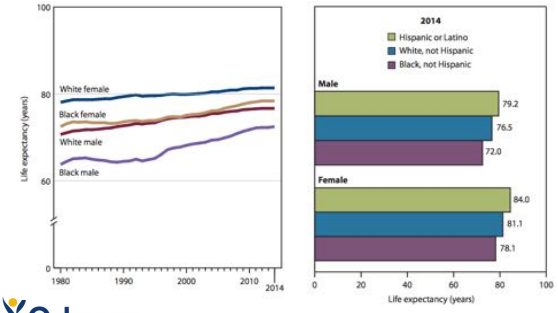
Life Expectancy 2014



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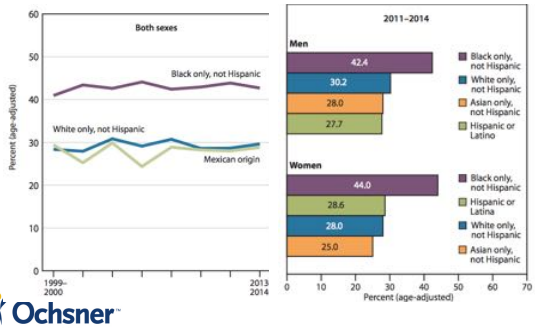
SOURCE: CDC/NCHS, National Vital Statistics System (NVSS)

Hypertension 2014



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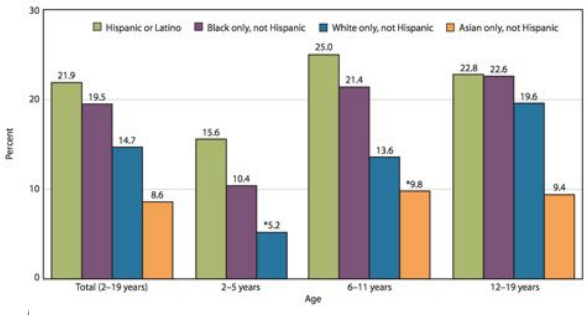
Childhood and Adolescent Obesity 2014



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Racial/Ethnic Health Disparities

Since 1988, there have been about 200,000 papers published dealing with documentation of racial and ethnic health disparities

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Institute of Medicine Report 2002

- 584 pages detailing the extent of racial and ethnic differences in healthcare that are not otherwise attributable to known factors such as access to care
- Evaluated potential sources of racial and ethnic disparities in healthcare, including the role of bias, discrimination, and stereotyping at the individual (provider and patient), institutional, and health system levels
- Recommendations to eliminate health disparities

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A central goal of the physician workforce of tomorrow must be to eliminate health disparities

"Of all the forms of inequality, injustice in health care is the most shocking and inhumane."
Martin Luther King, jr - Medical Committee for Human Rights, 1966

- Multiple touch-points exist to effect change in medical education to accomplish this. Two approaches include:
  - Recognizing that all physicians, in any future scenario, will have to learn about cultural and social determinants of health and be trained accordingly
  - Enrich the workforce with individuals who are more likely to positively impact the elimination of health disparities

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Can Cultural Competency Reduce Racial And Ethnic Health Disparities?

- Interpreter services
- Recruitment and retention
- Training
- Coordinating with traditional healers.
- Use of community health workers
- Culturally competent health promotion
- Including family and/or community members
- Immersion into another culture
- Administrative and organizational accommodations.

Can Cultural Competency Reduce Racial And Ethnic Health Disparities? A Review And Conceptual Model

Cindy Brach
Irene Fraserirector
Agency for Healthcare Research and Quality

This article develops a conceptual model of cultural competency's potential to reduce racial and ethnic health disparities, using the cultural competency and disparities literature to lay the foundation for the model and inform assessments of its validity. The authors identify nine major cultural competency techniques: interpreter services, recruitment and retention policies, training, coordinating with traditional healers, use of community health workers, culturally competent health promotion, including family/community members, immersion into another culture, and administrative and organizational accommodations. The conceptual model shows how these techniques could theoretically improve the ability of health systems and their clinicians to deliver appropriate services to diverse populations, thereby improving outcomes and reducing disparities. The authors conclude that while there is substantial research evidence to suggest that cultural competency should in fact work, health systems have little evidence about which cultural competency techniques are effective and less evidence on when and how to implement them properly.

Medical Care Research and Review, Vol. 57 Supplement 1, (November 2000) 181-217

Case for Diversity

- Advancing cultural competency
  - *Adequate representation among students and faculty of the diversity in our society is indispensable for quality medical education*
- Increasing access to high-quality health care services
- Strengthening the medical research agenda
- Ensuring optimal management of the health care system

HEALTH CARE WORKFORCE

The Case For Diversity In The Health Care Workforce

Interventions to improve the racial and ethnic diversity of the U.S. medical workforce should begin well before medical school.

by Jordan J. Cohen, Barbara A. Gabriel, and Charles Terrell

PROLOGUE: The notion that substantial improvements in the health indicators of U.S. racial and ethnic minority populations have been achieved over the past fifty years is relatively uncontroversial. By way of example, David Mechanic recently reported in *Health Affairs* (Mar/Apr 02) that infant mortality among African Americans fell from 43.9 deaths per thousand in 1950 to 13.8 in 1998. However, as Mechanic also noted, the troubling fact that infant mortality among African Americans remained 130 percent higher than that among whites as recently as 1998 dramatically illustrates that despite improvements in absolute numbers, the issue of health disparities is an independent question that retains much contemporary salience.

HEALTH AFFAIRS (2002) Volume 21(5): (0-102

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Minority Physicians Disproportionately Dedicate their Careers to the Underserved

- Kington R, Tisnado D, Carlisle DM. Increasing racial and ethnic diversity among physicians: an intervention to address health disparities? In: Smedley BD, Colburn L, Evans CH, eds. *The Right Thing to Do, the Smart Thing to Do: Enhancing Diversity in the Health Professions*. Washington, DC: National Academy Press; 2001;64:68.
- Cantor JC, Miles EL, Baker LC, Barker DC. Physician service to the uninsured: implications for affirmative action in medical education. *Inquiry.*1996;33:167-180.
- Komaromy M, Grumbach K, Drake M. et al.. The role of Black and Hispanic physicians in providing health care for underserved populations. *N Engl J Med.*1996;334:1305-1310.
- Moy E, Bartman BA. Physician race and care of minority and medically indigent patients. *JAMA*. 1995;273(19):1515-1520.

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Premature Abandonment of Affirmative Action in Medical Education

- Affirmative action challenges decreased the progress being made to increase the pipeline of URM medical students

The Consequences of Premature Abandonment of Affirmative Action in Medical School Admissions

Jordan J. Cohen, MD

The US Supreme Court recently accepted on appeal 2 cases from the University of Michigan regarding the constitutionality of race-conscious decision making in higher education admissions. The consequences of the Court's decision will directly affect the future of medicine in the United States. Medical schools have a societal obligation to select and educate the physician workforce of the future. To outlaw the use of affirmative action in the admissions process would cripple the profession's ability to achieve racial and ethnic diversity. Preserving this diversity in medical school admissions programs is important for 4 major reasons: (1) adequate representation among students and faculty of the diversity in US society is indispensable for quality medical education; (2) increasing the diversity of the physician workforce will improve access to health care for underserved populations; (3) increasing the diversity of the research workforce can accelerate advances in medical and public health research; and (4) diversity among managers of health care organizations makes good business sense. This article explores these reasons in detail, reviews the history and effectiveness of affirmative action in medical school admissions programs, and explains why alternatives to affirmative action are unworkable.

www.jama.com

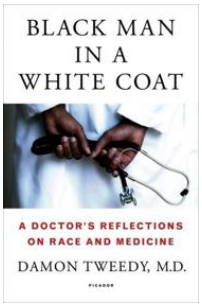
Table. Underrepresented Minority Matriculants to US Medical Schools, 1995 and 2001

State	1995	2001	Numerical Change, 1995-2001	% Change, 1995-2001
California	179	126	–53	–29.6
Texas	218	181	–37	–17.0
Mississippi	14	5	–9	–64.3
Louisiana	46	35	–11	–23.9
Washington	14	6	–8	–57.1
All other states	1554	1433	–121	–7.8
Total	**2025**	**1786**	**–239**	**–11.8**

JAMA 2003 289(9) 1143-1149

Affirmative Action Issues

- Concerns about lack of adequate preparation and mismatch
- Concerns of the learners regarding inferiority and stigma
  - "the quality that earns us preferential treatment is an implied inferiority..- Shelby Steele
- Class-based affirmative action may be a better fit?
- Concerns from society that lowering standards may lead to poorer health care delivery
- Are "qualified", "deserving" students being denied a fair chance to become doctors?



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A Research Agenda to Assess Affirmative Action

- Are the primary measures used in the residency selection process valid and reliable for making selection decisions?
- Do tests used in the residency selection process display racial bias?
- Do between-group differences in performance on cognitive tests explain the current under representation of minority groups in U.S. medical education?
- Are there viable selection models that promote diversity while maintaining validity?
- Does an increase in racial diversity within medical education result in improved educational outcomes?
- Can alternate pre-selection measures remediate the underrepresentation of minority groups in residency training?
- Is it possible to attain racial diversity and proportional representation without large declines in general performance?
- Do holistic methods represent a psychometrically valuable alternative to formulaic methods?
- Do affirmative action initiatives succeed in graduating competent underrepresented minority physicians?
- Do underrepresented minority physicians' practice choices lead to increased access to care for underserved communities?

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Modified from C. Kreiter Med Educ Online (2013) 18: 20531

Minority Physicians' Role in the Care of Underserved Patients

- Nonwhite physicians cared for 53.5% of minority and 70.4% of non–English-speaking patients
- Patients from underserved groups (except uninsured patients) were significantly more likely to see nonwhite physicians than White physicians.
- Patients of Black, Hispanic, and Asian physicians were more likely to have Medicaid; patients of Hispanic physicians were more likely to be uninsured.
- Increasing the racial and ethnic diversity of the physician workforce may be key to meeting national goals to eliminate health disparities

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Marrast LM, Zallman L, Woolhandler S, Bor DH, McCormick D. Minority Physicians' Role in the Care of Underserved Patients: Diversifying the Physician Workforce May Be Key in Addressing Health Disparities. *JAMA Intern Med.* 2014;174(2):289-291.

Merits of Increasing Minority Representation in Medicine

- Studies of service commitment, however, have shown that, compared with race, SES is a relatively weak predictor of medical students' going on to serve the underserved.
- URM students from the highest SES categories serve the underserved at greater rates than do white students from the lowest SES groups
- One possible reason for this finding is that SES changes over time, while race does not. In becoming a physician, a student from a poor or working-class upbringing moves quickly into a higher social tier and is no longer a member of a disadvantaged class. Race, however, confers more durable disadvantage.

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Saha S, Shipman SA. Race-neutral versus race-conscious workforce policy to improve access to care. Health Aff (Millwood). 2008;27(1):234-245.

Table 1. Unadjusted Association Between Disadvantaged Population and Receipt of Care From White vs Black, Hispanic, and Asian Physicians, Medical Expenditure Panel Survey, 2010

Patient Characteristic	No. (%)							
	Millions of Patients With a White Physician	Millions of Patients With a Black Physician	Unadjusted Odds Ratio (95% CI)[a]	Millions of Patients With a Hispanic Physician, No. (%)	Unadjusted Odds Ratio (95% CI)[b]	Millions of Patients With an Asian Physician, No. (%)	Unadjusted Odds Ratio (95% CI)[c]
All patients	62.2 (100.0)	3.3 (100.0)		5.9 (100.0)		9.8 (100.0)	
Non-Hispanic whites	53.2 (86.8)	1.1 (34.7)	1 [Reference]	2.4 (41.5)	1 [Reference]	5.2 (53.7)	1 [Reference]
Minorities	9.0 (13.2)	2.2 (65.3)	12.30 (8.30-18.00)	3.5 (58.5)	8.20 (5.98-11.23)	4.6 (46.3)	5.40 (4.16-6.99)
Black, non-Hispanic	4.1 (7.1)	1.9 (63.9)	23.24 (16.28-33.17)	0.5 (16.8)	2.65 (1.81-3.87)	1.0 (16.3)	2.56 (1.90-3.44)
Hispanic	3.1 (5.5)	0.1 (5.1)	0.96 (0.49-1.88)	2.7 (52.6)	19.04 (13.47-26.93)	1.1 (17.7)	3.68 (2.62-5.18)
Asian	0.9 (1.7)	0.1 (5.1)	3.06 (1.15-8.17)	0.3 (9.0)	5.63 (2.67-11.86)	2.3 (31.2)	25.73 (16.92-39.13)
Other	0.9 (1.7)	0.1 (7.4)	4.60 (1.78-11.94)	0.02 (0.6)	0.61 (0.17-2.15)	0.2 (3.8)	2.25 (1.19-4.25)
Income							
High/middle	48.9 (78.5)	2.1 (64.5)	1 [Reference]	3.9 (65.5)	1 [Reference]	7.0 (70.9)	1 [Reference]
Low	13.4 (21.5)	1.2 (35.5)	2.03 (1.46-2.75)	2.1 (34.5)	1.92 (1.44-2.55)	2.8 (29.1)	1.49 (1.23-1.81)
Medicaid							
None	54.8 (93.2)	2.5 (78.4)	1 [Reference]	4.4 (81.8)	1 [Reference]	7.9 (85.2)	1 [Reference]
Medicaid	4.0 (6.8)	0.7 (21.6)	3.75 (2.72-5.18)	1.0 (18.2)	3.04 (2.29-4.04)	1.4 (14.8)	2.38 (1.85-3.06)
Any health insurance	58.8 (94.3)	3.1 (95.2)	1 [Reference]	5.4 (90.1)	1 [Reference]	9.3 (94.0)	1 [Reference]
Uninsured	3.5 (5.7)	0.1 (4.8)	0.83 (0.49-1.41)	0.6 (9.9)	1.83 (1.30-2.57)	0.6 (6.0)	1.07 (0.78-1.47)
English home language	60.6 (97.3)	3.2 (96.8)	1 [Reference]	3.9 (66.7)	1 [Reference]	7.9 (80.4)	1 [Reference]
Non-English home language	1.7 (2.7)	0.1 (3.2)	1.18 (0.51-2.69)	2.1 (33.4)	17.83 (12.80-24.82)	1.9 (19.6)	8.69 (6.19-12.19)

[a] Odds of patients in a demographic group reporting a black physician relative to non-Hispanic white patients reporting a black physician.
[b] Odds of patients in a demographic group reporting a Hispanic physician relative to non-Hispanic white patients reporting a Hispanic physician.
[c] Odds of patients in a demographic group reporting an Asian physician relative to non-Hispanic white patients reporting an Asian physician.

Marrast LM, et al. *JAMA Intern Med.* 2014;174(2):289-291.

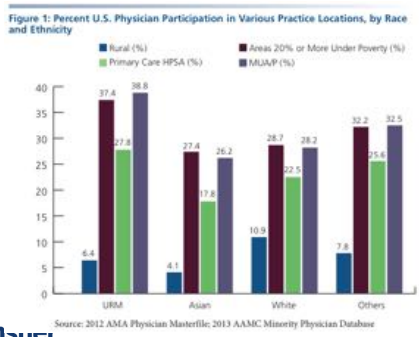
Table 1. Practice Specialty by Medically Underserved Areas (MUAP) and by Race and Ethnicity, 2013

Race and Ethnicity	Practice Specialty	N/A	No	Yes	Total
Asian	Specialist	160	29,205	10,693	40,058
	Primary Care	91	19,195	7,426	26,712
	subtotal	251	48,400	18,119	66,770
Black or African American	Specialist	38	9,775	5,246	15,057
	Primary Care	32	7,455	4,995	12,482
	subtotal	70	17,228	10,241	27,539
American Indian or Alaska Native	Specialist	5	939	401	1,345
	Primary Care	1	660	466	1,127
	subtotal	6	1,599	867	2,472
Hispanic or Latino	Specialist	29	9,550	6,585	16,164
	Primary Care	30	6,745	5,214	11,987
	subtotal	59	16,295	11,799	28,151
White	Specialist	933	164,250	65,899	231,082
	Primary Care	570	95,933	26,985	122,596
	subtotal	1,503	250,183	101,992	353,678
Others	Specialist	6	844	374	1,224
	Primary Care	2	566	291	861
	subtotal	8	1,412	665	2,085
Unknown	Specialist	1,754	105,718	47,246	154,718
	Primary Care	813	56,161	28,230	85,906
	subtotal	2,569	162,559	75,496	240,624
Total		4,466	497,674	219,179	721,319

Source: AAMC Data Warehouse: Minority Physician Database, 2013 AMA MASTERFILE, AAMC other data sources, and 2013 HRSA Geospatial Data Warehouse (05/14/2013).

Castillo-Page, et al.. "Diversity in Undergraduate Medical Education: An Examination of Organizational." *Developing Workforce Diversity Programs, Curriculum, and Degrees in Higher Education* (2016): 304.

Practice Distribution of Physicians by Race



IM Xierali et al., AAMC Analysis in Brief Volume 14(9) Aug 2014

It's not our fault….We don't control the pipeline…

Anesthesiology Residency and Fellowships 2014

Table 2. Resident Physicians on Duty in ACGME-Accredited and Combined Specialty GME Programs December 31, 2014

	Total No. of Programs[a]	No. (%) of Resident Physicians[b]					
		Total	Female	USMDs	IMGs	Canadians	Osteopathic
Specialty/Subspecialty							
Allergy and immunology	75	301 (0.3)	190 (63.1)	224 (74.4)	53 (17.6)	1 (0.3)	23 (7.6)
Anesthesiology	133	5686 (4.8)	2015 (35.4)	4423 (77.8)	675 (11.9)	3 (0.1)	585 (10.3)
Adult cardiothoracic anesthesiology	61	172 (0.1)	57 (33.1)	135 (78.5)	25 (14.5)	1 (0.6)	11 (6.4)
Critical care medicine	55	148 (0.1)	43 (29.1)	121 (81.8)	21 (14.2)	0	6 (4.1)
Obstetric anesthesiology	27	30 (<0.1)	18 (60.0)	23 (76.7)	5 (16.7)	0	2 (6.7)
Pediatric anesthesiology	53	191 (0.2)	114 (59.7)	149 (78.0)	27 (14.1)	1 (0.5)	14 (7.3)

Table 8. Race and Ethnic Origin of Resident Physicians in ACGME-Accredited and Combined Specialty Graduate Medical Education (GME) Programs on Duty December 31, 2014, by Specialty

	No. of Resident Physicians[a,b]								
	Black	American Indian/ Alaskan Native	White	Asian	Native Hawaiian/ Pacific Islander	Multiracial[c]	Other/ Unknown	Hispanic Origin[d]	Total
Specialty/Subspecialty									
Allergy and immunology	11	0	169	89	1	5	26	24	301
Anesthesiology	352	12	3509	1430	18	136	229	332	5686
Adult cardiothoracic anesthesiology	3	0	122	37	1	1	8	10	172
Critical care medicine	5	1	94	34	0	3	11	7	148
Obstetric anesthesiology	3	0	18	7	0	0	2	4	30
Pediatric anesthesiology	11	0	108	58	1	1	12	9	191

Brotherton SE, Etzel SI. Graduate Medical Education, 2014-2015. *JAMA*. 2015;314(22):2436-2454

Why Are Some Specialties Less Diverse?

- Overreliance on USMLE STEP 1 scores for screening candidates for interviews
  - Pressure from ACGME to achieve a first-time pass rate on Board examination of > 80-90%
  - Correlation between STEP1 performance, in-training examinations and Board pass rate
- Lack of advocacy for URM candidates among program directors

Other Factors?

"There is little doubt that women, African Americans, and Hispanics, have fewer opportunities to enter, or once in, to become contributing members of orthopaedic programs in the United States. The expressed reasons for this by faculty members sometimes sound reasonable, but on analysis all are spurious. It is the responsibility of the chief of service and the faculty members to change this pattern and offer all individuals equal opportunity and treat them identically to anyone in the program or on the faculty."

Mankin, HL *Diversity in Orthopedics* Clinical Orthopedics and Related Research 1999 362:85-87

Mankin's Examples of Spurious Explanations

- Women are not strong enough to do a man's job
- Working closely with women in the operating room makes a male orthopaedic surgeon nervous; touching a woman orthopaedic surgeon is distracting
- Some orthopaedic surgeons are more comfortable and therefore feel that they are better able to practice and teach more effectively when they are with their own people
- Their values (people of diversity) are different than ours and may be not as good for our patients and fellow faculty members
- People like to work with people they can take home, who speak the same language, and who have the same religious beliefs; they are more comfortable with them
- As much as one would like to do it, one does not want to be the first service in their hospital to break the barrier; one may be sympathetic but there is much peer pressure here

Mankin, HL Clinical Orthopedics and Related Research 1999 362:85

Mankin's Solution

- Believe in people as people and in their abilities as separate and unrelated to gender, color, race, creed, language, religion, or country of origin.
- A scientist is a scientist, not an African American person who does science. A surgeon is a surgeon, not a woman from Honduras who speaks the language with an accent and also does hand surgery. Judge them only on what they are and are in fact, put on earth to do: care for patients, teach, and do research
- Maintain a true belief that not only are people different from one another, but they must be different from one another to make the world a better place.

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Mankin, HL Clinical Orthopedics and Related Research 1999 362:85-87

Mankin's Solution

- Everyone regardless of origin, creed, and gender has something to contribute; often their contribution is more important as a result of their ethnic or gender diversity
- Allow those precious differences that make people who they are, to not only come out, but to be emphasized to improve quality and productivity and make the hospital and the caretaking system a better one.

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Mankin, HL Clinical Orthopedics and Related Research 1999 362:85-87

Residency Selection Practices

- Despite its intended purpose, many residency program directors continue to use applicants' USMLE Step 1 scores as a sole or primary filter for selecting candidates to interview, often disregarding the statistical characteristics of the score scale
- In general, the more competitive the residency discipline (e.g., orthopedic surgery, radiation oncology, dermatology, ophthalmology, and otolaryngology), the higher the USMLE Step 1 score needed to pass through the filter.

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Charles G. Prober, MD, Joseph C. Kolars, MD, Lewis R. First, MD, and Donald E. Melnick, MD (2015) *Academic Medicine* 90(10): 1-3

Does USMLE Performance Predict Physician Quality?

- The validity argument about using USMLE Step 1 and 2 scores for postgraduate residency selection decisions is neither structured, coherent, nor evidence based.
- …scores are not associated with measures of clinical skill acquisition among advanced medical students, residents, and subspecialty fellows.


ACADEMIC MEDICINE AAMC

Are United States Medical Licensing Exam Step 1 and 2 Scores Valid Measures for Postgraduate Medical Residency Selection Decisions?

Abstract

WC McGaghi, ER Cohen, and DB. Wayne (2011) Acad Med. 86:48–52

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ACADEMIC MEDICINE AAMC

A Plea to Reassess the Role of United States Medical Licensing Examination Step 1 Scores in Residency Selection

Charles G. Prober, MD, Joseph C. Kolars, MD, Lewis R. First, MD, and Donald E. Melnick, MD (2015) *Academic Medicine* 90(10): 1-3

- "We do not believe that USMLE Step 1 scores should continue to be the major determining factor in the selection of graduating medical students for interview for graduate medical education positions."
- "These scores (USMLE STEP1) do not measure many clinical aptitudes and skills, qualities of professionalism, or competencies specific to the planned training program."
- "Although using numbers as a filter is a convenient way to screen large numbers of applications, USMLE Step 1 scores do not come close to reflecting the totality of attributes critically relevant to a candidate's potential performance during residency training."

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Lack of Advocacy

- Resident Selection is done by faculty
- A more diverse admissions committee leads to more diversity in medical school, the same may be true for residency selection committees
- Paucity of URM faculty (only 2.9% are Black) makes this difficult and places unfair burden on those who serve
- Very few residency program directors are URMs

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Barriers to Underrepresented in Medicine Resident Recruitment

- Lack of racial diversity within a residency program, department, and/or institution
- Limited visibility of existing underrepresented in medicine faculty within a residency training program and/or during applicant recruitment.
- Perceived lack of residency program or institutional commitment to supporting diversity-related outcomes
- Incomplete understanding of how underrepresented in medicine applicants select and rank residency programs
- Limited post-interview contact with applicants
- Limited coordination between residency program and medical school diversity efforts
- Opportunities to work with underserved patient populations unavailable or not readily apparent to applicants

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Pierre, Joseph M., et al. *Academic psychiatry* (2016)

Transition to Residency

ACADEMIC MEDICINE AAMC

- Does your residency recruitment committee have URM faculty members?
- Does the department train the recruitment committee to play a vital role in URM recruitment?
- Does your department ask URM faculty to review (and potentially reverse) each offer to refuse an interview to an URM candidate?
- Has your department appointed a committee member to separately review URM applications and advocate for them at final committee meetings?
- Has your department begun a dialogue between URM residents and department leadership regarding how "URM-friendly" the program is?
- Does your department send representatives to national meetings of minority students (e.g., Student National Medical Association, Latino Medical Student Association)?
- Has your department created (and widely advertised) elective rotations for URM medical students?
- Do URM residents call each URM candidate to help establish personal contact, dispel misperceptions, and offer personal advice?
- Are there opportunities for URM residents to meet as a group and discuss the program?

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M Peek et al. URM Candidates Are Encouraged to Apply": A National Study to Identify Effective Strategies to Enhance Racial and Ethnic Faculty Diversity in Academic Departments of Medicine. Academic Medicine. 88(3):405-412, March 2013

Transition to Fellowship

ACADEMIC MEDICINE AAMC

- Does your department require section/division chiefs and fellowship directors to prominently mention the department's increasing commitment to URM representation?
- Does your department link legitimate diversity enhancement efforts to annual evaluations/financial incentives within the sections?
- Does your department require program directors and search committees to examine (at least annually) the fairness of the selection process and results in achieving diversity?
- Is information about funding opportunities available to URM fellows (and junior faculty) widely disseminated?
- Does your department sponsor an annual social affair with key URM and non-URM faculty, department leaders, and URM residents/fellows?
- Does your department use visiting professorships to showcase research accomplishments of nationally known URM physician scientists?

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M Peek et al. URM Candidates Are Encouraged to Apply": A National Study to Identify Effective Strategies to Enhance Racial and Ethnic Faculty Diversity in Academic Departments of Medicine. Academic Medicine. 88(3):405-412, March 2013

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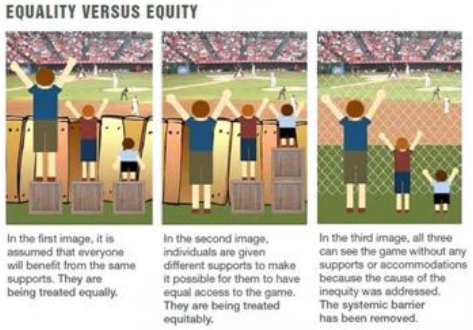

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