Chapter 8
Nurturing a Culture of Diversity and Inclusion in Resident Clinic

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Introduction

The racial and ethnic makeup of the US population is increasingly diverse. In 2015, the demographic breakdown was 73% Caucasian, 17.6% Hispanic/Latino, 12.7% African-American, 5.4% Asian, 0.8% American Indian and Alaskan Native, and 0.2% Native Hawaiian or other Pacific Islander [1]. The same degree of diversity is not reflected within the physician workforce. For example, the percentage of underrepresented minority (URM) faculty by race and ethnicity in US medical schools accounts for only 4% Hispanic/Latino, 2.9% Black or African-American, 0.1% American Indian or Alaskan Native, and 0.1% Native Hawaiian or other Pacific Islander [2]. In 2011, it was reported by the Association of American Medical Colleges (AAMC) that only 8.5% of medical school matriculants were Hispanic/Latino and 6.1% were African-American, and thus the lack of diversity within the physician workforce is not expected to significantly change in the near future [3]. There is a vast literature focusing on the discrepancy between the burgeoning minority population and their underrepresentation in medical education. Different branches of this literature sheds light on the needs of patients in contexts such as the physician-patient relationship, the growing need for cultural competence, and the importance of communication skills and a high level of professionalism. It is only in the last few years that healthcare organizations and the academe, in addition to promoting pipeline efforts, are paying growing attention to diversity and inclusion in the workforce. It is arguable that the demographic incongruity between providers and patients is most conspicuous in the clinics staffed by medical residents. Patients receiving

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primary care in university resident clinics tend to be underrepresented minorities (URM) and/or socioeconomically disadvantaged [4]. It is therefore imperative that in addition to cultural competence training provided to physicians, special attention should be given to diversity and inclusion in the setting of the resident clinic. This chapter provides guidance to residency program and resident clinic leadership on how to foster a culture of diversity and inclusion in the setting of resident clinic.

Learning Objectives

1. Foster a culture of diversity and inclusion in the resident clinic setting.
2. Attract, recruit, and retain a diverse workforce.
3. Better familiarize faculty/trainees with the communities they serve.
4. Strengthen interprofessional skills through cultural competence training.

Outline

- Expanded welcoming comments
- Engagement and beyond
  - Recruitment and retention efforts to diversify the workforce
  - Goal: A climate conducive to members appreciating each other at a cultural and social level

    An environment that welcomes the sharing of cultural information
    The blending of continuing education with social activities
    The ongoing engagement of clinical and nonclinical staff
- Definition of community beyond simple demographics
  - Community health needs assessment
  - Internal and external resources to address the needs of the community
  - Participation in community projects
- Cultural competence training for all clinic members
  - Can relate and understand one another and our patients
  - Understand patients' health-seeking behaviors and adherence to care

Expanded Welcoming Comments

From the little that is actually known about effective recruitment and retention of minority residents, it appears that a counterproductive experience for minority physicians at all levels is that of social isolation [5, 6]. Given the enormous amount of content competing for coverage during orientation, dedicating any

portion of this precious time to highlight the institution's appreciation for diversity and a spirit of inclusivity sends a very powerful message. Simple, short introductions wherein residents and faculty introduce themselves and provide a two- or three-sentence summary of their background and their interests are an excellent way to jumpstart networking within a class and help interns to quickly identify potential mentors. For those who belong to a Minority Housestaff Organization (MHO) or similar group, social events during orientation are an effective way to counteract the sense of "outsider" that many URM physicians feel. Having an MHO also goes a long way toward highlighting the priority that an institution and its members place on supporting diversity. We will briefly focus on Yale's own MHO as a case study. This organization's stated goal is to promote mentorship, community outreach, and networking/social events. Its co-chair has stated "Our goal is to make it easier for current and future minority residents to find a community and locate the resources and support that are necessary for professional development." The MHO has accordingly sent members to national meetings, organized second look visits for minority applicants, and sponsored events such as Minority Men in Medicine. The latter was a social outing for URM residents with a lively fusion of soul food and the 1990s rhythm and blues (R and B) music.

There are several much-needed strengths that URM residents bring to our community. In addition to a heartfelt appreciation for the ethnic diversity of patients and providers, they frequently feel drawn to provide service to the indigent. They also bolster an environment that is at once welcoming and supportive of minorities [7]. In the authors' experience, active appreciation for the diversity of patients and provision of service to the medically indigent are not typically emphasized enough within residency training programs. A starting point is focusing on the prevention of social isolation, emphasizing support, and instilling a strong sense of welcome in the program's efforts to improve diversity. It is also known that diversity begets diversity, meaning that the conspicuous presence and promotion of existing minorities as role models and mentors is an important facet of attracting and retaining other minority physicians.

Extending a sense of welcome must begin long before trainees arrive for orientation. We must proactively court minority students rather than hoping they will simply leap over societal barriers and come to us. Strategies include the following.

Engagement and Beyond

Recruitment and Retention Efforts to Diversify the Workforce

The success of residency programs depends in part on the recruitment of highly qualified leaders, teaching faculty, and medical school graduates. Having been long recognized in the industry, diversity offers many advantages to a residency program. At a personal level, school or workplace diversity can result in an increased sense of well-being, decreased levels of stress, and the development of genuine respect

between colleagues of differing backgrounds [8, 9]. At the program level, a diversified workforce increases productivity and offers a competitive advantage to the recruitment of diversely talented individuals and helps to sustain a pipeline attracting and retaining future fellows and faculty and potentially increasing the physician workforce in the community [10–13]. Studies have shown that physicians from URM groups are more likely to care for patients similar to their own ethnic background and to provide for the underserved patient population [14–17]. Furthermore, ethnic minority patients are more likely to experience greater satisfaction when cared for by an ethnic minority physician, resulting in higher likelihood of satisfaction for the physician [14]. Consequently, it behooves residency programs to actively promote the recruitment of URM and to sustain an increased proportion of women, the latter comprising over 30% of the physician workforce as reported in 2014 [18]. Because there is intense competition for the small numbers of highly qualified URM medical students, it is critical that the leadership and teaching faculty of residency programs understand how URM and female medical students go about choosing a program of residency in internal medicine. A study published in 2005 looked at factors medical students consider when choosing a residency program and how such factors differ by gender and ethnicity [7]. That study suggested that the decision of URM medical students is positively influenced by a greater degree of diversity among the faculty, residents, patients, and city. The study also demonstrated that in addition to diversity, medical students also appreciate a supportive academic and political environment and the feeling of being wanted by the program. When selecting a residency program, women also valued gender diversity, availability of family-oriented programs, and active discussion regarding potential opportunities for their partners.

Recruitment and retention of a diversified workforce, especially in a resident clinic caring for an underserved patient population with limited resources, require a solid infrastructure and supportive environment. That same setting must allow faculty members to achieve productive academic careers and to maintain a healthy work-life balance. This is important for many obvious reasons. Not the least of these is that trainees view the faculty as role models, and this perception can influence the trainees' career choices and whether they remain at the institution of their training.

Given that the current number of qualified URM individuals in medicine is small, long-term investment in pipeline programs is also very important. These programs should begin at high school or earlier by exposing the young students to healthcare role models they can relate to. It is also important to involve the parents and guardians to ensure students are supported in their aspirations. Other examples include mentoring programs during college and post-baccalaureate programs [19]. These efforts bring minority candidates into the academic fold of the medical school with the increased likelihood of retaining them there for residency. The author describes a program to recruit students to her medical school at the University of Kentucky. Many of the program components could be generalized to residency, notably using current minority residents and their personal contacts as a springboard for recruitment. An office of minority affairs is also needed to identify potential candidates. The candidates are invited to a 2-day recruitment event that introduces them to life

on campus. “Incorporating current medical [residents] in recruitment programming allows institutions to access a knowledgeable and inspirational resource that is readily available” [19]. This allows the candidate to picture themselves as a member of the community, guarantees contacts should they choose to matriculate, and allows the hosts to serve as role models of successful young physicians.

Goal: A Climate Conducive to Members Appreciating Each Other at a Cultural and Social Level

While creating a network of peers and mentors that share one’s “minority status” appears to be critical for long-term success and retention, this cannot occur in isolation. In addition to finding people with a common background, it is important to establish the value of embracing the many ways in which we are different. Because some minorities may not have an easily recognizable peer group (e.g., a lesbian Christian from Pakistan), they will need a forum that celebrates their uniqueness. This creates an atmosphere of tolerance and inquiry. One touchstone that serves as an easy starting point for sharing one’s culture is food. A regular potluck meal where people are encouraged to prepare their favorite foods is a wonderful, nonthreatening way to connect and learn some basics about another culture, with the added benefit of socializing with colleagues one might not have otherwise sought out. We hold regular potlucks at our clinic site that are attended by faculty, residents, nurses, and staff. This allows for exposure to a more varied group and has resulted in an organic appreciation for the culinary talents of others and is a powerful point of connection. More than once, a participant has gotten visibly homesick at the sight of a favorite food not seen since they left home. The reason it is called “comfort food” is readily apparent.

Our clinic attempts to create a sense of belonging through a variety of activities and structures. Every new intern is assigned to a team of three residents, one attending, one nurse, and a medical assistant. The team serves as the “home base” for each resident. One’s team defines the group you work with consistently throughout residency, which patients you care for, and more often than not, with whom you socialize with. To foster this sense of belonging, we organize friendly competitions and social events that highlight the team concept. On the first day of clinic orientation, at a “welcome” ice cream social, the interns are given a colored shirt that makes it clear which group they belong to. They join their group and get vulnerable patient sign-out. The chief residents organize a “clinic jeopardy” and a clinic scavenger hunt that put the teams in competition and create a bonding experience. The games themselves help the interns get comfortable navigating around the clinic and allow them to meet and learn “fun facts” about those who work there. Our “proof of success” is that it has become the norm for the residents on each team to arrange a group outing (pizza, salsa dancing, and indie movie night) at the end of each 2-week rotation that often involve faculty and clinic staff.

Definition of Community Beyond Simple Demographics

(a) Community health needs assessment
(b) Internal and external resources to address the needs of the community
(c) Participation in community projects

Trainees should be acquainted with much more than the basic demographics of their patients' community for a better understanding and sense of belonging with the patients they serve. The introduction should include a neighborhood-guided tour by someone well versed in the community, the ideal being someone that has undergone a community resident leadership program where they have learned about the mapping of community assets (a focus on the community strengths rather than on needs as developed by John Kretzmann and John McKnight) [20]. Trainees can be made aware of any community distrust of the healthcare system or home institution and its rationale, as well as common health-seeking behaviors and barriers to healthcare as perceived by the community. Home visit programs are another way for trainees to become closer to the community they serve, in addition to the specific healthcare needs of the patients. Certain not-for-profit organizations are required to conduct community health needs assessment (CHNA) and to design strategic plans to address the health needs of the community [21]. It is essential to inform faculty, trainees, and staff of pertinent CHNA results and engage them in the organization's strategic plans to address those needs.

Increasing numbers of healthcare organizations include patients and family members in hospital and ambulatory center committees [22, 23]. Similarly, trainees and faculty should be present on these committees since this is an excellent opportunity for them to hear directly from the patient or family member about important issues that may be afflicting their community. Moreover, these individuals can inform the institutional committee members of opportunities within the community where trainees and faculty could play a constructive role. Examples include community projects, social justice organizations, and functions that are purely social in nature. Reading the local newspaper, listening to community radio, and eating at local restaurants are worthwhile ways to learn all about what the community offers. In order to make this possible for both trainees and faculty, it is absolutely critical to incorporate dedicated time for these types of activities and for the educational experience in the resident clinic not to be secondary to the inpatient service.

Cultural Competence Training for All Clinic Members: Ability to Relate and Understand One Another and Our Patients

Intern orientation is usually an exciting and overwhelming experience, a time chock full of pragmatic topics to help them be as ready as possible to start residency. Although interns may be mostly focused on the operational and clinical aspects of that first rotation, resident clinic is a longitudinal experience. In short order, many

interns yearn for a sense of belonging and for someone they can relate to. This is especially important for URM individuals to help prevent social isolation and to vent and share their experiences with both implicit and non-implicit bias, such as being mistakenly taken as someone from housecleaning rather than as a doctor.

A vast amount of the literature on cultural competence in healthcare addresses the physician-patient relationship. It is important to ensure that health professionals are culturally competent with a focus on interprofessional relationships. The ability to relate to and understand one another involves getting to know more about each other than just a familiarity with our training, extra credentials, and academic accomplishments. The cultural introduction needs to be a story of what truly matters to us as a person—personal values, family, and traditions. There needs to be a space for this to occur, and appropriate opportunities must be created wherein individuals can interact socially and share their stories. Sharing stories is an effective way to communicate something meaningful in our lives, a way to eliminate bias, and a means of introducing conversation that might not otherwise be comfortably broached, such as the preconceived assumptions. Regardless of ethnic background each of us has, a culture and cultural competence is not an issue exclusive to URMs. To some degree, all interactions are intercultural regardless of ethnicity. Even when we come from similar backgrounds, our individual experiences influence our experience of cultural beliefs and behaviors. As we consider the creation of a cultural environment that embraces inclusivity, it is important to define diversity broadly so as to include URM, gender, sexual orientation, sexual identity, religion, disability, foreign graduates, and even graduates from different regions within the United States.

Cultural diversity is becoming increasingly important in multiple domains of our lives—in our family unit, at social functions, and in the workplace. It is not only the patients we serve who are diverse, but we providers are also diverse and not necessarily concordant with our patients. For this reason, training in cultural competence is crucial for creating an environment where we acknowledge our differences, where we help each other feel welcome and free to be ourselves, and where we facilitate culturally respectful conversations to better understand our differences. The Liaison Committee on Medical Education introduced standards on cultural competence in 2000, which are now in use at many medical schools [24]. There is also a tool called Tool for Assessing Cultural Competence Training (TACCT) [25] developed by the AAMC and a resource guide listing resources and guidelines for the teaching of cultural competence [26].

Many academic institutions may have diversity and inclusion committees cloistered within their departments, but an effective committee needs to be part of the larger mission and vision of the organization and not a committee in isolation. It requires the commitment of the organization's leadership which includes a clear message to the faculty, trainees, and staff that the committee is intended to innovate and create change. Committee members need to include stakeholders such as the department chair, education vice-chair, diversity officer, designated institutional official, division chiefs, residency program directors, fellowship directors, medical directors, faculty, residents, medical students, and staff members. It needs to meet at a regular frequency and have financial and administrative support to operationalize and accomplish its goals.

Conclusion

Given the acute cultural discordance between the faculty, residents, patients, and communities they serve in the resident clinic, it is critical that we cultivate a culture of inclusive diversity which makes everyone feel welcome and promotes a sense of belonging and academic success that is attractive to others. It is important to emphasize that providing healthcare in the environment of the resident clinic can be challenging for several reasons such as discontinuity of care, disenfranchised patient population, and limited access to resources. Acquaintance with community helps to alleviate these challenges by instilling a compassionate understanding of community needs and a prioritized approach to addressing those needs. In addition, ongoing training in cultural competence can potentially help decrease misunderstanding and bias. A diversified workforce alone will not resolve all tension because, as unique individuals, each person functions in accordance with his or her individual culture. As Dr. Adela Allen said, *"We should acknowledge differences, we should greet differences, until difference makes no difference anymore"* [27].

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