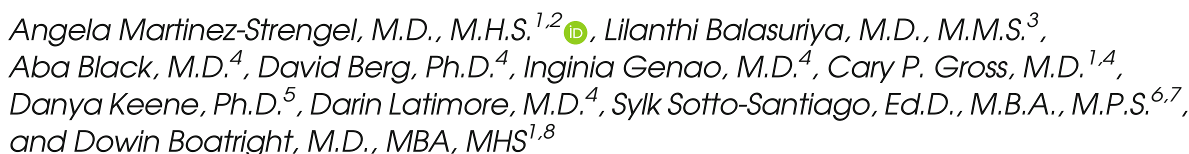
ORIGINAL RESEARCH

Perspectives of Internal Medicine Residency Program Directors on the Accreditation Council for Graduate Medical Education (ACGME) Diversity Standards



Angela Martinez-Strengel, M.D., M.H.S.[1,2], *Lilanthi Balasuriya, M.D., M.M.S.*[3], *Aba Black, M.D.*[4], *David Berg, Ph.D.*[4], *Inginia Genao, M.D.*[4], *Cary P. Gross, M.D.*[1,4], *Danya Keene, Ph.D.*[5], *Darin Latimore, M.D.*[4], *Sylk Sotto-Santiago, Ed.D., M.B.A., M.P.S.*[6,7], *and Dowin Boatright, M.D., MBA, MHS*[1,8]

[1]National Clinician Scholars Program, Yale School of Medicine, New Haven, CT, USA; [2]Department of Pediatrics, Yale School of Medicine, New Haven, CT, USA; [3]Department of Psychiatry, Yale School of Medicine, New Haven, CT, USA; [4]Department of Internal Medicine, Yale School of Medicine, New Haven, CT, USA; [5]Yale School of Public Health, New Haven, CT, USA; [6]Department of Internal Medicine, Indiana University School of Medicine, Indianapolis, IN, USA; [7]Alliance for Academic Internal Medicine, Alexandria, VA, USA; [8]Department of Emergency Medicine, Yale School of Medicine, New Haven, CT, USA.

BACKGROUND: To increase diversity and inclusion in graduate medical education, the Accreditation Council for Graduate Medical Education (ACGME) issued a revision to their Common Program Requirements during the 2019–2020 academic year mandating that all residency programs must have policies and practices to achieve appropriate diversity among trainees and faculty.

OBJECTIVE: To explore the perspectives of internal medicine program directors (PDs) and associate program directors (APDs) on the ACGME diversity standard.

DESIGN: Qualitative study of internal medicine residency program leadership from academic and community programs across the USA.

PARTICIPANTS: Current PDs (n = 12) and APDs (n = 8) of accredited US internal medicine residency programs.

APPROACH: We conducted semi-structured, in-depth qualitative interviews. Data was analyzed using the constant comparative method to extract recurrent themes.

KEY RESULTS: Three main themes, described by participants, were identified: (1) internal medicine PDs and APDs had limited knowledge of the new Common Program Requirement relating to diversity; (2) program leaders expressed concern that the diversity standard reaches beyond the PDs' scope of influence and lack of institutional commitment to the successful implementation of diversity standards; (3) participants described narrow view of diversity and inclusion efforts focusing on recruitment strategies during the interview season.

CONCLUSIONS: Our findings of lack of familiarity with the new diversity standards, and limited institutional investment in diversity and inclusion efforts raise a concern about successful implementation across GME programs. Nevertheless, our finding suggests that structured implementation in the form of education, guideposts, and financial allocation can alleviate some of the concerns of program leadership in meeting the new ACGME diversity standard in a meaningful way.

KEY WORDS: workforce diversity; Graduate Medical Education; diversity accreditation standards.

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INTRODUCTION

Physician diversity has benefits across the healthcare field, as higher levels of diversity in the medical workforce have been linked to improved access to care for diverse and underserved populations, increased cultural competence at the organizational level, and more innovation across the healthcare space.[1, 2] However, Black, Hispanic/Latinx, and Native American, or historically underrepresented in medicine (URM) medical students, are less likely to match into a residency position upon graduation compared to White students.[3] Those who do secure a Graduate Medical Education (GME) position experience daily challenges including workplace discrimination, pressure to assimilate, and high levels of burnout.[4–7]

To increase diversity and inclusion in GME, the Accreditation Council for Graduate Medical Education (ACGME) issued a revision to their Common Program Requirements during the 2019–2020 academic year mandating that all residency programs "must engage in practices that focus on … systematic recruitment and retention of diverse and inclusive workforce" of trainees and faculty.[8] While failure to adhere to these standards could jeopardize a training program's accreditation,

how residency program leadership perceive and plan to incorporate the new diversity requirement remains unknown.

The ACGME diversity standard parallels medical school accreditation standards introduced in 2009 by the Liaison Committee on Medical Education (LCME).[9] While many medical schools initially struggled to operationalize the standards, recent data demonstrate gains in the percentage of female, Black, and Hispanic/Latinx matriculants to medical school after the LCME diversity accreditation standards were released.[10] Although the modest success of the LCME diversity standards on medical student diversity is reassuring, GME residency and fellowship recruitment features a unique set of challenges not present in undergraduate medical education.

While there are 154 LCME-accredited medical schools, there are over 11,000 ACGME-accredited residency and fellowship programs, each relying on a limited administrative staff and budget.[11] Moreover, residency and fellowship training occur within larger hospital systems which often have their own competing organizational priorities and values. Despite these challenges, the response of GME training programs to the new ACGME diversity standard has the potential to substantially influence the diversity of the physician workforce. Nevertheless, few data exist describing how residency program directors perceive and interpret the ACGME diversity accreditation standard. This is important because program directors are responsible for the review and implementation of ACGME standards at the residency program level, and therefore will directly impact how interventions to address diversity are designed. Understanding the perspectives of internal medicine program leadership is particularly important, as internal medicine constitutes approximately 30% of all residency positions each year.[12, 13] Moreover, internal medicine internship is a key pathway for physicians pursuing primary care, adult medical specialties, and various other subspecialties, therefore shaping the future physician workforce.

To address this gap in knowledge, we conducted a qualitative study of internal medicine program directors and associate program directors to elicit their perspectives on the ACGME diversity standard. We also assessed specific program interventions that program leadership intended to implement to adhere to the new diversity standard. To help connect our findings to the larger dialog in medical education, we employed a theoretical framework previously developed based on the implementation of teaching mandates at university hospitals, which identifies Institutional Leadership, Departmental Strategy, Departmental Structure and Culture, and Individual Strategy as key factors in the implementation process.[14, 15] We use this conceptual model to understand how current response to the ACGME diversity standard correlates to previously identified factors necessary for transformational change to occur in the complex setting of graduate medical education.

METHODS

Design and Sampling

We performed a qualitative study of internal medicine residency program directors (PDs) and associate program directors (APDs) between April 2019 and January 2020, with coding processes based in grounded theory.[16] Eligible participants were current PDs and APDs of accredited US internal medicine residency programs. Because the definition of underrepresented groups can vary on the basis of regional demographics, we set out to interview PDs and APDs from institutions across various geographical regions of the USA. Additionally, because residency program size affects available resources and recruitment strategies, we planned to include representation from larger academic and smaller community programs.

Our research group was composed of individuals identifying as African American, Ghanaian American, Latina/x, Southeast Asian American, and White American, and all contributed to the design and analysis of this study. The coders specifically were of mixed White European-Latinx, Southeast Asian American, and Latin descent. The coders' professional identities included a pediatric-trained postdoctoral fellow, psychiatry resident, and internal medicine physician and associate chair for diversity and inclusion in the department of internal medicine.

Our initial study group was a convenience sample at the Academic Internal Medicine Week Conference (April 14–17, 2019, Philadelphia, PA). This conference is sponsored by the Alliance for Academic Internal Medicine (AAIM), an organization focused on advancement and professional development of internal medicine leadership, including internal medicine residency. We felt this conference would represent a cohort of PDs and APDs most engaged in residency program development, and would be an information-rich environment to explore institutional plans for the new ACGME diversity standards. Initially, two authors (A.M.S. and L.B.) invited PDs and APDs to participate via random in-person recruitment, and conducted semi-structured, in-depth qualitative interviews. All interviews were one-on-one with exception of two interviews which were two-on-one because of participant availability and preference. After the initial data was analyzed, we used purposive sampling to identify additional participants from Southern and Midwestern institutions—asking prior participants and colleagues for introductions to PDs and APDs from these geographical locations who might contribute to our understanding. We followed up on these after an email contact or directly using the name of our contact as an introduction and conducted over the phone, one-on-one interviews. Each participant was interviewed once.

Table 1 Demographic Characteristics of Participants

Demographic	No. of participants (%)
Female	14 (70%)
Race/ethnicity	
White	15 (75%)
Asian	2 (10%)
URM	3 (15%)
Geographic location	
Midwest	3 (15%)
Northeast	8 (40%)
West	6 (30%)
South	3 (15%)
Program type	
Academic	11 (55%)
Community	5 (25%)
Combined	4 (20%)

URM underrepresented minority in medicine

Data Collection

Interviews followed an interview guide (Appendix Table 3), while allowing interviewers' flexibility to explore themes raised by participants. Interviews were audiotaped and professionally transcribed. We analyzed the data throughout the data collection process and stopped conducting interviews when no new codes of concepts emerged. All participants were informed of the topic of the interview before providing verbal informed consent to participate in the study and were made aware that their responses may be published anonymously. The study was approved by an institutional review board at Yale University. We performed the study using the Standards for Reporting Qualitative Research (SRQR) reporting guideline.[17]

Data Analysis

We took an inductive approach to generating codes and analyzed data using the constant comparative method, in which essential concepts from interview data were coded and compared over successive interview to extract recurrent themes.[18] Three of us (A.M-S, L.B., and I.G.) independently read three transcripts to generate codes. We coded in an ongoing manner, combining and reconciling codes as they were generated over additional seven interviews to develop a finalized list of codes prior to coding the remaining data. We completed creating thematic categories, when all codes emerging from the data matched existing categories, and completed the interview process when no new data was emerging and we felt we reached meaningful saturation by understanding the range of experiences described in the interviews.[19] Two investigators then coded the remaining interviews, meeting together to discuss data interpretation as a group. We coded the data using Dedoose, an online qualitative research database for data analysis.[20]

RESULTS

The 20 participants included 12 program directors (PDs) and 8 associate program directors (APDs) representing 18 internal medicine residency programs of varied size and geographic locations (Table 1). One invited APD declined to participate in our study. The majority of our participants were White (75%) and 70% were female. The length of interviews ranged from 18 to 49 min (median, 24 min). Twelve interviews were conducted in person. The 12 interviews conducted in person and 1 phone interview took place after the ACGME diversity standard was announced, but prior to the standard going into effect on July 1, 2019. The remaining interviews (n = 8) were conducted after July 1, 2019, and the diversity standard had officially gone into effect as part of the Common Program Requirements.

Participants described three main themes concerning their perception of the ACGME standard: (1) lack of awareness of the new ACGME diversity standard, (2) program directors express misgivings about the ACGME diversity standard, (3) cautious optimism that the diversity standard could serve as a catalyst for change. Table 2 provides additional illustrative quotations for the themes and subthemes.

Program Directors Were Not Familiar with ACGME Diversity Standards

Throughout the study period, many PDs and APDs reported lack of familiarity with the new Common Program Requirements on diversity. Some program leadership reported only becoming aware of the diversity standard while preparing for an upcoming site visit. As one APD explained, there was limited discussion within the program about individual components of program requirements in the absence of scheduled ACGME visit: "Prior to that, complete disclosure, I had not [heard of the diversity standard]."

APDs particularly expressed lack of familiarity with the new diversity standard, explaining that diversity efforts were not part of their core responsibility and were tasked to other individuals. For example, one APD explained: "You know, I am not directly involved with that aspect of the program, so I am not sure exactly what they are doing."

PDs noted having limited discussion with their APDs and other program leadership about the new diversity standard. While more PDs became familiar with the new diversity standard after it going into effect in July 2019, especially towards the end of our study period, most did not explicitly discuss the requirement with their program. As one PD mentioned: "I don't know that I've necessarily sat down and told my APDs that it's part of the common program requirement. I think we've had conversations [about diversity], but I don't know that I've actually ever told them, that they are in the common program requirements and that's why we need to make efforts related to it."

Program Directors Express Misgivings About the ACGME Diversity Standard

Skepticism About the Scope of the Diversity Standard. Program directors interpreted the diversity Common Program Requirements as mandating change beyond the residency program leadership's sphere of influence. Skepticism about program directors' ability to implement institutional changes at large stemmed from the lack of control over finances, faculty

Table 2 Themes and Subthemes with Illustrative Quotations

Themes and subthemes	Illustrative quotations
1. Lack of familiarity with ACGME diversity standards	
Perceived lack of standard dissemination	"I haven't [heard of the diversity standard]. Yeah, I'm not sure if [the PD] is changing anything, and I don't know if it's because we haven't looked at how we've done and we feel like we're already meeting requirements, or if we haven't looked at it… it's just not something [the PD] discussed with us." – APD4 "I don't think I've heard about this standard before." – PD4
2. Program directors express misgivings about the ACGME diversity standard	
Skepticism about the scope of the diversity standards	"I'm not going to be developing a position to hire fill. I'm not going to be working across schools with a school of medicine… it's going to be deciding, figuring out what exactly are my resources and what is reasonable for me to do within the amount of time that I'm thinking about doing it." – PD2 "I mean medical departments, they're just such complex organizations and a lot can get just lost from the transition from UME to GME to fellowship to junior faculty. So, I don't know, I think an interesting question is asking people what are the enablers and barriers in the whole pathway, because I can speak a lot about at our one level, but it's just, if you don't then support the residents to the next transition, it's very hard to work at one isolated section of the whole becoming a doctor experience." – PD9
Lack of actionable guidelines from ACGME	"I'm not sure how [the standard] can change things. I mean like with ... we would interview anyone who'd be interested from faculty point of view to be hired. And for residents, it's a very non-biased filter system that we look through" – PD12 "Because you can talk about diversity and inclusion and you can talk about how we need to have this, but if you don't designate a local champion and put money in their pocket, so that they're freed up from clinical time, then it doesn't matter. It's all a wash. It's all just voluntary. And voluntary stuff just doesn't happen with the same gusto" – PD8
Perceived violation of match regulations	"I mean there's a lot of discouragement between continued correspondence with recruitment. With match violations or things like that. I think there's a lot of discouragement there, and I'm probably not going to take a chance writing many people unless they reach out to me and I might respond" – PD13 "There's, among internal medicine program directors, sort of an unofficial contract around contact of applicants after interviews. I think it comes from a really good place of not wanting to interfere with the spirit of the match, and not wanting to influence residents and say, "Hey, you've been ranked to match in our program." I think it has hit a little bit of a barrier in recruitment of our underrepresented physicians." – PD19
Standards disadvantage non-URM students	"Our program is in a small town that probably does not attract the most diverse group of people. But diversity would mean a program that would be able to have representation of various genders, represent people who are first to go to college, or are first generation in medicine, or various socioeconomic background. Like rural backgrounds for example. It's not as easy to find, ERAS doesn't have a filter for that." – APD3
Standards place disproportionate burden on female and URM trainees	"Here is just what we're talking about, education and then pulling together… the residents who have a lot of energy and great ideas together who want to work on this" – PD2 "Always my fear is that if you don't have an inherently diverse place, and then you have a diverse member of your team, are people going to ask them to be the face of that, unfairly at the cost of their time. Maybe they don't want to meet other diverse applicants, maybe they want to work on their fellowship application". – APD5
Standards disadvantage small community programs	"I think from an ACGME perspective, the thing that I often run into is, you know, when I'm looking at tools or blueprints or things like that, a lot of things are geared toward larger academic institutions. And then we are not, you know, an academic institution. And so, you know, thinking about what it means to establish a pipeline because we don't have an established pipeline." – PD2
3. Cautious optimism the ACGME diversity standard could serve as a catalyst for change	
Program directors see accreditation standards as a lever to affect change	"I think we're interested in hearing how specific is it going to be… can we leverage ACGME requirements to talk to our Deans, to talk to our Chairs, to talk to our Chiefs and say, 'This is not just the right thing to do now, but now there's a standard that we have to meet.'" – APD16 "We're constantly talking about ACGME guidelines. When new guidelines come out, we'll usually have a conversation about, "Are we meeting these? Do we need to adjust in order to meet these new guidelines?" I would say that violation of ACGME guidelines is one of the big things that gets the program's attention." – PD18

selection, and limited resources. As one PD explained: "I feel like [the standards] are outside of the jurisdiction of a program director. Because if you actually read them, they talk about …[efforts] within the faculty, within the leadership, within the hospital administrator. That is not fair to put that on the residency program director."

In addition to perceived lack of power over institutional priorities, PDs expressed reluctance to take on additional managerial responsibilities. Participants described the diversity standard as adding unfair workload to their position. One PD noted: "Most program directors don't control the resources, the finances, don't hire or fire faculty, nor do we want that. Nor should we when we have all the other things to do in our day."

Program directors identified institutional culture as crucial to promoting diversity efforts and creating change. They described attitudes among the departmental leadership, including the department chair and medical school deans, as critical for expanding diversity efforts beyond resident recruitment. Lack of women and racial and ethnic minorities among the department leadership was perceived as a barrier beyond the scope of a program director. As one PD pointed out: "Other barriers… when you look at department chairs, full professors, and the

leaders at your institution, you're talking about centuries long history of white men kind of running medicine. It's hard to make those changes and certainly I am not in a position to make those changes at the top like I only have so much influence over who they select to be the dean of the medical school and who they select to be chairs."

Lack of Actionable Guidelines from ACGME. Program leadership pointed at the lack of actionable steps in the new Common Program Requirements as a limitation to successful implementation. PDs observed that, without additional direction from ACGME, the new requirements would be unlikely to precipitate specific program level or institutional diversity and inclusion efforts. As one participant explained: "The ACGME standards feel very check-box-y. Like my program could definitely say we are meeting the standards today. But we are not successful at recruiting diverse group of residents or creating an inclusive place for those residents. So I don't feel like this is going to necessarily create change for many of these programs."

Participants expressed the need for clarification from ACGME on what was expected from their proposed policies around diversity and inclusion. While the program leadership felt standards were likely left intentionally up for interpretation, they expressed the need for more ACGME guidance: "I guess just clarity. If they're looking for something specific in those policies ... that's still somewhat vague to me. I'm not exactly sure. And they probably purposefully left that vague so it could be interpreted. I'm not sure if it would really change much of our current actions."

Perceived Violation of Match Regulations. Participants expressed apprehension about potential violations of the residency match system while implementing the new diversity standard. Specifically, some PDs felt that abiding current regulations meant refraining from offering interview days or second look opportunities directed to historically underrepresented applicants. PDs struggled to balance potential efforts around URM resident recruitment with their interpretation of rules on post-interview communication set by the National Resident Matching Program (NRMP) and AAIM. As one PD explained: "We have a pretty clear and consistent [policy regarding] no-post interview communication. I know some programs run the extreme, paying for kind of second look weekends and having applicants represent URM communities come back. And we just don't have the resources for that and so we don't have any kind of proactive outreach for specific applicants afterwards. And in some ways you could say that's the right way to do it, we're kind of playing by the rules but we do know some of our peers and institutions are just much more forward."

In addition to potentially promoting differences in how different programs recruit, PDs also worried about potential stress placed on URM applicants. Participants explained they did not want to mislead URM applicants by inviting them for an additional visit post-interview season, when through the match system they could not guarantee any one person a spot. PDs felt that match rules helped to protect both the program and all applicants: "You don't want to be disingenuous though… Alliance for Academic Internal Medicine specifically has a policy, limiting post interview communication. Where we're really being asked not to recruit, for lack of a better word, students, just to not put that stress and pressure on them. It feels a little hypocritical to me, to recruit in air quotes, minority students, the last thing I want to do is put pressure on them, of course."

Standards Disadvantage Non-URM Students. Some participants expressed discomfort reconciling their broad definition of diversity and the focus on recruitment of racial and ethnic minorities among their institutions. Program leadership identified gender, sexual orientation, and economic and rural background as aspects of diversity they would like to pursue in addition to URM applicants. Some PDs felt current standard disproportionately advantaged racial and ethnic minorities in comparison to these groups as well as to non-URM applicants. As this PD stated: "At the same time, if we're all recruiting for minorities students and not recruiting for the non-minority. It just feels a little uncomfortable to me."

Standards Felt to Place Disproportionate Burden on Female and URM Trainees. PDs described residents as key drivers for current URM recruitment efforts. As one PD described: "I'd say in the department of medicine, [diversity] is an area lacking… But I will mention our internal medicine residency has a resident diversity council and they're very involved in recruiting."

Some participants were concerned that the new diversity standard would disproportionately tax women and residents of color. One APD involved stated: "Okay, but do you know that your junior faculty, your women faculty, your URM faculty are disproportionately bearing that volunteer burden, and you may not be contributing to that being the case directly, but you are perpetuating this inequity and we need to think about how we do that."

Standards Disadvantage Small Community Programs. Participants from smaller programs and community programs felt the standards were written with larger academic institutions in mind. They worried new requirements increased the risk of citation among community programs that do not have a larger GME support or affiliated UME office. As this PD expressed: "I'm not going to be working across schools with a school of medicine. I do have other residency programs within our institution that I can build things with and I'm interested in doing that, but we're still talking about really small numbers here."

Cautious Optimism of the ACGME Diversity Standard Could Serve as a Catalyst for Change

Program Directors See Accreditation Standards as a Lever to Affect Change. Despite concerns around lack of guidance

from ACGME, some participants acknowledged that Common Program Requirements could serve as a potential catalyst for change across programs and institutions. While there was concern about the lack of deliverables in the wording of diversity standard, several PDs felt that new ACGME requirements would allow diversity efforts to garner institutional support. New standards were also viewed as a lever to engage a greater audience by those involved in diversity and inclusion efforts. One APD noted: "Perhaps just having a statement is supportive. Because it's something you can wave in someone's face and say, "I'm telling you we need to be doing this, now we really need to be doing this." Whenever there's a requirement, you will have to report what you do."

Program directors further explained that, while institutional culture valuing diversity is essential to change, the standards could force institutional support and accelerate the process. Prior to the standard implementation, participants felt that change was slow and it was difficult to obtain buy in from different parts of the programs and different levels of leadership at the institution. This PD reflected on the change she saw since the standard implementation: "I think that the requirements have been the push that we needed in order to perhaps get us the institutional support. So I mean I do think that's sometimes the benefit of requirements, was that then to have a reason to advocate for these or to push the institution. I think the culture is definitely shifting, but was taking maybe longer to shift, and with the help of these requirement, it accelerated it. So it's a little bit of both if you will. That they're working almost synergistically to then propel us a little bit further forward than we would have."

DISCUSSION

In this qualitative study, we identified several themes with important implications for the new ACGME diversity standard. First, we found that the internal medicine program directors and associate program directors had limited knowledge of the new Common Program Requirement relating to diversity. While PDs interviewed after the diversity standard implementation in July 2019 were more familiar with the new standard, the internal dialog about the standard among residency leadership was infrequent. Second, program leaders expressed apprehension about lack of institutional commitment to the successful implementation of diversity standards. Third, participants described a narrow view of diversity and inclusion efforts focusing on recruitment strategies during the interview season. Nevertheless, study participants did acknowledge that the ACGME standards could represent a tool for precipitating change at their institutions.

Our study is consistent with previous reports of difficulties operationalizing the LCME diversity standards.[21] Additionally, program leadership apprehension about ACGME standards was similarly noted during the implementation of duty hour regulation.[22–24] Our study highlights the importance of departmental and institutional support that was identified as key in successful implementation of competency-based medical education.[13] Our study provides additional insight into opportunities and barriers for the implementation of the new diversity ACGME Common Program Requirement, as well as potential impact on current and future trainees.

i) Lack of familiarity and communication

PDs' and APDs' lack of familiarity with the new diversity standard raises concerns about the successful implementation of this accreditation policy across GME programs.[25] Preparation and dissemination of supportive guidelines for residency and fellowship programs is critical to increase uptake across institutions and mitigate the potential risk of programs receiving a citation or being placed on probationary status. The AAMC Roadmap to Diversity was created as a response to the 2009 LCME diversity standards to help medical schools implement the new requirement, and similar tools from ACGME may be useful for residency program leadership.[26, 27] Recently, additional guidance has been published from ACGME identifying the development of URM learners at any pre-residency stage, as well as implicit bias and bystander training of faculty, as two processes meeting the new requirement.[28]

ii) Lack of institutional commitment

We identified several themes consistent with previously described theoretical framework for implementation of medical teaching policies at university hospitals, as well as the experiences in implementation of competency-based medical education.[12, 13] These conceptual models identify institutional leadership strategy and financing, departmental strategy and culture, and individual strategy as major factors facilitating the shift in culture necessary for transformational change to occur. Nevertheless, our study suggests that, even among programs actively engaged in diversity and inclusion efforts, this work is largely the responsibility of a limited number of individuals, often female and URM faculty. Additionally, PDs and APDs often described efforts surrounding diversity and inclusion as volunteer work, potentially indicating a lack of institutional commitment. As with all ACGME Common Program Requirements, creating a culture of diversity, equity, and inclusion should be the responsibility of all trainees, faculty, and staff across the institution. Findings from our study also suggest that IM program directors would benefit from greater support from department chairs and section chiefs in order to successfully comply with the new ACGME diversity standard. This additional support could include money and protected time for faculty to focus on diversity and inclusion initiatives, the hiring of external consultants to provide recommendations, and the appointment of a department Chief Diversity Officer.

iii) Narrow focus on recruitment strategies during the interview season

The ACGME diversity standard mandates GME programs to focus on "systematic recruitment and retention of diverse and

inclusive workforce."[7] Nevertheless, study participants disproportionately identified recruitment efforts, such as interview days, second look events, and post-interview communication, as key interventions in compliance with the diversity standard. This narrow focus on recruitment interventions has potential to perpetuate ongoing inequities experienced by trainees and limit the retention of a diverse physician workforce. Trainees consistently report workplace discrimination and harassment, including verbal, physical, and sexual harassment, based on race/ethnicity, gender, and sexual orientation.[3–6, 29] This has been linked to higher rates of leave of absence during residency training, as well as higher physician turnover throughout their career.[29–32] We must remain conscious of the needs and challenges trainees and faculty face in the working environment of clinical practice and academia, that extends beyond issues of recruitment. ACGME should be explicit in identifying efforts focusing on promoting a workplace free of harassment and discrimination and therefore benefit all members of the institution.

Study participants expressed concerns that the ACGME diversity standard would require PDs and APDs to engage in activities that would potentially represent violations to the NRMP code of conduct. While the NRMP and AAIM discourage unnecessary post-interview communication, neither bans targeted recruitment efforts and non-mandatory second look opportunities for applicants.[33, 34] Moreover, the ACGME standard does not dictate specific recruitment interventions. The narrow focus by residency programs on recruitment activities like 2nd look events and post-match communications offers an opportunity for the ACGME and AAIM leadership to provide greater education on evidence-based interventions to promote diversity in applicant selection such as holistic review, implicit bias training for program leadership and all individuals involved in applicant selection, and structured interviews.[27, 35–44] These interventions have been shown to reduce the influence of bias in applicant recruitment and often involve little to no financial cost, making them attractive for all programs irrespective of size or resources available.

Our findings should be interpreted in the context of the study design. Because program directors and associate program directors were interviewed across a 9-month time period, their familiarity with new Common Program Requirements increased over time. Nevertheless, because ACGME introduced the new changes over a year prior to our study, we expected those in program leadership to be aware of these at the time of study onset. Some themes may not have been captured because internal medicine programs vary in many aspects in addition to their geographic location, program size, and affiliation and might have not been represented by our sample. We also studied internal medicine program directors and associate program directors only, and cannot extrapolate our findings to the experiences of other medical specialties or institutional GME level leadership. Future studies may assess these, as well as the perspectives of higher institutional leadership, trainees, faculty, and applicants.

CONCLUSION

The new ACGME diversity standard represents a unique opportunity to influence diversity, equity, and inclusion efforts across residency programs. Nevertheless, current focus of residency program leadership on recruitment efforts, relying on volunteer work by a limited number of faculty and residents, highlights the need for more structured guidance to promoting diversity and more importantly inclusion. Our finding suggests that GME-specific educational materials combined with increased financial and time allocations for diversity efforts may improve adherence to the new ACGME diversity standard.

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Corresponding Author: *AngelaDowin Martinez-StrengelBoatright, M.D., M.H.S.; National Clinician Scholars Program, Yale School of Medicine, New Haven, CT, USA (e-mail: angemar@lhs.org).*

Author Contribution *D.B., A.M.S., and D.L. conceptualized the project. C.P.G. obtained financial support for the project. D.B., A.M.S., A.B., D.K., and D.N.B. developed the interview guide. A.M.S. and L.B. performed qualitative interviews. A.M.S., L.B., and I.G. coded the data. D.B., A.M.S., L.B., and I.G. analyzed and interpreted the data. C.P.G, D.K., and D.N.B. supervised and verified the development of methodology. D.B. and D.N.B. provided guidance throughout. A.M.S. and D.B. prepared the original manuscript. A.M.S, L.B., A.B., D.N.B, I.G., C.P.G., D.K., S.S.S., and D.B. reviewed and provided critical revision of the manuscript for important intellectual content.*

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Declarations:

Ethics Approval: *Yale University Institutional Review Board deemed this study exempt.*

Conflict of Interest: *The authors declare that they do not have a conflict of interest.*

Disclaimer: *The contents of this study are solely the responsibility of the authors and do not necessarily represent the official view of NIH.*

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