

## Transcript

### Taking Action on Harmful Bias and Discrimination in Clinical Learning Environments 2020 Macy Conference Recommendations

Peter Goodwin:

Good day everyone, and welcome to the Josiah Macy Jr. Foundation's webinar series: *Taking Action on Harmful Bias and Discrimination in Clinical Learning Environments*. Before we get started, a few housekeeping items. Today's session is being recorded and will be available next week on the foundation's website, [www.macyfoundation.org](http://www.macyfoundation.org). The chat function on your Zoom screen is currently disabled and will be throughout the presentation portion of the webinar. We will enable the chat function once we start the question and answer portion of the webinar. At that time, you'll be able to chat with all attendees and panelists. Please feel free to use it to share information or best practices or to comment on responses to the questions that you, the audience, posed for our panelists. In addition, the Q&A function on your Zoom screen is active and will be throughout the webinar. You can use it to pose questions to the panelists. Let me now turn it over to today's presenters.

Holly Humphrey:

Hello everyone. My name is Holly Humphrey. I am the president of the Josiah Macy Jr. Foundation, a position I have held since July of 2018. Prior to joining the Macy Foundation, I practiced pulmonary and critical care medicine at the University of Chicago, where I also served as the dean for medical education for 15 years. And for the 14 years prior to that, I served as the director of the Internal Medicine Residency Program. Let me turn it over to Camila.

Camila Mateo:

Hi everyone. My name is Camila Mateo and I'm a primary care pediatrician at Martha Eliot in Boston Children's Hospital and the associate director of anti-racism curriculum and faculty development at Harvard Medical School. And I was able to join this conference as a paper author with my co-author, Dr. David Williams. And so I'll turn it over to Fidencio.

Fidencio Saldaña:

Thanks Camila. Hello everyone. My name is Fidencio Saldaña. I am a cardiologist at Brigham and Women's Hospital and the dean for students at Harvard Medical School. And I had the pleasure of being one of the organizers for this conference.

Holly Humphrey:

So, for today's webinar, we have allocated our time in four major categories. I will begin by providing some background of how we got to where we are today. Then my colleagues will provide an overview of recommendations that grew out of a conference that we attended together. I will then make some concluding remarks and then we're going to save ample time to engage with all of you in a question and answer session. So let me begin by providing some background. As many of you know, the current health care workforce does not reflect the diverse identities and experiences that affect people's health and health care. Few initiatives to improve the diversity of the workforce have been replicable or sustainable, and advancing diversity, equity, and inclusion within the health professions is central to improving the overall well-being in the United States and reducing attrition among historically underrepresented populations in health professions, schools, and in professional practice.

And so, with the emerging issues that have been a part of our health professions environments and a part of trying to improve the health for all Americans, the Macy Foundation appointed a planning

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committee to help us decide how we wanted to tackle a very, very big societal problem. And so this planning committee met and began planning what will become a series of conferences. We began with the conference on addressing harmful bias and reducing discrimination in our clinical learning environments so that we could really try to move the needle on what's happening in those environments. The conference that we convened involved 44 leaders in health professions education, health care delivery, learners, and educational accreditors. To prepare for this conference, we commissioned four papers and three case studies. You already heard from my colleague, Camila Mateo, that she was an author of one of those commissioned papers.

The 44 participants spent three days deliberating and ultimately generating consensus recommendations, which we will be reviewing with you today. These recommendations were then refined by our planning committee, and the final product was reviewed and approved by all of our conferees. So, these recommendations are actually intended to serve as an urgent call to action for health professions, education and health care organizations all across America to transform our clinical learning environments in which current and future generations of health professionals, practitioners, and educators are working and learning with the ultimate goal of achieving better health for all Americans. This conference was actually held in February of 2020, and if you just think back to February of 2020, the world was a very different place. It was actually before the pandemic took hold in the United States and before the multiple murders of Black Americans in the spring of this year.

And so today's webinar is intended to be the beginning of a nationwide conversation on this topic in order to catalyze real action. And to that end, we have planned a series of webinars. Today, we will be focusing very broadly on the topic of addressing harmful bias and reducing discrimination in our learning environments. And then in January, we're going to address this topic in the context of the environments for learning for our nurses. In February, we will turn to the complex topic of dealing with bias and discrimination when it is represented by our patients. In March, we will talk about a long oppressed and marginalized group of those with LGBTQ+ identities and the many complex ways in which harmful bias and discrimination rears its ugly head. In April, we have a session that will focus specifically on anti-Black racism and how we can really transform our clinical learning environments such that anti-Black racism is expunged and not present.

And then in July, we're going to talk about a topic that's often in the shadows and that is not often talked about and that is dealing with those who theoretically should not be discriminated against, those with disabilities. But in fact, are there structural ways in which they are discriminated against? And so as you can tell, there are so many complexities to this topic that in order to do the topic real justice, we are going to devote a separate webinar for each of these topics and perhaps there will be more to come after that. Now, let's go back to the conference that I mentioned that took place in February of 2020. One of the very first things that all of the conferees engaged in was crafting a vision statement. And what you see projected right now is the vision statement that our conferees agreed on.

And I will just read it because it frames what we're about to discuss. "Our nation's health professions learning environments from classrooms to clinical sites to virtual spaces should be diverse, equitable, and inclusive of everyone in them no matter who they are. Every person who works, learns, or receives care in these places should feel that they belong there." And so now let me turn it over to Camila who will take us through some of the themes that became readily apparent throughout our three-day conference.

Camila Mateo:

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Thank you so much. And so we're going to start with the first theme that came up pretty quickly, which is intersectionality. And so originated by Dr. Crenshaw, intersectionality is a framework to understand the ways in which identity-based systems of oppression and privilege like racism and sexism, for example, do not exist as separate entities, but instead overlapping converge on different groups and individuals who identify as members of several marginalized communities. And as Dr. Humphrey mentioned, we had a very diverse group of folks coming together to discuss how to address bias and discrimination. And as we did, we waded into a conversation that I would describe as comfortably uncomfortable. In particular, there was a palpable tension between conferees that described the need to focus anti-bias efforts in the health professions on the history of racism, specifically against Black and indigenous communities because of our unique history in the United States.

While other groups stressed the focusing on racism against these groups without also having time dedicated to naming the marginalization of other groups within the health professions, such as members of the LGBTQ community or those living at the intersections of identity could minimize the lived experiences of all of these groups. And so overall, it became clear that being able to honor both of these important points within our learning environments as we design curricula and think about how to move forward in training is a critical part of addressing these issues. When we're thinking about structural and systematic change, this was a big part of what we were wanting to address when we were thinking about how to do this in a coordinated and top-down manner. I think the real theme that came up here is that a lot of the movement in trying to address these issues in the learning environment has been a grassroots movement, often coming from our students and learners and our faculty and leaders catching up and trying to be able to listen to and address the many ways in which bias and discrimination are manifesting.

And I think a big part of our conversation was the importance of also having strong top-down prioritization of addressing bias and discrimination within our organizations and being able to couple that with the important grassroots work that is happening on the ground from our learners, from our junior faculty in order to move all of this forward. Another theme that arose was the need for a common and intentional language to address bias and discrimination. And so many participants made the point that language matters and is often evolving and changing over time and making sure that there is a shared language around these topics at the start of this work at an institution is crucial to ensure clear communication. And so, participants also pointed out the need to name broader systems of oppression like racism, sexism, ableism, as root causes of inequity and of implicit biases that each of us hold as opposed to discussing bias or discrimination without acknowledging these broader systems.

In particular, conferees agreed that if we aren't doing this, not only are we missing an opportunity to communicate effectively, we're missing an opportunity to center the stories and perspectives of marginalized communities most affected by these forces in our learning environments. And we often do so to protect the comfort of majority group members in our communities. And so for this reason, we also did come up with a glossary that is available with the conference recommendations. We also talked a lot about how is it that we can incentivize the advancement of diversity, equity, and inclusion principles as we think about this work in our institutions and organizations? And specifically started thinking about how the coupling of advancing DEI or diversity, equity, and inclusion efforts with institutional excellence, and also things like compensation grant funding, et cetera, is a model that should be thought about critically on the organizational level to be able to effectively incentivize real change.

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Some examples of this included thinking about the Athena Swan initiative, where, in the UK specifically, there was a mandate for grant funding from the government in the UK around health to be tied and only available to folks and institutions that were able to demonstrate parity, specifically gender parity in their institution and improvement in gender parity in their institution as demonstrated by being a part of the Athena Swan initiative. And actually saw a significant increase in efforts on the institutional level to be able to see evidence of improvements in parity once those improvements were coupled to the incentive of being able to apply to grant funding.

And finally, another theme that came up was really focused on the importance of interprofessional education and training. And so as Dr. Humphrey mentioned, a great strength of this conference was its interprofessional nature. And one of the themes that rose out of our discussion was that many of the tools needed to effectively engage in interprofessional education are the same tools needed to implement diversity, equity, and inclusion within an organization. These tools include fostering psychological safety within the learning environment, ensuring members are demonstrating a culture of mutual respect, and making sure that different perspectives, experiences, and expertise are valued. Evidence also suggests that training to address bias and discrimination is effective when implemented and coordinated throughout the health professions institution and not siloed in any particular department division or health profession. And so because of this, interprofessional education is likely an important tool to successfully address bias and discrimination in our learning environments. And so with that, I'll pass it over to Fidencio to start talking about our recommendations.

Fidencio Saldaña:

Thanks very much, Camila. What I hope everyone will notice is the way these themes come up over the next few slides that detail the recommendations, each of which had a variety of action items that you can find on the PDF link to the report. So, recommendation number one is to build an institutional culture of fairness, respect, and anti-racism by making diversity, equity, and inclusion top priorities. So the key to this recommendation, as Camila had mentioned in the themes, is that it really stresses the importance of change at the highest levels of organizations as well as stressing that diversity, equity, and inclusion shouldn't just be a priority of an institution or organization, but truly that it should be a top priority. So it calls upon a broad group of leaders to act to achieve diversity, equity, and inclusion. And these leaders are named, they are governing board members, trustees, executive leaders, deans, to really take action recognizing that achieving diversity, equity, and inclusion will actually enhance an institution or organization's ability to achieve its missions and goals.

So again, drawing on that theme that grassroots efforts are important, but we really need to be holding our leadership accountable. So in doing so, the action steps would include really approaching this topic with curiosity. We are not all experts in diversity, equity, and inclusion, but we can make a commitment to gain the knowledge and tools needed to effectively commit to prioritizing and advancing issues of diversity, equity, and inclusion. It also calls for diversifying leadership at all levels, but especially at the leadership level where many times diversity can be lacking. As institutions develop strategic plans, it will be important for them to really think about including training programs on diversity, equity, and inclusion in these plans. Camila also mentioned that organizations should be incentivized to make this a priority, really creating a culture of accountability. And importantly, the burden should be put on others that have not traditionally had the burden of doing this kind of work.

So, administrators and faculty members from historically marginalized groups should really be joined by others so that there's a broad coalition in an organization to do this work. And also very important data

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in all of our health professions. We really highlight the importance of data in making our clinical decisions and tracking numbers. And the same thing really should be done with issues of diversity, equity, and inclusion. Next are federal and state bodies such as the National Institute of Health, the Agency for Healthcare Research and Quality, and the Health Resources and Service Administration, really should develop research agendas that support the advancement of diversity, equity, and inclusion. And finally, another group that is very important are the health professions accrediting bodies such as the Joint Commission, the ACGME, the LCME, the ACEN, and the CCNE, as well as foundations that can help to incorporate and report on metrics and programs that help advance diversity, equity, and inclusion. And finally, I think an important action step is recognizing the importance of the representation in visual spaces that we work and inhabit, and particularly representation from historically marginalized groups. So that is recommendation one. Camila, over to you.

Camila Mateo:

Absolutely. So, recommendation two. It's hard to address anything without being able to effectively identify it. So recommendation two is that institutions really develop and continually assess systems to identify and mitigate harmful bias and discrimination. And this includes what you might immediately think of like learner phrasing, bias reporting systems, or patient-facing interventions to screen and provide resources that address social determinants of health. But the group made a point to emphasize that this work requires an evaluation of all practices, processes, and norms within the institution to evaluate for bias that may go unseen without this critical and overarching review.

And so this includes having clear metrics to evaluate for bias or discrimination, looking at our internal recruitment processes, our technical standards, learner assessment, promotion, and even compensation to see whether there are disparities between groups. It includes thinking about how folks are able to access our institutions, are we making sure to include a variety of different payers and insurers, especially public insurers, so we can provide access to as diverse a population as possible. And these inequities, if identified when identified, should then be transparently communicated and leaders should be held accountable as Fidencio was mentioning, in setting and meeting measurable goals that close these identified gaps and opportunity. And so that's recommendation two.

Fidencio Saldaña:

Recommendation number three is to integrate equity into health professions curricula, explicitly aiming to mitigate the harmful effects of bias, exclusion, discrimination, racism, and all other forms of oppression. And as a medical educator, this is one that is definitely very near and dear to my heart. So this particular recommendation calls for educational leaders to ensure that required health professions curricula examine the harm caused by bias, exclusion, discrimination, and all forms of oppression. And the conferees really felt that the required word was really the key word, and that many times these types of topics can be offered as an extra or as a standalone topic, but it's important that they really be a required part of the curriculum. And as we will note in a moment that they'd be integrated into the curriculum as well. So this is a twofold endeavor in that we need to teach health professions learners these topics.

But what we'll see is that we also need to teach our faculty that these require faculty development on how to teach learners about these topics. So it's important that the curricula teach about the lasting negative impacts of events in our history on people's health and opportunities, as well as the system of structural oppression which contributed to today's health inequities, inequalities, and disparities. So this

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does go beyond just the discussion of health disparities, but really getting at the root cause of where these disparities came from. And many times it doesn't necessitate looking back to our history, furthermore, organizations should be educating everyone in the organization, so health professions, leaders, faculty, staff and learners, really everyone in the community so that everyone can demonstrate competency in promoting diversity, equity, and inclusion. And again, this is purposely broad and that typically we may focus on faculty or health professionals, learners specifically, but this calls on education of the entire community.

So the action steps really start with institutions regularly assessing for evidence of harmful bias and discrimination within their environment. We know that incidents exist of harmful bias and discrimination, and it's important that institutions develop a manner where individuals truly feel safe providing this feedback and know that something will be done with it. The curriculum should include learning about who is in the community. The more we know about our community, the better we can care for them. And this is more than a voyeuristic view of a community, but truly getting to know the community on a deeper level. The recommendation calls for the formation of best practices in order to facilitate the development of a true interprofessional training program.

I'm sure many of us currently have seen our own institutions, hospitals, schools, clinical sites develop these independently, but it would be much richer if these were developed in collaboration or perhaps even next by some national organizations as well. As mentioned, it will be very important in this curricula that these topics be integrated into the overall curricula in a meaningful way, that racialized content is eliminated, such as topics that have recently been discussed such as the GFR/PFT or even using racial identifiers in inpatient presentations.

In addition, there should be content to focus on managing bias and discrimination in the clinical environments. So, in addition to reporting, including bystander training that truly should be mandated in a meaningful way by institutions. And finally, there's a topic of assessment. Many learners always ask, is this going to be on the test? And that really implies, is this topic important or not for me really to take a closer look at? So by assessing these topics or medical schools, nursing school, other health profession schools can show that these topics are important because we're assessing students in these content areas. And the other form of assessment is the way that we assess our learners. It will be important that there are equitable assessment tools that are developed to eliminate bias from the evaluation system. Camila, back to you.

Camila Mateo:

Thanks. And so as has been mentioned a couple of times already, having a workforce that reflects the diversity of our current patient populations is arguably the most powerful way to reduce bias and discrimination within our learning environments. And recommendation four focuses on exactly that, achieving critical diversity in the health professions and increased diversity among trainees is associated with a host of positive outcomes that we're all striving for, including the reduction of bias towards marginalized communities, higher rated preparedness in caring for diverse patients, and an increased intention to work with underserved populations among trainees of all backgrounds. It also leads to high quality science with increased diversity of research teams being associated with greater scientific impact. Unfortunately, while initiatives promoting institutional diversity are common, they're often decoupled from concrete improvements in representation. Meaningful and transformative change requires moving from diversity initiatives that reflect goodwill to measurable improvements in representation and inclusion. Action steps that the group came up with to try to achieve this goal

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included a focus on pathway programs from K-12 to college for underrepresented groups to be exposed to and encouraged to pursue a career in health professions.

It also included admission committees striving to contain a diversity of backgrounds and adopting quality control processes like standardized interviews. It also included ensuring support and mentorship for underrepresented groups who become a part of our community to try to improve the retention and retainment of underrepresented groups in academic medicine specifically.

Holly Humphrey:

Okay, thank you. Fidencio and Camila, as I already mentioned, our conference where these recommendations were developed took place in February, but following that conference, as the group continued to work to refine both the recommendations and the action steps, we found ourselves as a nation profoundly grieving for the murders that we were reading about on an almost daily basis for Black Americans. And so the Black Lives Matter movement, the candlelight vigils, the grief and grieving that followed was very much a part of the context in which we refined the recommendations and action steps. The grief and grieving was also accompanied by activism and advocacy. And I don't know about you, but for me, this gives me great hope about the future of our country and about our health professions learning environments. So the activism and advocacy is something that will go on and help us implement the kinds of changes real change that we want to see now in follow-up to the conference.

Not only have we refined our recommendations and our action steps, but just a week ago *Academic Medicine* published a supplement that contains the four papers that we commissioned for this conference as well as the three case studies that were commissioned for the conference. But together with those papers, there was an open call for additional papers and you will find all of them, the original commissioned papers together with those papers submitted in the special call [in this supplement](#), which you can access online or for those of you who receive the published edition, if you don't already have it in your hands, you should have it shortly.

So as we transition to our question and answer part of today's conference, I just want to again emphasize that this is the first of what will be a series of webinars to take a deeper dive into this very complex topic. So let me now open it up to all of you. You may ask your question through the Q&A function that is a part of today's webinar. If you post your question in the Q&A function, we will do our best to answer it. Now, I'd also like to point out that on the slide that you are viewing right now is the [web address for the conference recommendations](#) together with all of the action steps that are a part of those recommendations. And so you should feel free to access that report at that site. This will also be followed by a more in-depth summary of the conference itself in a [conference monograph](#) that will come out either by the end of this year or early in 2021.

So to get our question and answers started, I'd like to turn to Fidencio. Fidencio just a few moments ago. You presented recommendation three that had an action step involving institutions gathering data and feedback from the learners on evidence of harmful bias and discrimination in the learning environment. I don't know about you, but I often found that very difficult to implement. I wanted to hear from the students and the residents where they might be experiencing harmful bias and discrimination, but it isn't always easy to get that information. So can I ask you to maybe talk a little bit more about the challenges of collecting that information and then potentially really acting on it?

Fidencio Saldaña:

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Thanks, Holly. I know that is a great question and that has come up in our discussions with the conferees at our conference. It has come up with medical educators across the country at a variety of conferences as well. And I think the challenges that we hear from our learners are manyfold, but really two seem to rise to the top. One is feeling that there's a lack of safety, what will happen to this information, it's beyond anonymity in submitting a concern, but that the individual would be identifiable by the description of the concern. So I think that's one challenge that many learners will present. And the other challenge that learners will present is what's the use? If I submit this data, it's going to go in a box and not really looked at and nothing will come up. It's the purpose of even bothering to report.

And I think really that's where the theme in the first recommendation of really creating a culture that we're able to change both of those thoughts from our learners is can we create a culture similar to what has happened with patient safety? Our conferees really alluded to the way that the idea of reporting a near miss or a medical error has really changed over the last 20 years from when many of us were in training, that it really has become a patient safety issue with the patient at the center.

And is there a way that we can really turn this in a very similar way where we can create an accessible system for students to be able to report this and that it really becomes a cultural norm and that we're able to then be transparent as to what happens? I think the culture is really that of a growth mindset where we're all human beings that will make mistakes, but we really want to do better for ourselves, for our trainees and our patients. And it is a challenge, but I think it is very doable and I know many schools across the country are moving in that direction.

Holly Humphrey:

Thank you, Fidencio. Let's hear from our participants with additional questions.

Peter Goodwin:

So, for the panelists, there's a number of questions coming in. We're triaging them here at the Macy Foundation. Let me go through some of them and direct them to you. This first one is actually specifically to you, Dr. Mateo. It's regarding your longitudinal anti-racist curriculum. Do you have plans to share it with other medical schools so that they might use it either as a guide or even adopt it?

Camila Mateo:

That's a great question. I think to step back a little bit before it, right now we're in the process of collaborating with the many educators at HMS who have been working on creating anti-racist curricula or curricula addressing diversity, equity and inclusion and trying to create and map what that curricula looks like to make sure that those pieces of the curricula that are already there are honored and a part of it, as well as figuring out where are the gaps and where might we want to include new or different content for the students. Similarly, with faculty development, thinking about what are the pieces of faculty development training that need to be included for folks that are going to be working closely with students, as well as making sure that faculty are up-to-date with what the students are learning as they're learning it and being able to coordinate that kind of training.

And so I think we're a bit away from a complete longitudinal curricula and right now are working on trying to create that curricula and certainly would love to share it as broadly as possible, especially to try to see what kind of feedback other educators in other areas may have. I think a big part of this work is trying to make sure that as we embark on it, we're being as collaborative as possible and understanding



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that different audiences and different folks may need and thrive with different approaches and trying to be as flexible and effective as possible.

Peter Goodwin:

Thank you. I would let the attendees know that the chat function has now been enabled, if you'd like to use that as well. This next question for the panel has to do with curricula. In order to integrate equity into curricula, one needs to know where bias, exclusion, and discrimination first exists in it. Can any of you give an example of this?

Holly Humphrey:

Camila, would you like to take that one? And then Fidencio, I'll ask you if you'd like to comment as well because I'm sure in some ways there are probably several examples, but they are often not examples that jump out right away.

Camila Mateo:

Absolutely. So it's a great point that you raise. I think that in general, the process of being able to think about or the way that we've been approaching it so far at HMS has been thinking about two approaches that are complimentary. One is thinking about what kinds of specific content that is focusing on the knowledge, skills, and attitudes needed to close racial ethnic gaps and understand the structural drivers of bias and discrimination as it pertains to race and other social identities. What's the specific content that may have to target that directly while also being able to review all content and identify whether or not there are areas that could be improved in order to eliminate bias and discrimination that exists.

And so some pieces that have come up that have certainly been discussed in the literature by many, including Dr. Williams and Dr. Kumar Jones, is making sure that when we're talking about specifically, an example I'll use is race, race ethnicity, because that's where a lot of my efforts have focused lately when we're talking about racial ethnic disparities, making sure that we are naming racism as a primary structural and systemic driver of the inequities that we see. Another important piece is making sure that we don't conflate race with a biological construct and make sure that we are helping our faculty and students understand clearly that race is a social construct that is very much reflective of structural and systemic differences and differences in opportunities specifically allocated by race in the US, which is where we are right now. So a lot of our discussions focus specifically on that place and this place.

And so I think those are a couple of examples that have come up often where in reviewing curricula and reviewing slides, meeting with course directors, trying to make sure that we're really paying attention to the way that we talk about racial ethnic disparities and making sure that we're providing the historical context and social context needed for students and faculty to understand how do these disparities arise and how can I work to close them as I become a provider.

Holly Humphrey:

Thank you, Camila. Fidencio, would you like to share an example?

Fidencio Saldaña:

Of course, a few examples come to mind. I think even thinking to our standardized tests like the USMLE in which perhaps there's an African American male with sickle cell anemia and many examples like that

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have been used that really don't tell the whole picture. And I think we need to be cognizant of things as we describe patients in clinical vignettes in different cases. Does putting a patient's ancestry race ethnic background, does it really add anything to the learning agenda? Interestingly, things that have come up over the years, not just at HMS but with other colleagues, is that unconscious bias. Why is it that when we look at, let's say pathology of STDs that coincidentally all of the pictures are of patients of color, and maybe in normal pathology are patients that are not of color.

The whole issue of even skin that one of our students, LaShyra Nolen, has a nice piece in the New England Journal of Medicine about how even our materials and things that we've learned from may be biased in one way or the other within dermatology, it would be the lack of skin of color in many of our learning materials. So those are a few examples that we've seen.

Holly Humphrey:

Yeah, thank you. Those are great examples. Peter?

Peter Goodwin:

So we have several questions related to faculty, and I'll try and summarize. People are interested in understanding practically how can institutions prepare their instructors, their faculty to acknowledge the self-biases that exist that they have toward marginalized students?

Holly Humphrey:

Oh, this is a really important question, so I want to thank all of you for asking that because I think this is a very heavy lift for institutions if we're going to do this well and thoroughly. And it's a heavy lift in part because of so many competing priorities. And so that's why we were so insistent with recommendation one that this has to rise to the very highest level of priority because if you're really going to develop your faculty in the way that this question is inviting us to do, you're going to have to be all in. It's not a simple thing. So, Fidencio, would you like to comment on this in terms of how do you actually do that?

Fidencio Saldaña:

Absolutely. And again, I think it also goes, as you alluded to Holly, it goes back to recommendation one, where it's looking really at top-level leadership that this has to be a top priority. As an example, I'll use a medical school example, when a medical school goes into a curricular change and perhaps they're changing pedagogy. An example at HMS going from lecture-based to problem-based to now a case-based collaborative learning at teaching and learning studios requires a skillset. And in order for faculty to participate, it really takes development on how to teach in a learning studio and how to develop appropriate materials and how to develop cases. And that's where we have to think of issues of bias as just as important. That is going to require really two types of training.

It requires training on feeling comfortable in teaching these topics, but it also requires training on how to teach a diverse set of learners as well. Having support from leadership to, and I think we have to use the word mandate, those of us that do trainings in hospitals through HealthStream that are required once a year, that comes to mind. But these need to be meaningful programs that really enrich and train faculty on how to do this. Honestly, the first step is talking about it. I think just being here and talking about it and talking about it in your institution and just speaking that this is something that needs to be done as a first step.

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Holly Humphrey:

Thank you. If we have time, I'll come back and ask you if you have any specific wisdom on the faculty development that you might use for your medical school admissions committees. But Camila, let me see if you have anything that you'd like to add related to training the faculty.

Camila Mateo:

Yeah, I think it's definitely one of the most important parts of this work because I think this is where we can see a lot of our efforts be made or broken, I think, in being able to create a community where faculty and learners are being able to learn side by side as we work on this. I think another difficulty around is that it's continual, right? It's not a box you can check once a year or twice a year. Being able to actively engage and reflect on and attempt to mitigate your own biases is continual work, it's longitudinal work, and it's work that takes time. I think something in addition to the logistics of how is it that I can create a space for my faculty to develop in this way? How is it that I can assess where they're at and be able to meet their needs in working towards this?

I think stepping a little bit further back is what resources do I need to provide to my faculty for them to be able to engage in this training? What kind of protected time? What kind of incentives, what kind of compensation? What kind of support am I giving faculty development in general and how can I use those tools to be able to empower my faculty to engage with this kind of training? So certainly making something mandatory as a part of that, but also being sure that you're creating a space where you have that time to engage with the set aside from other responsibilities, as many of our faculty have many competing responsibilities, and it's not to say that this isn't incredibly important, I'll be the first to say that I think it's central to any faculty being an effective educator.

At the same time though, I do recognize those competing demands and think that that's where some of the structural resource allocation time, et cetera, around faculty development would be a crucial part of it as well, because I think if you don't set up the environment for someone to actively engage, it's difficult to get over that activation energy for them to sort of step into that space in the first place.

Holly Humphrey:

Yeah, those are really helpful comments. In my experience, I often found that this was or is an area where the students can have a really impactful role as teachers in a way by identifying what they're experiencing, what they think are some of the key issues. Have either of you found ways in which to incorporate the students in the role of a teacher for your faculty development programming?

Fidencio Saldaña:

It's a great question, Holly. I think we involve our students as an example, as in many other institutions, we have a task force to address racism for our program and medical education. We include students in all those committees that can help us inform the best way in which that we can develop these topics and teach faculty. What's been interesting is that over the years, students have more informally been teaching faculty and really approaching faculty about slides or topics. As we've talked about, many times, our students are way ahead of the faculty. So that is a fantastic idea and that it happens informally and almost to the students' frustration because it really should not be their responsibility to teach faculty. But I think elevating them to say, you have a special expertise, let's have you help us participate, would be an amazing thing to be able to do.

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Holly Humphrey:

Right. Okay, Peter?

Peter Goodwin:

So, one of the challenges that educational institutions in rural areas face is that while they control in some sense the environment where their students learn, where they train though is in different communities, and so it presents challenges on many different dimensions. But do you have any suggested actions or recommendations on how to work with clinical education partners who are outside the primary institution so that the students and the faculty who are placed there are working in safe and inclusive environments?

Holly Humphrey:

I think that is a wonderful question, and it's a question that I have thought a lot about. And one of the ways in which I personally approach this is I ask myself, what are the enduring principles of inclusion that would welcome any type of population, including populations that I have little or no experience with, but people who are seeking health and health care and are there some enduring principles that transcend race, ethnicity, gender, the kinds of things we've been talking about. And I think the more that the institution can collaboratively work to identify some enduring principles and ideally incorporate the affiliated institution to better understand the population of patients that the students and residents will have the privilege of caring for, perhaps that's a framework, perhaps that's a way forward.

But I think as medical educators and health professions educators, the more that we can think about a very high-level framework that's inclusive of all, and then apply it specifically to the specific populations in terms of the cultural humility and the very special facets of a given population, whether that's in rural America or involving ethnicities that we may not have experience with. Fidencio or Camila – do you have any experience in this area that you'd like to comment on?

Fidencio Saldaña:

So Holly, we don't have clinical sites in rural areas in our institution, but we have many affiliate hospitals that we try to bring together. Our clinical skills course, for example, has hundreds of faculty spread out all over the area. And that course has really leveraged the technology of Zoom to bring everybody together to try to create a community. And I think if once folks realize that they are part of a community and maybe there are some shared values as you mentioned, I think that may be a way to educate and encourage progress in those particular areas versus it's an isolated one-off clinical site that bringing folks together in that type of situation may be beneficial.

Holly Humphrey:

Camila, is there anything you'd like to add?

Camila Mateo:

I would just echo being able to bring a community together. I think community organizing principles in general in doing this work is a lesson and a tool and practice that I think that we can bring to medical education as it pertains to addressing bias and discrimination in general. How is it that we can create collaborative communities? How is it that we can organize and elevate the voices of different folks that

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are already working on these issues, whether they're faculty, students, faculty staff, folks in other provider positions, and even folks that we are serving community members, and how do we leverage that together? So I think that that's a great way to be able to move forward on some of this work.

Holly Humphrey:

Okay. Peter, back to you.

Peter Goodwin:

So this next question gets at the issue of more of a top-down approach to addressing the issues of bias and discrimination through regulation. Do any of the panelists have an example of a metric of diversity, equity, and inclusion that you would recommend to an accrediting body? For instance, what does an equitable learner assessment look like?

Holly Humphrey:

Well, now that is a very good question. Camila, I know you've thought a lot about this and you've written about it. I don't know if you might have a specific example.

Camila Mateo:

I think in general what I've been thinking about and talking about when I write about it is more approaches rather than specific outcomes, which I think again, is a space where having as many voices and perspectives at the table is probably the best way to be able to come down on specific outcomes that would be helpful. I think what's hard is that more than anything, I am really interested in what are the structures and approaches for which that folks are using to identify these differences and try to get at the root causes of differences in recruitment and opportunity in being able to move forward. And so I think that it can be difficult to figure out exactly what an equitable learner assessment looks like. I would probably look to the folks who wrote the commission paper specifically on equitable learner assessment in the Macy Foundation conference for outcomes and examples that they gave.

But I think that in general, a lot of it is focusing on how is it that there is a clear structure and accountability structure specifically to be able to identify these differences and how is it being acted upon? And I think being able to focus on a transparent communication of how that is happening and learning from those experiences at different institutions and being able to share different experiences at different institutions will find a way to move forward and being able to create outcomes and metrics that we can then use. What are the examples that exist outside of medical education that we can look to and potentially be able to apply to our particular environment and learning environments. So I'm sorry if that's not the concrete answer, but I think it's a difficult, but very good question.

Holly Humphrey:

Yeah, I agree with you, Camila. I think it is a difficult, but a really essential question. And I would just like to say to all of you participating today that this is a question that I personally care a lot about because we care about improving our clinical learning environments so that they really are authentically inclusive and that we don't have learners or faculty or staff or patients feeling excluded at a time when they're already feeling so vulnerable. And so we at the Macy Foundation are especially interested in trying to

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understand the characteristics of a learning environment that promote and create inclusion. And we're so interested in this that we're willing to provide grant funding to help discover the answers.

And so this is just a call for proposals that if you or your colleagues have some ideas that you would like to put forward as a pilot project or as a more comprehensive program or project, I encourage you to submit those ideas to the Macy Foundation through our website for a president's grant or for a board grant for a more comprehensive approach to try to help us figure out the answer to that question and to any host of related questions on this important topic.

Peter Goodwin:

So we've approached the hour at two o'clock, but we do have permission from the panel to stay for a few more minutes. So we're going to stay on here for another five minutes or so. I'll try to get to one or two more questions. We will not get to all of them, however, the staff has been recording the questions, and we will do our best to provide answers to all of them subsequent to this webinar. So here will be the penultimate question. This individual's asking, as individual programs embark on diversity, equity, and inclusiveness with regards to their educational changes, how do they address the discomfort of those from majority groups?

Holly Humphrey:

Well, you're right. That is a penultimate question. I think it's a very important question and one that I personally take very seriously because sometimes our academic institutions can be zealous in our attempt to create inclusion, and there's an unintended consequence that can create exclusion, as I said, quite unintentionally. Fidencio, in your role as a dean of students, have you had to deal with this particular issue and do you have any suggestions for our participants on how to address it?

Fidencio Saldaña:

That's a great question. I think the most recent examples that really pop into mind as part of my role, I also work with our admissions committee in addressing issues of bias when they've been reported, and they are challenging conversations, and I think it's really trying to... One is, as we do with our students, really it's acknowledging that growth. This is on a one-to-one level, really acknowledging that growth mindset with that individual, that we're all here to really improve ourselves and become better individuals for our learners and for our patients that we're taking care of and really stressing that it is not a character issue, but something that we can think about and change.

And that it's okay to have that discomfort. That when you are being told that you said or did something that was not quite right, we all strive for it to do our best and almost for perfection, many of us that acknowledging it's okay to be uncomfortable, this is really for the betterment of our learners and for our patients. And being able to dialogue and have that conversation is important. And I'll turn it over to Camila because I know that there are also ways of educating and reading that we can encourage our community to do on this particular topic.

Camila Mateo:

Yeah, thank you. I think the first thing that I think of when I hear that question, which again is an excellent one, is specifically from an educator standpoint, what are the conditions that I need to create as an educator to be able to open up the space for folks to engage with the material, understanding that

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there could very well be, and will be, discomfort, and that the discomfort will likely be different depending on the different backgrounds of the folks in that space. And so creating that brave space where folks trust the space enough to take some calculated risks, trust the space enough and believe that the intention of the space is to learn from one another in creating that safety, which safety is the wrong word, but that trustworthiness of the space so that folks feel like they can ask these questions or verbalize some of that discomfort is I think probably the first step.

And sometimes the step that, especially if we have a curriculum that isn't allowing us a ton of time to talk about these topics that we may want to zoom past a little bit to get to some of the core content, but that I think we really benefit from creating that space where folks can even verbalize that kind of discomfort. I think validating it is also a big part of it, validating that discomfort exists, why that might exist. But I think that when it's come up for me in facilitations, like when I'm in a group, for example, and facilitating conversations, this is specifically talking about conversations around racism specifically. I find that asking, approaching that discomfort with curiosity, with questions is something that has led to some pretty moving moments where specifically if folks who identify as white verbalized discomfort or just discomfort to name it, discomfort in general, just asking why do you feel uncomfortable or why do you think you feel this way?

And being able to open that up, if the space is open enough for someone to verbalize that discomfort, it may very well be open enough to engage in that kind of conversation. I think that it's certainly a balance when you're in these conversations to be able to approach these types of questions with curiosity, but also make sure that you are respecting the diversity of the space and making sure that things like microaggressions are not being left unsaid or undealt with if you're facilitating a space like this. And so I think it really takes a lot of balance, a lot of patience, but I think that the biggest part of it is setting up the space in the first place.

Holly Humphrey:

Thank you, Camila. That was really a beautiful, beautiful answer and filled with such compassion and authenticity. I'll just build on that by saying three things that I found helpful using the foundational approach that Camila just mentioned. And those three things are, number one, when I had the privilege of interacting with majority students who may feel excluded in conversations about racism or bias and discrimination, I always tried to invite us to think about it through a patient's eyes and it depersonalized it in a way that I think built on that curiosity that Camila just mentioned. And so suddenly there was a certain motivation to try to understand this through the eyes of a patient. Secondly, I had the experience of creating an identity and inclusion committee that was open to all students and had specific representation from various identity groups. And from time to time that identity and inclusion committee composed of students, student leaders, would do an environmental survey of their peers that was confidential, and it had that trustworthiness that Camila mentioned.

And it was in that survey that sometimes a student or students would share exactly what's behind this question in terms of feeling very excluded or feeling as if they had a more centrist position and they felt as if they were in a very left-leaning school and that they were uncomfortable about that. And so being able to hear that and learn from it together in a way that is safe and comfortable and accompanied by all those elements that Camila mentioned is very important. And then thirdly, I think an important part of our curricula going forward in health professions will include new topics, topics that have not been formally included in the past, such as critical race theory, such as civil discourse. I think that the types of

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frameworks and information that are part of critical race theory and part of civil discourse, by and large, have not been part of our formal curricula.

They may have been part of our hidden curricula, but not part of our formal curricula. And I think that those frameworks and the knowledge skills and attitudes that accompany learning about those disciplines will go a long way toward not only our teaching and learning, but ultimately the care for our patients. So, Peter, I think we're probably well beyond our time limit. I want to thank all of you for participating today. I want to thank especially my colleagues, Fidencio and Camila for their commitment of time and energy not only to this webinar, but to that conference that you heard us speak about in today's webinar. And the really deep thinking and experience that they personally brought to this conversation and to this webinar. So thank you all for participating today. We will be following up to do our best to answer the questions that we were not able to get to today.

And I invite all of you to join us in January for the next webinar where we will focus on the nursing education space and specifically the kinds of issues and themes that are in those learning environments, many of which are very familiar and similar to what we've covered today. But there are some differences and there are some hierarchies that you can probably well imagine that are important in that space, which we will do our best to address in January. So thank you all very much, and we will be in touch.

Peter Goodwin:

Thank you. That concludes today's webinar.