SHARE SGIM Forum
JANUARY 2020 V43, NO.1

PERSPECTIVE

DEVELOPING AN ANTI-RACIST RESIDENCY RECRUITMENT PROCESS

Joseph Truglio, MD, MPH; Ann-Gel S. Palermo, DrPH, MPH; Leona Hess, PhD, MSW; Princess E. Dennar, MD; Antonia Eyssallenne, MD, PhD

Dr. Truglio (joseph.truglio@mssm.edu) is program director, Combined Internal Medicine and Pediatrics Residency, Icahn School of Medicine at Mount Sinai, New York, NY. Dr. Palermo (ann-gel.palermo@mssm.edu) is associate dean for diversity and inclusion in biomedical education, Icahn School of Medicine at Mount Sinai, New York, NY. Dr. Hess (leona.hess@mssm.edu) is director of strategy and equity education programs, Department of Medical Education, Icahn School of Medicine at Mount Sinai, New York, NY. Dr. Dennar (pdennar@tulane.edu) is program director, combined internal medicine and pediatrics residency, Tulane University School of Medicine, New Orleans, LA. Dr. Eyssallenne (AEyssallenne@med.miami.edu) is assistant professor of internal medicine and pediatrics, University of Miami Miller School of Medicine and Jackson Memorial Hospital, Miami, FL.

Introduction

Racism is a system of structuring opportunity and assigning values based on the social interpretation of how one looks (what we call *race*). This system unfairly disadvantages some individuals and communities, unfairly advantages others, and saps the strength of the whole society through the waste of human resources.[1] Structural racism, including structural barriers, societal norms and unearned privilege amongst white students and physicians, has a particularly powerful impact on medical trainee recruitment. This has contributed to individuals and communities of color being underrepresented in medicine and medical education. Holistic review (see the table) in part aims to reduce this inequity by promoting purposeful inclusivity of metrics, experiences, and attributes that capture the mission-relevant characteristics of an applicant.[2] This approach prevents a disproportionate reliance on a single feature of an applicant and is considered a best practice in medical school admissions. Holistic review provides a more balanced consideration of applicant metrics than traditional approaches, yet does not explicitly address the institutional racism at the heart of racial inequities in health care. In this article, we call for the application of anti-racism to the holistic review process in residency recruitment and describe our experience in developing an anti-racist approach to recruitment for a new Internal Medicine and Pediatrics (MedPeds) program.

Anti-racism

Anti-racism is "an active and consistent process of change to eliminate individual, institutional and systemic racism" and redistribute power and privilege.[3] This is done by identifying and dismantling structures and processes that perpetuate the values and norms of white dominant culture and centering the voices and experiences of those individuals and groups historically underrepresented, underprivileged, and under-resourced within a system.

An anti-racist recruitment process builds upon holistic review and centers marginalized and oppressed patients, community members, and applicants in the formation of the program mission and generation of the applicant metrics (see the table). The explicit aim is not simply to recruit a high percentage of applicants from backgrounds underrepresented in medicine (URM), but also to shift power in residency recruitment and training away solely from the academic medical center to the patients and communities that will be cared for by residents. The process and outcome metrics should therefore be defined and measured in partnership with those communities.

Our approach focused on three overlapping and interdependent actions: redistributing power, dismantling institutionalized racism, and dismantling personally mediated racism.

Redistributing Power

We sought to deliberately integrate power sharing throughout our process. Early on, we held a meeting of stakeholders, including local community health workers, leaders from community-based organizations, faith leaders/pastors, and patients. The group contributed to our program's mission and identified characteristics of applicants that best aligned with this mission and reflected the experiences of the community. The product was used to inform the screening of applicants for interviews and to develop the interview sheets used to review applications and interview applicants. During recruitment, each applicant was interviewed by a physician and a non-physician representing a wide diversity of personal and professional backgrounds. Each interviewer presented their applicants and contributed to the applicant's ranking.

continued on page 2

PERSPECTIVE *(continued from page 1)*

Application of Anti-racism to the Holistic Review Process	
Holistic Review Process[2]	**Anti-racist Review Process**
Selection criteria are • broad-based • clearly linked to school mission and goals • promote diversity	Mission, goals and concepts of excellence are defined in partnership with marginalized and oppressed patient populations.
A balance of experiences, attributes, and academic metrics (EAM) is • Used to assess applicants with the intent of creating a richly diverse interview and selection pool and student body; • Applied equitably across the entire candidate pool; and • Grounded in data that provide evidence supporting the use of selection criteria beyond grades and test scores.	The assessment of EAM • Seeks to promote social and racial justice • Explicitly prioritizes stated values of patients/community • Eliminates those metrics that perpetuate structural racism and unearned privilege
• Individualized consideration to how each applicant may contribute to the learning environment and practice of medicine • Balancing the range of criteria needed in a class to achieve the outcomes desired by the school	• Individual and structural racism explicitly included in assessment • Recognition of challenges of white admission staff and committee members in identifying and valuing the contributions of applicants of color
Race and ethnicity may be considered only when: • narrowly tailored to achieve mission-related educational interests and goals associated with student diversity • considered as part of a broader mix of factors	Power and privilege (amongst applicants, faculty, and community) are universally considered and explicitly discussed in program design and while making recruitment decisions

Mitigating Institutionalized Racism

Institutional policies and practices that support prejudicial and discriminatory beliefs disadvantage some socially constructed racial groups while benefiting others. For example, preference is given to applicants who have been inducted into certain honor societies, when induction is based on standards that only the privileged and highly resourced can attain. We aimed to deemphasize those factors that were most impacted by institutionalized racism and least predictive of the characteristics we sought in applicants. The impact of racism on the Alpha Omega Alpha (AOA) selections process has been described in the literature and observed in our own institution.[4] We therefore blinded our selections committee to AOA status. Numerous studies demonstrating that USMLE scores are predictive only of future performance on standardized tests, and that once above a threshold of approximately 215-220, higher scores do not significantly improve this predictive value.[5] Further, an over-reliance on such standardized exam scores perpetuates institutionalized racism embedded within educational systems—segregated housing and public school systems, access to test preparation programs, generational experience in medical education within white families, etc. We did not use USMLE scores for our initial review process. Once applicants were selected for a potential interview, the program director removed USMLE scores from their application if they had a Step 1 score of 220 or higher. Those with Step 1 scores less than 220 were reviewed by the program director for evidence of ability to pass future licensing exams—performance on Step 2, shelf scores, and/or explicit documentation of factors that would impact their Step 1 performance (i.e., personal or family health). After this process, USMLE scores were removed.

Mitigating Personally Mediated Racism

The inclusion of multiple interviewers sought to reduce the impact of any individual's bias on the recruitment process. Our interviewers were either all implicit bias and anti-racist trainers or completed in-person or home-grown on-line implicit bias training. We blinded our interviewers to those metrics and characteristics known to trigger bias, including applicant picture, self-identified race, sex, gender and age, until the time of the interview. Committee meetings were grounded in maintaining a critical consciousness of the many biases at play, with members encouraged to openly discuss concerns around individual and institutional biases.

An Emergent Process

Anti-racism is an inherently emergent process. We engaged in continuous self-reflection, guided in part by of the below questions:

- Who determines our program's mission? Who is impacted by our program but does not have a voice in this mission?
- What voices within our institution/community are not heard in the recruitment process? What voices are over-represented?
- What assumptions are made regarding applicant metrics? How are bias and stereotyping present in this process?
- What patterns emerge in our ranking and match outcomes?

continued on page 3

PERSPECTIVE *(continued from page 2)*

- In what ways does our program perpetuate and support institutionalized racism?

Through this process, we identified several areas for growth. After the first committee meeting, it was noted that there was a concentration of power amongst program leadership, all white men, positioned at the head of the table. At subsequent meetings, "ground rules" were established to promote empowered dialogue and to encourage anyone to "call out" potential biases at play in the discussions. We have introduced universal orientation workshops and mandatory in-person anti-racist training for interviewers. Notably absent from the meetings were community members. We have since created a program advisory board, including community members and patients, more actively involved in our program's design and recruitment processes.

We observed that traditional metrics, in particular medical school ranking, were overly represented at the top of our rank list. This prompted a reevaluation of how applicant metrics were weighed and a restructuring of the final rank list to better reflect our program's mission. We now have rank list reviews in each committee meeting to further redistribute power to all committee members and to foster explicit discussions of alignment of program mission with rank list.

Conclusion

Through applying anti-racism to the holistic review process, we identified multiple areas where our profession continues to perpetuate institutional racism in health care. We have also begun to move towards an anti-racist residency recruitment process. Much work remains. An explicit national conversation regarding how GME recruitment perpetuates racist structures, practices and policies is needed.

References

1. Jones CP. Confronting institutionalized racism. *Phylon*. https://www.scribd.com/document/339817267/Jones-Confronting-Institutionalized-Racism-Phylon-2003-pdf. Accessed December 15, 2019. (Membership required to read article.)
2. Association of American Medical Colleges. Holistic review. https://www.aamc.org/initiatives/holisticreview/. Accessed December 15, 2019.
3. CRRF. Anti-racism. https://www.crrf-fcrr.ca/en/resources/glossary-a-terms-en-gb-1/item/22793-anti-racism. Accessed December 15, 2019.
4. Boatright D, Ross D, O'Connor P, et al. Racial disparities in medical student membership in the Alpha Omega Alpha Honor Society. *JAMA Intern Med*. 2017;177(5):659-665.
5. McCaskill E, Kirk J, Barata D, et al. USMLE Step 1 scores as a significant predictor of future board passage in pediatrics. *Ambulatory Pediatrics*. https://www.sciencedirect.com/science/article/abs/pii/S153015670700007X. https://doi.org/10.1016/j.ambp.2007.01.002. Accessed December 15, 2019.

SGIM