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The Role of Inclusivity in DEI Initiatives: Cultivating an Inclusive Clinical Learning Environment for All

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ABSTRACT

Many U.S. academic medical centers, medical societies, and accreditation bodies are committed to continuing initiatives of recruiting a diverse workforce. It is this focus of DEI that is often weighted towards diversity recruitment within undergraduate and graduate medical education. These recruitment initiatives result in an influx of an underrepresented in medicine (UIM) physician workforce into clinical learning environments that may not reflect inclusivity. The authors provide a brief introduction to the topic of inclusion, discuss its importance in the clinical environment, and suggest ways that medical education leaders can incorporate the tenets of inclusion into their curriculum and training. There are harms to having an exclusionary clinical learning environment that impact the clinical performance and well-being of all learners, particularly those coming from UIM backgrounds. There are also clear benefits to creating inclusion practices, however, there must be intention and strategic planning to work towards solutions to creating a safe, inclusive environment for all.

Keywords: Medical education, Graduate Medical Education, Diversity, Equity, Inclusion, Inclusivity, Faculty Development

Introduction

In the wake of a global pandemic and an international spotlight on health care disparities, there was a momentum to address health care inequities, which led many academic medical centers to incorporating diversity, equity, and inclusion (DEI) into their institutional mission. Even more, many academic health centers are expanding their quadruple aim to include DEI as the fifth aim of their institution's vision and mission.[1] Despite the United States Supreme Court's decision on race-based admissions, many U.S. academic medical centers, medical societies, and accreditation bodies are committed to continuing initiatives of recruiting a diverse workforce.[2,3] It is this focus of DEI that is often weighted towards recruitment of a diverse workforce within undergraduate and graduate medical education, which reflects the diversity of the communities served. Many institutions, medical schools, and graduate medical education programs created initiatives to expand their census of underrepresented in medicine (UIM) as the key driver to addressing health care disparities.[4] The effect of these initiatives was an influx of a UIM physician workforce into unprepared clinical learning environments and a lack of consideration of the inclusivity of these settings.[5] Often it is the "I" in diversity, equity, and inclusion, which is underdeveloped. [6] In the following manuscript, the authors provide a brief introduction to the topic of inclusion and its importance in the clinical environment; moreover, how medical education leaders can begin to incorporate the tenets of inclusion into their curriculum and training.

Definitions

Inclusion refers to the promotion of diversity and the uniqueness of individuals through policy, practice and cultural norms.[7] It is established by an institution's culture with the goal of making each individual feel that they belong. The clinical learning environment (CLE) defines an aspect of the institutional culture within the clinical setting experienced by learners while training and working.[7,8] There is variation to the degree in which learners may feel welcomed, including those from historically excluded identities.[8] Postgraduate medical programs must analyze the formal, informal, and hidden components of training which may perpetuate an exclusive or isolating culture if they wish to create an inclusive CLE, which values and respects all.[7] Often UIM trainees are asked to adapt to the institutional culture, which is often defined by dominant societal norms, instead of the onus placed on institutions to be accepting and appreciative of differences and assets brought by the diversity of its workforce. Inclusivity is achieved when learners feel that they belong and are allowed to portray their full selves, share their opinions and experiences, and thereby enhance the function of team dynamics within the CLE.[8]

Benefits of Inclusivity

Inclusivity brings a wealth of benefits. Creating inclusive learning environments has improved the CLE for all learners. Institutions have found that with the increase in diversity of their resident body, there is an overall improvement in the cultural competency for all trainees. [9] Retaining a diverse and inclusive workforce improves access to health care for underserved patients, because UIM physicians tend to work more in urban and socioeconomically disenfranchised communities.[4] In addition, improving the learning experience for UIM learners, improves educational outcomes for all learners.[7] When any learner is subjected to isolation and/or discrimination, the overall well-being of the trainee suffers mental anguish, including depression, burnout, and even attrition.[8] Inclusivity is essential to the retention efforts of maintaining a diverse workforce. It is paramount to future diversity recruitment to have learning environments which are safe, comfortable, and inclusive for all learners and faculty to thrive.

Harms of Exclusion

The effects of working and learning in an environment that is perceived to be exclusionary is traumatic and has a lasting impact on trainees' mental health and clinical and academic performance. In a survey documenting the existence of discrimination experienced by practicing physicians in Massachusetts, 445 respondents (46% women, 42% racial/ethnic minorities, or 40% International Medical Graduates (IMGS)) found that 63% of these physicians experienced discrimination.[10] Even further, when investigating medical students and the impact of discrimination on their well-being, authors found that medical students with 3 marginalized identities (*Female; Non-white; LGB*) had the largest proportion of recurrent experiences of mistreatment and discrimination.[11] These students with the same identities also had the largest difference in exhaustion scores as compared to their White, male, heterosexual counterparts.[11] Discrimination comes in a variety of intentional and unintentional acts or comments, and may be as subtle as a perceived disrespect by co-workers or a lack of professional advancement.[10] Interviews of postgraduate trainees at one U.S. medical school found themes that emerged which help articulate the experiences of UIM physicians in the CLE.[12] One participant stated, "At least once every time at the conference, I look around the room and I realize I'm the only person of color in this room and just by the basis of that I feel different." [12] Some UIM trainees felt the expectations placed on them were different as compared to their peers, and lack of common life experiences led to social isolation despite spending a significant amount of time with their team.[12,13] Homophily, or the concept that individuals tend to gravitate towards people with similar backgrounds and interest, lead UIM trainees to self-isolate or for their majority colleagues to be unintentionally exclusionary.[14] Some of the discrimination comes directly from the patients, and without the support of supervisors the impact is magnified.[15]

The impact of micro- and macro-aggression is often constant as UIM physicians traverse the daily CLE. Stereotype threat, or the fear of fulfilling a negative stereotype about your race, ethnicity, or gender impairs performance by exhausting cognitive resources and distracting from learning.[16] In a study investigating stereotype threat amongst medical students on core clerkships, 82% of Black students had high scores on a tool measuring vulnerability to stereotype threat, as compared to 4% of Whites.[16] These effects may lead to placement on remediation plans, or even worse resignation and/or termination from training programs.[17,18] In 2015, Black residents accounted for about 5% of

all residents in the United States, however they accounted for nearly 20% of those dismissed from training programs.[19] Again, the conclusion is drawn that creating inclusive, safe learning environments directly impacts the retention of a diverse workforce that we, collectively as an academic community, are striving towards.

Conclusion: Working Towards Solutions

Institutions must develop solutions to address the harms of exclusionary learning environments. In order for academic medicine to create inclusive, comfortable and safe CLEs, we must first recognize the struggles faced by UIM trainees, students, and faculty, and the complex ways in which discrimination manifests,[5] which are frequently set by the societal discriminations, biases, and gendered treatment that is the very foundation in which medicine was built.[20, 21, 22, 23] Inclusive CLEs allow all learners, especially those from historically excluded identities, to thrive in their training and working environment. It is especially essential in order to retain the diverse workforce we are striving towards.[21] It is paramount that graduate medical education programs preemptively discuss strategies to mitigate exclusionary practices in conjunction with their diversity recruitment initiatives, and to be prepared to accept the influx of the new diverse workforce.[20] We must investigate where over-policing of UIM trainees, or the disparate scrutiny and discipline, including remediation, probation, and/or dismissal, is taking place in the CLE.[20] When remediation is required, we should be transparent about the reasons for the performance improvement plan, the objective measures used to both assess the need for remediation and the progress towards completion, and ensure it is a non-punitive process that is a means to provide scaffolding and support to help the learners thrive in their training.[20] While it is important for all trainees to have mentors, it is particularly important for UIM trainees, in order to monitor their progress in the new CLE and assess for areas of improvement in this environment. [24] It is important to allow for bidirectional feedback so that trust is built for the program leadership, and confidence is maintained that when concerns are brought forth, there will be every attempt to address them.[25] Faculty development is essential. All faculty should undergo up to date and practical DEI training to prepare them to work with a diverse group of learners.[26] It is important to engage in dialogue with the learners and other members of the clinical team to co-create how CLEs can become more inclusive.[7] While the "I" in DEI is often under-developed, it is the crux in maintaining an inclusive CLE for all.

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