1

Using Evidence to Counter the Arguments Against Diversity

Quinn Capers, IV, MD, FACC

Rody P. Cox Professor of Medicine

Associate Dean of Faculty Diversity

Chair, ACC Diversity and Inclusion Committee

Twitter: @DrQuinnCapers4

2

ARGUMENTS AGAINST ENHANCING DIVERSITY IN MEDICINE

1. "There is a lack of diversity in medicine, but this (residency, med school, faculty recruitment) is not the place to fix the problem … Fix Kindergarten first."
2. "Diversity = lowering quality"
3. "The ONLY thing that should count is MERIT!"
4. "Patients don't care about the race of the physician, they just want the 'best'"
5. "What about MY kid (nephew, niece, grandchild, etc.)?!?!?!"

3

ARGUMENTS AGAINST ENHANCING DIVERSITY IN MEDICINE

1. … Fix Kindergarten first."

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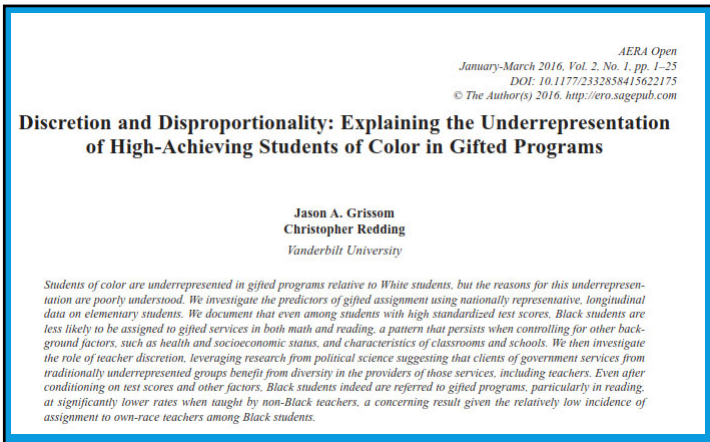

AERA Open
January-March 2016, Vol. 2, No. 1, pp. 1–25
DOI: 10.1177/2332858415622175

Discretion and Disproportionality: Explaining the Underrepresentation of High-Achieving Students of Color in Gifted Programs

Jason A. Grissom
Christopher Redding
Vanderbilt University

Students of color are underrepresented in gifted programs relative to White students, but the reasons for this underrepresentation are poorly understood. We investigate the predictors of gifted assignment using nationally representative, longitudinal data on elementary students. We document that even among students with high standardized test scores, Black students are less likely to be assigned to gifted services in both math and reading, a pattern that persists when controlling for other background factors, such as health and socioeconomic status, and characteristics of classrooms and schools. We then investigate the role of teacher discretion, leveraging research from political science suggesting that clients of government services from traditionally underrepresented groups benefit from diversity in the providers of those services, including teachers. Even after conditioning on test scores and other factors, Black students indeed are referred to gifted programs, particularly in reading, at significantly lower rates when taught by non-Black teachers, a concerning result given the relatively low incidence of assignment to own-race teachers among Black students.

"… even among students with high standardized test scores, Black students are less likely to be assigned to gifted services … a pattern that persists when controlling for other background factors …

5

"DO SCHOOL COUNSELORS EXHIBIT BIAS IN RECOMMENDING STUDENTS FOR ADVANCED COURSEWORK?"

FRANCIS. 2019. B.E. JOURNAL OF ECON POLICY ANALYSIS

- 152 high school counselors took survey evaluating 6 student "profiles"
- Names of the "students" were varied along with academic strength of profile
- Girls with "Black sounding name" (Deja Jackson) with strongest academic performance were less likely to be recommended for AP calculus compared to Deandre Washington, Hannah Douglas, and Jake Connor.

- Findings:
  - The study finds that that Black girls are uniquely disadvantaged – a black girl in the strongest academic and behavioral profile is equally as likely to be recommended as someone blindly reviewed in the weakest academic and behavioral profile and is rated as being least academically prepared

6

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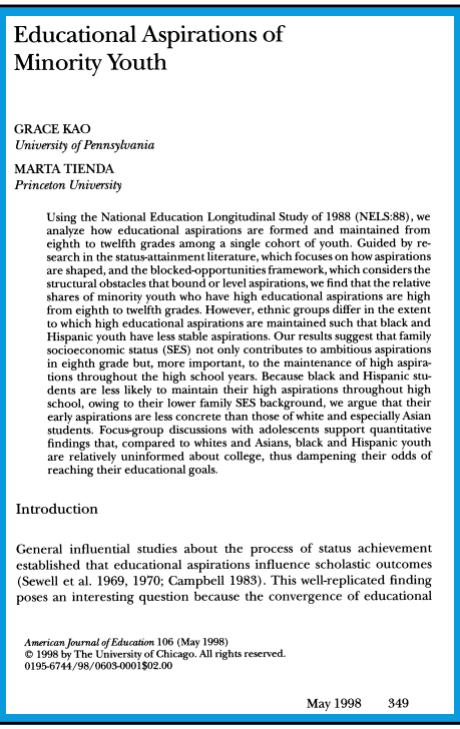


Educational Aspirations of Minority Youth

GRACE KAO
University of Pennsylvania
MARTA TIENDA
Princeton University

Using the National Education Longitudinal Study of 1988 (NELS:88), we analyze how educational aspirations are formed and maintained from eighth to twelfth grades among a single cohort of youth. Guided by research in the status-attainment literature, which focuses on how aspirations are shaped, and the blocked-opportunities framework, which considers the structural obstacles that bound or level aspirations, we find that the relative shares of minority youth who have high educational aspirations are high from eighth to twelfth grades. However, ethnic groups differ in the extent to which high educational aspirations are maintained such that black and Hispanic youth have less stable aspirations. Our results suggest that family socioeconomic status (SES) not only contributes to ambitious aspirations in eighth grade but, more important, to the maintenance of high aspirations throughout the high school years. Because black and Hispanic students are less likely to maintain their high aspirations throughout high school, owing to their lower family SES background, we argue that their early aspirations are less concrete than those of white and especially Asian students. Focus-group discussions with adolescents support quantitative findings that, compared to whites and Asians, black and Hispanic youth are relatively uninformed about college, thus dampening their odds of reaching their educational goals.

Introduction

General influential studies about the process of status achievement established that educational aspirations influence scholastic outcomes (Sewell et al. 1969, 1970; Campbell 1983). This well-replicated finding poses an interesting question because the convergence of educational

American Journal of Education 106 (May 1998)

0195-6744/98/0603-0001$02.00

Cohort study: 25,000 White, Black, Asian, and Hispanic children followed from the eighth to the twelfth grade.

Black boys and Hispanic girls were the most likely to drop aspirations to attend college or graduate/professional school during the study period.

7

ARGUMENTS AGAINST ENHANCING DIVERSITY IN MEDICINE

- … Fix Kindergarten first.
- Counter-argument: we need to work on "kindergarten" and the end-game (medical school, residency, faculty recruiting) simultaneously.

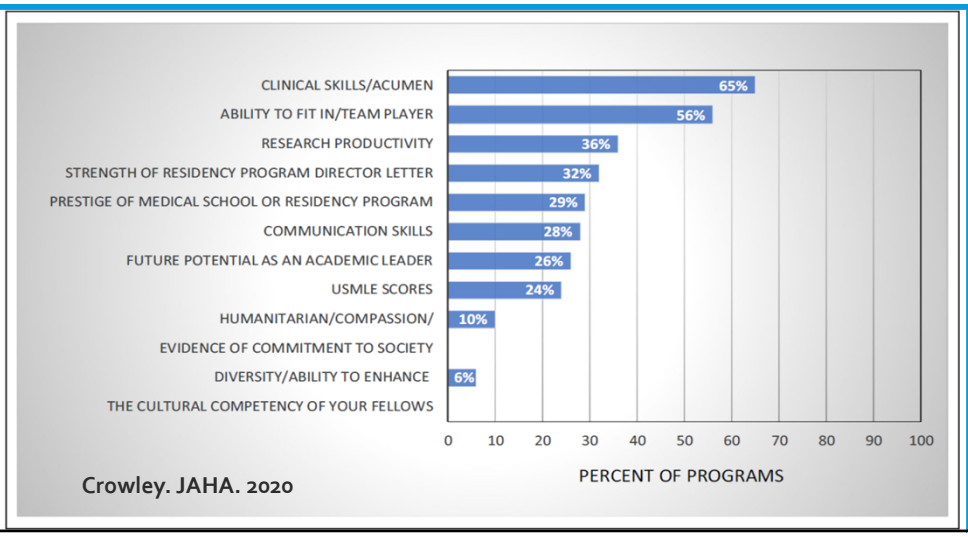
8

ARGUMENTS AGAINST ENHANCING DIVERSITY IN MEDICINE

- 2. Diversity = lowering quality"

9

HOW DO YOU DEFINE … "QUALITY?"



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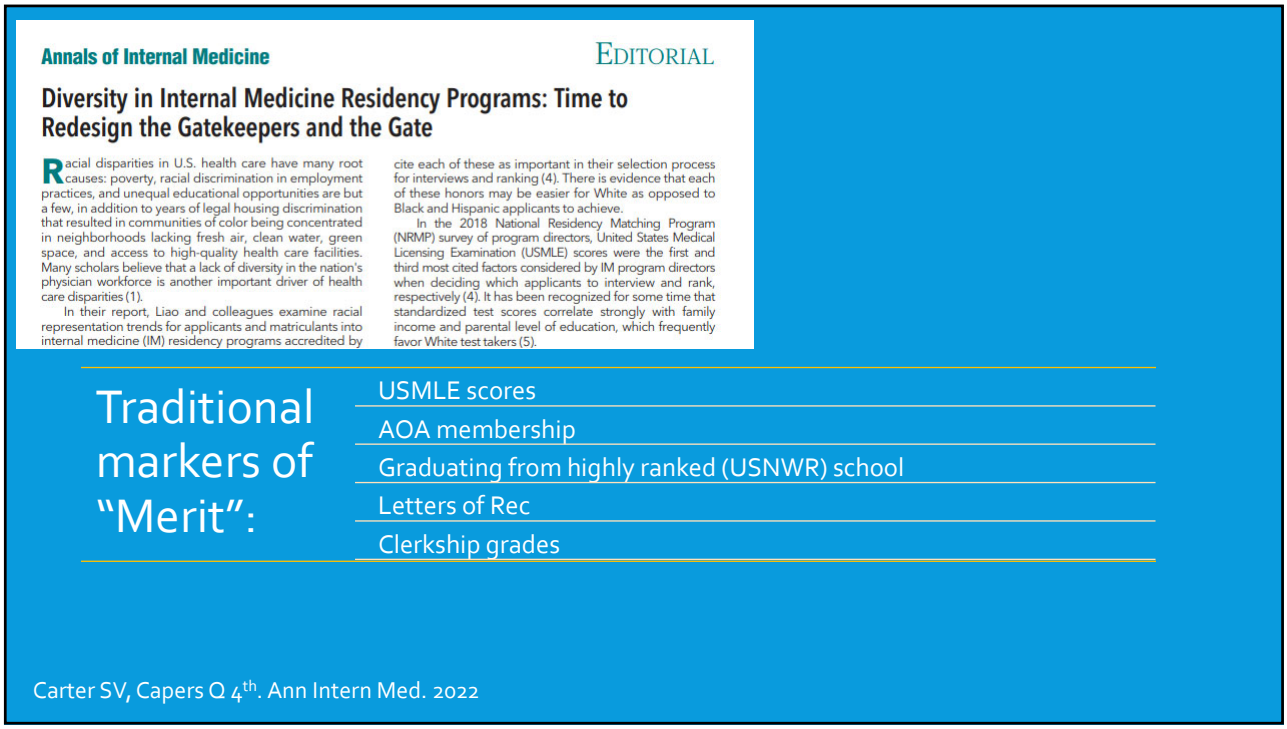


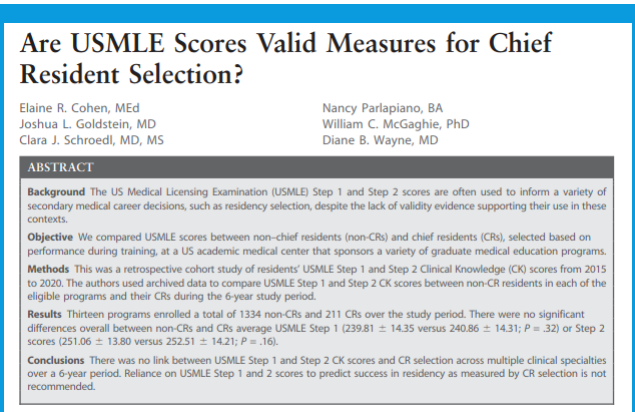
Traditional markers of "Merit":

- USMLE scores
- AOA membership
- Graduating from highly ranked (USNWR) school
- Letters of Rec
- Clerkship grades

Carter SV, Capers Q 4th. Ann Intern Med. 2022

11

HOW DO YOU DEFINE … "QUALITY?"



- Northwestern University
- 1,300 Chief Residents from 13 residencies
- USMLE Step 1 scores between CR and non-CR did not differ

Cohen ER. J Grad Med Educ. 2020

12

ARGUMENTS AGAINST ENHANCING DIVERSITY IN MEDICINE

- "Diversity = lowering quality"

- Counter-Argument:

1. Beyond an evidence-based threshold, higher standardized test scores do not predict a higher "quality" physician
2. URMs with the highest standardized test scores are still at a disadvantage (going back to grade school.)

13

ARGUMENTS AGAINST ENHANCING DIVERSITY IN MEDICINE

- 3. "The ONLY thing that should count is MERIT!"

14

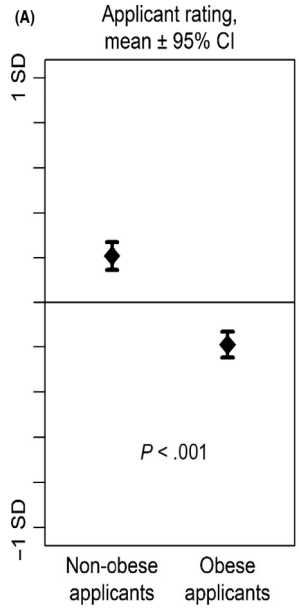
AWARENESS OF IMPLICIT BIAS MITIGATES DISCRIMINATION IN RADIOLOGY RESIDENT SELECTION

MAXFIELD. MED ED. 2020

Participants

51 Radiology Faculty at 3 ctrs reviewed applications and "graded" them. Some applicant photos were of overweight/obese individuals.

- Faculty unaware of anti-obesity bias
- IAT: most had anti-obesity bias
- Rated obese applicants lower than non-obese applicants, despite identical academic credentials



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15

Is There Unconscious Bias in the Orthopaedic Residency Interview Selection Process?

Colton R.J. Webber, MD, Ryann Davie, BS,† Zachary Herzwurm, MD,* Jonathon Whitehead, MD,* Daniel W. Paré, BS,† and Kelly C. Homlar, MD**

357 applications reviewed by 14 faculty

Applicants scored 1-10 (10 most desirable)

Pre-redaction: entire ERAS application

Post-redaction: ERAS app redacted of photo and name, race, gender, pronouns, medical school, other references to race or gender

J Surg Educ. 2022 .

TABLE 4. Minority vs White Applicant Comparison

	Minority	White	p-value
N	93	227	
Step 1	243.42 ± 8.11	247.19 ± 9.14	0.00
Step 2	251.40 ± 10.82	254.80 ± 9.94	0.01
Articles	5.91 ± 7.75	3.80 ± 5.07	0.00
Presentations	2.48 ± 3.84	2.20 ± 3.98	0.56
Posters	5.89 ± 9.13	3.48 ± 4.18	0.00
Pre-redaction Rank	7.44 ± 2.08	8.07 ± 1.71	0.01
Post-redaction Rank	7.51 ± 1.70	7.88 ± 1.74	0.08
Ranking Change	0.24 ± 1.63	-0.04 ± 1.33	0.11
AOA	29	84	0.32
GH	10	29	0.25

16

ARGUMENTS AGAINST ENHANCING DIVERSITY IN MEDICINE

- "The ONLY thing that should count is MERIT!"

- Counter-Argument:
- Data reveal the possibility of negative bias towards candidates who:

1. Have an "ethnic"-sounding name
2. Appear overweight/obese
3. Are not "White"

17

ARGUMENTS AGAINST ENHANCING DIVERSITY IN MEDICINE

- 4. "Patients don't care about the race of the physician, they just want the 'best'"

18

ALSAN. AMERICAN ECONOMIC REVIEW. 2018

- Results:
- Diabetes screening (finger stick): 63% with BM MD vs 43% WM MD
- Cholesterol screening (finger stick): 62% of BM MD vs 36% WM MD
- Flu shot: 56% with BM MD vs 46% of BM with WM MD

19

Black patients more likely to agree to open heart surgery if recommended by Black vs White physician

Saha. J Gen Int Med. 2020

20

THE EFFECTS OF ONCOLOGIST IMPLICIT RACIAL BIAS IN RACIALLY DISCORDANT ONCOLOGY INTERACTIONS

- Treatment of 112 Black pts several weeks later
- Office visits were recorded and "graded" by neutral observers
- Oncologists higher in implicit racial bias had shorter interactions
- Patients and observers rated these oncologists' communication as less patient-centered

Penner. Journal of Clinical Oncology 34, no. 24 (August 2016)

21

ARGUMENTS AGAINST ENHANCING DIVERSITY IN MEDICINE

- "Patients don't care about the race of the physician, they just want the 'best'"
- Counter-Argument: Pts may not care about the race of their physician, but if they were aware of this data… they might

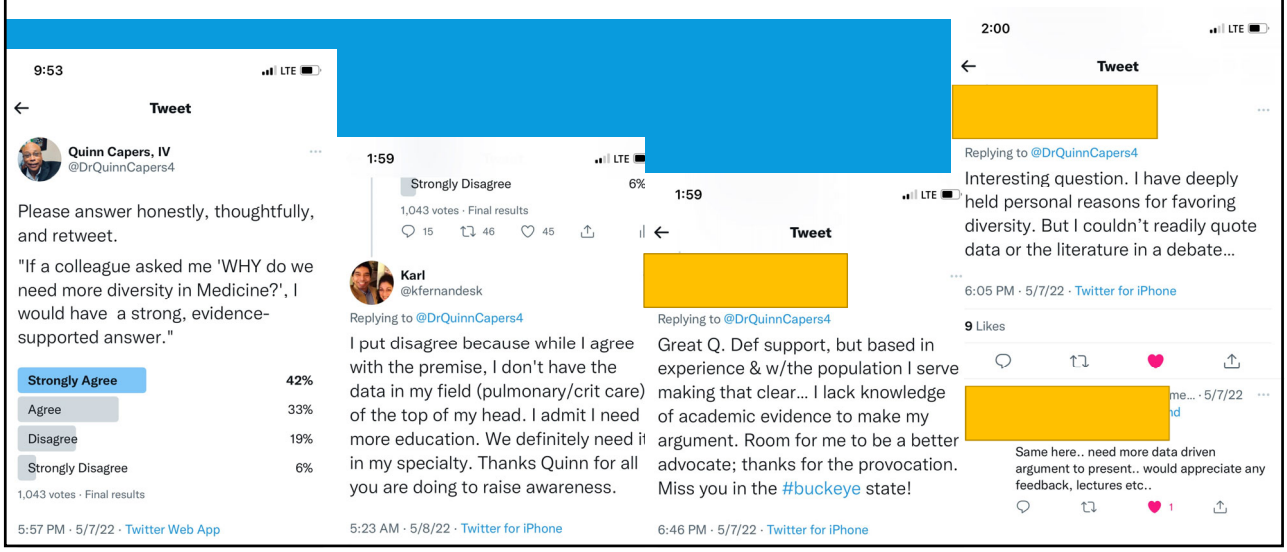
22

ARGUMENTS AGAINST ENHANCING DIVERSITY IN MEDICINE

- 5. What about MY kid (nephew, niece, grandchild, etc.)?!?!?!

23

TWITTER POLL



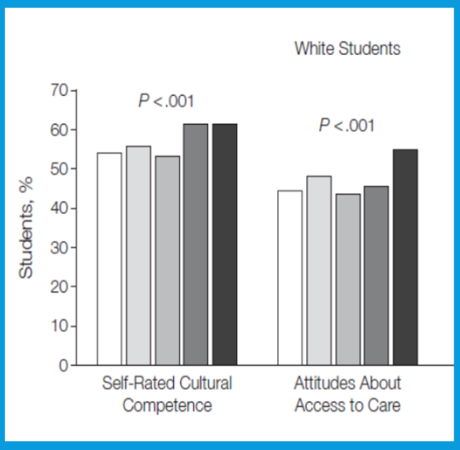
24

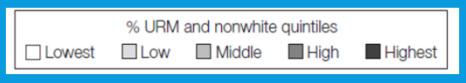
WHY DO WE SEEK DIVERSITY IN MEDICINE?

- Multiple Choice Question
- A) Physicians Who Train in Diverse Environments Rate Themselves as More Comfortable Treating Minority Patients
- B) Because Underrepresented Minority Physicians Are More Likely to Serve the Underserved
- C) Because Minority Patients Are More Likely to Follow Recs of Minority Physicians
- D) Diversity in Medicine Should Help Reduce Racial Healthcare Disparities
- E) Diversity on Research Teams Enhances Impact of Research

25

Student Body Racial and Ethnic Composition and Diversity-Related Outcomes in US Medical Schools





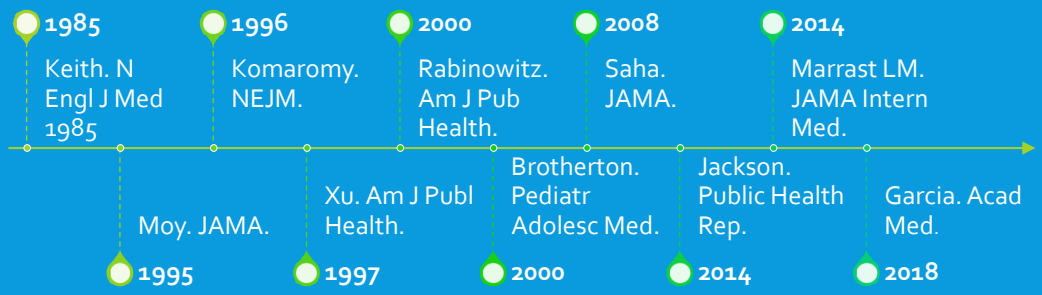
COMMENT

In a cohort of more than 20 000 graduating medical students, white students attending more racially diverse medical schools rated themselves as better prepared than students at less diverse schools to care for racial and ethnic minority patients and had stronger attitudes about inadequate access to health care. These associations be-

Saha. JAMA. 2008

26

MINORITY PHYSICIANS MORE LIKELY TO SERVE UNDERSERVED PTS



27

Analysis IN BRIEF

AAMC Tomorrow's Doctors, Tomorrow's Cures®

Volume 9, Number 8
July 2010

Association of American Medical Colleges

Changes in Medical Students' Intentions to Serve the Underserved: Matriculation to Graduation

80,000 med students asked: "Do You Plan to Locate Your Practice in an Underserved Area" upon entry and graduation from medical school

Black and Hispanic students more likely to answer "Yes" than White and Asian students upon entry into medical school

Black and Hispanic students that were initially undecided were more likely to answer "Yes" by graduation

White and Asian students that were initially undecided were more likely to answer "No" by graduation

28

28

JGIM Journal of General Internal Me...
@JournalGIM

Black patients are more likely to trust & accept recommendations from black physicians. Patient centered communication lessens but does not eliminate the impact of race. Training more minority physicians may help reduce disparities in health care. @somsaha rdcu.be/b081N

Fig. 1 Actors portraying physicians.

Recent studies suggest that when advised by race-concordant physicians, Black patients are more likely to agree to:

1) Glucose and cholesterol tests
2) Vaccinations
3) Open Heart Surgery

1. Alsan. American Economic Review. 2018
2. Saha. J Gen Int Med. 2020

29

ENTERING THE 4TH DECADE OF RACIAL DISPARITIES IN CARDIOVASCULAR PROCEDURES

1993 2022

Racial Differences in the Use of Revascularization Procedures After Coronary Angiography

John Z. Ayanian, MD, MPP; I. Steven Udvarhelyi, MD, MSc; Constantine A. Gatsonis, PhD; Chris L. Pashos, PhD; Arnold M. Epstein, MD, MA

Objective.—To assess whether rates of coronary revascularization procedures differ between blacks and whites after coronary angiography is performed and to assess the relationship of these rates to hospital characteristics.

Design.—A retrospective cohort study using 1987 and 1988 data on hospital claims and characteristics from the Health Care Financing Administration.

Setting.—One thousand four hundred twenty-nine acute care hospitals that provide coronary angiography in the United States.

Patients.—A national sample of 27 485 Medicare Part A enrollees, aged 65 to 74 years, who underwent inpatient angiography for coronary heart disease in 1987.

Main Outcome Measure.—The adjusted odds of revascularization with either coronary angioplasty or bypass graft surgery within 90 days of angiography for whites relative to blacks, controlling for age, sex, region, Medicaid eligibility, principal diagnosis, comorbid diagnoses, and hospital characteristics of ownership, teaching status, urban/suburban or rural location, and availability of revascularization procedures.

Results.—White men and women were significantly more likely than black men and women, respectively, to receive a revascularization procedure after coronary angiography (57% and 50% vs 40% and 34%, both $P<.001$). The adjusted odds of receiving a revascularization procedure after coronary angiography were 78% higher for whites than blacks (95% confidence interval for odds ratio, 1.56 to 2.03). Statistically significant racial differences in the adjusted odds of receiving a revascularization procedure were present in all types of hospitals except rural hospitals, and these differences did not vary significantly by any of the four hospital characteristics (all $P>.20$ for interaction terms).

Conclusions.—Among Medicare enrollees, whites are more likely than blacks to receive revascularization procedures after coronary angiography. Racial differences of similar magnitude occur in all types of hospitals. These differences may reflect overuse in whites or underuse in blacks, but they are unlikely to reflect access to cardiologists or hospitals that perform revascularization procedures. Potential explanations include unmeasured clinical or socioeconomic factors, differing patient preferences, and racial bias at the hospitals performing angiography.

(JAMA. 1993;269:2642-2646)

NUMEROUS studies have shown that major procedures for diagnosing and treating coronary heart disease are used less frequently among blacks relative to whites.[1] Coronary angiography is used to define the anatomic severity of coronary artery disease and is a prerequisite for coronary revascularization with either percutaneous transluminal coronary angioplasty (PTCA) or coronary artery bypass graft (CABG) surgery. These revascularization procedures are effective in relieving symptoms of coronary heart disease,[2-4] and for some groups of patients with advanced disease, CABG surgery also prolongs survival.[5] Variations by race in the use of these procedures raise substantial concerns about access to appropriate care.

At least four steps are potentially involved in the decision to perform a coronary revascularization procedure. First, patients with symptoms of coronary heart disease may seek care from a primary care physician. Second, patients with these symptoms may be referred to a cardiologist, or they may seek such care on their own. Third, a subset of these patients are referred for angiography. Finally, for patients with clinically significant stenoses of their coronary arteries, a cardiologist or cardiac surgeon may recommend a revascularization procedure. Barriers to access may exist at any of these steps, and prior studies have demonstrated racial dif-

Journal of the American Heart Association

ORIGINAL RESEARCH

Association of Race and Ethnicity on the Management of Acute Non–ST-Segment Elevation Myocardial Infarction

Tarryn Tertulien, MD, MSc; Stephen T. Broughton, MD; Gretchen Swabe, MS; Utibe R. Essien, MD, MPH; Jared W. Magnani, MD, MSc

BACKGROUND: Prior studies have reported disparities by race in the management of acute myocardial infarction (MI), with many studies having limited covariates or now dated. We examined racial and ethnic differences in the management of MI, specifically non–ST-segment-elevation MI (NSTEMI), in a large, socially diverse cohort of insured patients. We hypothesized that the racial and ethnic disparities in the receipt of coronary angiography or percutaneous coronary intervention would persist in contemporary data.

METHODS AND RESULTS: We identified individuals presenting with incident, type I NSTEMI from 2017 to 2019 captured by a health claims database. Race and ethnicity were categorized by the database as Asian, Black, Hispanic, or White. Covariates included demographics (age, sex, race, and ethnicity); Elixhauser variables, including cardiovascular risk factors and other comorbid conditions; and social factors of estimated annual household income and educational attainment. We examined rates of coronary angiography and percutaneous coronary intervention by race and ethnicity and income categories and in multivariable-adjusted models. We identified 87 094 individuals (age 73.8±11.6 years; 55.6% male; 2.6% Asian, 13.4% Black, 11.2% Hispanic, 72.7% White) with incident NSTEMI events from 2017 to 2019. Individuals of Black race were less likely to undergo coronary angiography (odds ratio [OR], 0.93; [95% CI, 0.89–0.98]) and percutaneous coronary intervention (OR, 0.86; [95% CI, 0.81–0.90]) than those of White race. Hispanic individuals were less likely (OR, 0.88; [95% CI, 0.84–0.93]) to undergo coronary angiography and percutaneous coronary intervention (OR, 0.85; [95% CI, 0.81–0.89]) than those of White race. Higher annual household income attenuated differences in the receipt of coronary angiography across all racial and ethnic groups.

CONCLUSIONS: We identified significant racial and ethnic differences in the management of individuals presenting with NSTEMI that were marginally attenuated by higher household income. Our findings suggest continued evidence of health inequities in contemporary NSTEMI treatment.

30

J. Racial and Ethnic Health Disparities (2014) 1:171–180
DOI 10.1007/s40615-014-0021-7

Racial Disparities in Cardiovascular Care: A Review of Culprits and Potential Solutions

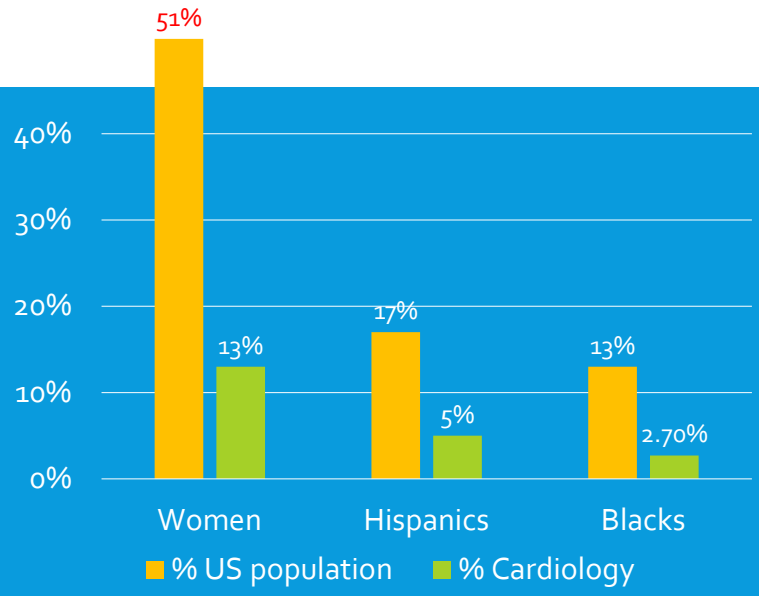
Quinn Capers IV · Zarina Sharalaya

Received: 28 January 2014 / Revised: 25 March 2014 / Accepted: 30 April 2014 / Published online: 23 May 2014

J of Racial and Ethnic Health Disparities: 2014

31

THE PROBLEM …



AAMC Diversity Facts and Figures

32

THE PREEMINENCE OF ETHNIC DIVERSITY IN SCIENTIFIC COLLABORATION

ALSHEBLI. NATURE COMM. 2018

- Analyzed over 9 million papers and 6 million scientists
- Studied the relationship between research impact (# citations) and several types of diversity (ethnicity, discipline, gender, affiliation, academic "age")
- "Broadly, we found that diversity was positively correlated with impact … discipline and affiliation diversity were the least correlated …ethnic diversity had the strongest correlation …"

33

33

WHY DO WE SEEK DIVERSITY IN MEDICINE?

- Multiple Choice Question
- A) Physicians Who Train in Diverse Environments Rate Themselves as More Comfortable Treating Minority Patients
- B) Be… …o Serve the Unde…
- C) Be… …rity Physicians
- D) Diversity in Medicine Should Help Reduce Racial Healthcare Disparities
- E) Diversity on Research Teams Enhances Impact of Research

ALL OF THE ABOVE

34

SO, WHAT CAN WE DO TO ENHANCE DIVERSITY IN MEDICINE?

1. Recruit—Deep Pipeline
2. Recruit---Immediate Pipeline
3. Identify and Mitigate Bias in Medicine and Selection Processes
4. Elevated "Diversity Competency" to a top consideration when making recruitment decisions
5. Be an Activist against structural and societal bias/racism and adverse SDOH

35

SO, WHAT CAN WE DO TO ENHANCE DIVERSITY IN MEDICINE?

1. Recruit—Deep Pipeline

36

Ohio State University-Columbus City Schools K-12 Health Sciences Academy

37

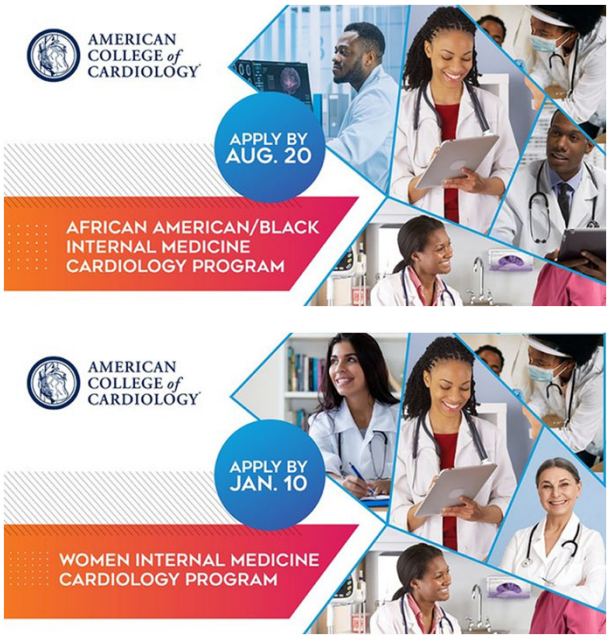
SO, WHAT CAN WE DO TO ENHANCE DIVERSITY IN MEDICINE?

1. Recruit—Deep Pipeline
2. Recruit---Immediate Pipeline

38

- ACC Internal Medicine Mentoring Programs

- Cohorts:
  - Black IM Residents
  - Women IM Residents
  - Hispanic IM Residents



39

MAKING HISTORY AT ACC 2022

ASPIRING CARDIOLOGISTS (WOMEN, HISPANIC, BLACK IM RESIDENTS)

40

40

SO, WHAT CAN WE DO TO ENHANCE DIVERSITY IN MEDICINE?

1. Recruit—Deep Pipeline
2. Recruit---Immediate Pipeline
3. Identify and Mitigate Bias in Medicine and Selection Processes

41

Implicit Racial Bias in Medical School Admissions

Quinn Capers IV, MD, Daniel Clinchot, MD, Leon McDougle, MD,
and Anthony G. Greenwald, PhD

Abstract

Problem
Implicit white race preference has been associated with discrimination in the education, criminal justice, and health care systems and could impede the entry of African Americans into the medical profession, where they and other minorities remain underrepresented. Little is known about implicit racial bias in medical school admissions committees.

Approach
To measure implicit racial bias, all 140 members of the Ohio State University College of Medicine (OSUCOM) admissions committee took the black–white implicit association test (IAT) prior to the 2012–2013 cycle. Results were collated by gender and student versus faculty status. To record their impressions of the impact of the IAT on the admissions process, members took a survey at the end of the cycle, which 100 (71%) completed.

Outcomes
All groups (men, women, students, faculty) displayed significant levels of implicit white preference; men ($d = 0.697$) and faculty ($d = 0.820$) had the largest bias measures ($P < .001$). Most survey respondents (67%) thought the IAT might be helpful in reducing bias, 48% were conscious of their individual results when interviewing candidates in the next cycle, and 21% reported knowledge of their IAT results impacted their admissions decisions in the subsequent cycle. The class that matriculated following the IAT exercise was the most diverse in OSUCOM's history at that time.

Next Steps
Future directions include preceding and following the IAT with more robust reflection and education on unconscious bias. The authors join others in calling for an examination of bias at all levels of academic medicine.

Academic Medicine. March 2017

42

BIAS AND EQUITY TEACHING ROUNDS

Bias and Racism Teaching Rounds at an Academic Medical Center

Check for updates

Quinn Capers IV, MD; David A. Bond, MD; and Uday S. Nori, MD

Racism and events of racial violence have dominated the US news in 2020 almost as much as the novel coronavirus pandemic. The resultant civil unrest and demands for racial justice have spawned a global call for change. As a subset of a society that struggles with racism and other explicit biases, it is inescapable that some physicians and health-care employees will have the same explicit biases as the general population. Patients who receive care at academic medical centers interact with multiple individuals, some of whom may have explicit and implicit biases that influence patient care. In fact, multiple reports have documented that some physicians, health-care workers, and health professional students have negative biases based on race, ethnicity, obesity, religion, and sexual identity, among others. These biases can influence decision-making and aggravate health-care disparities and patient-physician mistrust. We review four actual cases from academic medical centers that illustrate how well-intended physicians and health-care workers can be influenced by bias and how this can put patients at risk. Strategies to mitigate bias are discussed and recommended. We introduce what we believe can be a powerful teaching tool: periodic "bias and racism rounds" in teaching hospitals, in which real patient interactions are reviewed critically to identify opportunities to reduce bias and racism and to attenuate the impact of bias and racism on patient outcomes.

Capers. CHEST. 2020

CHEST 2020; 158(6):2688-2694

KEY WORDS: bias; racism; strategy

43

43

SO, WHAT CAN WE DO TO ENHANCE DIVERSITY IN MEDICINE?

1. Recruit—Deep Pipeline
2. Recruit---Immediate Pipeline
3. Identify and Mitigate Bias in Medicine and Selection Processes
4. Elevate "Diversity Competency" to a top consideration when making recruitment decisions

44

Received: 1 April 2021 | Revised: 23 April 2021 | Accepted: 25 April 2021
DOI: 10.1002/ccd.29751

ORIGINAL STUDIES
Hildner Lecture SCAI 2021

WILEY

Black lives matter ... in the cath lab, too! A proposal for the interventional cardiology community to counteract bias and racism

Anezi I. Uzendu MD[1] | Konstantinos Dean Boudoulas MD[2] | Quinn Capers IV MD[3]

Selecting Fellows (Point Score System):

- Clinical Skills
- Collegiality
- Academic Curiosity
- Leadership Potential
- Diversity Competency (Diversity/Ability to Enhance Cultural Competency of the Program)

Uzendu. Cath Cardiov Interv 2021

TABLE 1 Fellowship evaluation form: diversity/ability to enhance cultural competency of the program

1.	Community outreach (since beginning medical school, has candidate participated in activities that reach out to and provide service to the broader community? Examples: Volunteering in free clinic, community clean up, tutoring, etc.)
	0 or 1 activity on electronic residency application service (ERAS) = 1 point
	2 distinct activities on ERAS = 2 points
	3 or more distinct activities on ERAS = 3 points
2.	Immersion experience with culture other than your own (since beginning medical school, meaningful efforts to learn about or work with people from cultures other than their own. Examples: Bi-multilingual, service activities overseas, coursework, etc.)
	0 or 1 activity = 1 point
	2 distinct activities = 2 points
	3 or more distinct activities = 3 points
3.	Since beginning medical school, training at hospital serving largely underserved/disadvantaged populations (example: "Safety net" or county hospital; free clinics)
	0 or 1 training program on ERAS = 1 point
	2 distinct training programs on ERAS = 2 points
	3 or more distinct training programs on ERAS = 3 points
4.	Experience working on or investigating problems of disparities/ health inequity (examples include research project, employment, scholarly writing)
	0 or 1 project on ERAS = 1 point
	2 distinct projects on ERAS = 2 points
	3 or more distinct projects on ERAS = 3 points
5.	Question: Ask question related to depth of understanding about racial healthcare disparities. Grade on numeric scale based on completeness and depth of knowledge.
	Answer with only surface understanding of the problem = 1 point
	States the problem and 1 underlying cause (SDOH, structural racism, etc.) = 2 points
	States the problem and discusses 2 or more underlying causes = 3 points
	Total points: 0–5 = less competitive; 6–9 = competitive; 10–15 = outstanding

45

For 8 years in a row, an underrepresented minority Interventional Cardiology Fellow

46

SO, WHAT CAN WE DO TO ENHANCE DIVERSITY IN MEDICINE?

1. Recruit—Deep Pipeline
2. Recruit---Immediate Pipeline
3. Identify and Mitigate Bias in Medicine and Selection Processes
4. Elevated "Diversity Competency" to a top consideration when making recruitment decisions
5. Be an Activist against structural and societal bias/racism and adverse SDOH

47

Imagine being a kid that wants to be a Dr.

And you move every 3 years
Hunger is your daily reality
Your schools are underfunded and crowded
Your family transportation is unreliable

48

48

49

CONCLUSIONS

There are Many Arguments Against Enhancing Diversity in Medicine

These Arguments are Easily Dismantled by Evidence

Diversity in Medicine Will Enhance:

- Care for underserved communities
- Impact of biomedical research
- Cultural Competence of ALL physicians
- Health Equity for All

50

50