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Becoming an Anti-Racist Training Program

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Stark health inequities exacerbated by the Coronavirus disease 19 pandemic, along with high-profile cases of police brutality and murders of Black and Brown people, brought overdue attention to the impact of structural racism across all societal institutions in the United States. Our residency program, similar to many, was forced to confront our inaction. Racism within medicine and medical education has profound implications for the workforce, care delivery, and patient outcomes.[1,2] Racial health disparities persist in pediatrics despite a long-standing focus on marginalized populations.[3] We must train providers to actively recognize and rectify these inequities.[4] Antiracism ideals and actions actively oppose racism and intersecting systems of social oppression and require action-oriented interventions to transform individuals, organizations, and larger systems.[5] Here we share the journey of our residency program in partner with our departments and institutions to become actively antiracist in an effort to improve medical training, influence larger institutional change, and ultimately improve the equity and quality of care provided to patients.

Approach to Formulating a Strategic Plan

Our program began with critical reflection and discussion as an executive leadership committee composed of Program Directors (PDs), Associate Program Directors (APDs), and Chief Residents. Our committee lacked racial and ethnic diversity; of 14 members, only 2 self-identified as being from a racial or ethnic group underrepresented in medicine (UIM). Two chief residents had formal roles in leading equity, diversity, and inclusion (EDI) efforts; however, there was a lack of formal training in antiracism across the leadership. Accordingly, there was a disproportionate burden on residents and our existing Diversity Council, a resident-led, faculty-supported organization aimed at advancing EDI initiatives via recruitment, education, and community working groups, which previously had minimal programmatic support and no PD/APD members.

We established an antiracism leadership team, including 2 Chief Residents, 2 APDs with newly protected time for this work, and an existing Faculty Diversity Officer funded programmatically to protect time for expert teaching and to serve as a consultant to identify the impact of systemic racism in our program and improve our learning environment. The leadership team was charged with developing and leading a strategic plan, supporting residency and Diversity Council initiatives, and liaising and collaborating with hospital stakeholders, including department chairs, affiliated medical school leaders, Offices of Health Equity, and Graduate Medical Education (GME) leaders.

We then hosted a series of virtual, residency-wide brainstorming meetings to gather feedback on existing antiracism efforts, identify areas of need, and solidify next steps. These meetings occurred in large and small groups across all resident years and racial identity groups. Meetings were conducted during workday hours with and without program leadership to increase the diversity of perspectives and allow all to contribute transparently and honestly. Ideas were gathered anonymously through an online form. We conducted separate virtual forums with our Diversity Council, residency selection committee, and rotation directors. Our executive committee reviewed the most recent residency annual Diversity Council climate survey, program recruitment and retention demographic trends, and postmatch surveys of UIM residency applicants. This brainstorming phase generated more than 200 action steps.

Before engaging in grouping and prioritizing these steps, the leadership team established a shared mental model that cultivating antiracism in our residency program with a specific focus on education and experience of trainees is a meaningful approach to advancing antiracism more broadly across our institutions. Given that residents operate across many clinical settings in our hospitals, the team shared the belief that residency-centered work would have a subsequent influence on the culture and climate of the Pediatric Department, the hospital, and ultimately patients who will receive more equitable care from less-biased providers and within improving care systems.

Next, the leadership team grouped action steps thematically into 5 domains: program/institution, education,

APD	Associate Program Director
EDI	Equity, diversity, and inclusion
GME	Graduate Medical Education
PD	Program Director
UIM	Underrepresented in medicine

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recruitment and retention, workplace culture and climate, and patient care/advocacy. In conversations with department chairs and hospital EDI stakeholders, the initial patient care/ advocacy domain was restructured to emphasize trainee education on health disparities and antiracist patient communication and care delivery. Additionally, action items that proposed specific research or hospital-level needs related to patients were shared with department chairs and hospital EDI stakeholders directly. These topics also were emphasized in appropriate intersecting domains for continued education and advocacy by the residency program, such as department-wide health equity rounds, a grand rounds case-based series on the impacts of structural racism, and implicit bias in patient care.[6]

We plotted all action steps on an impact-feasibility matrix using a 10-point scale for both anticipated impact and feasibility. Impact was characterized by estimating the degree to which an action would advance antiracism ideals for the residency program, and feasibility was determined by estimating resource utilization and anticipated time to implementation. All items fell into 1 of 4 quadrants: (1) high impact, high feasibility ("quick wins"); (2) high impact, low feasibility ("major projects"); (3) low impact, high feasibility ("fill-ins"); or (4) low impact, low feasibility ("low priority"). A literature review helped to predict impact and feasibility; for example, literature on the implementation of UIM recruitment,[7,8] retention,[9,10] and mentorship activities[11,12] guided plotting of these items. However, some items lacked evidence, such as implementing a bias reporting system. We focused on quick wins and major projects while including some fill-ins and avoiding low-priority tasks. The matrix guided our timeline: we immediately implemented quick wins while planning a longer timeline for major projects. An example of a quick win was implementing a weekly antiracism team meeting to respond to incidents of bias from residents, and a major project was hiring more racially and ethnically diverse program leadership.

In developing our strategic plan (**Table**), we acknowledged that antiracism work is never "complete," and that continuous scrutiny is required to monitor implementation, impact, and progress. Using a quality improvement framework, our antiracism team assessed qualitative feedback gathered through scheduled open resident forums and collated data from weekly bias reporting meetings, the Diversity Council climate survey, and recruitment and retention metrics to iteratively refine the plan. To maintain accountability and transparency both retrospectively and prospectively, we committed time during each weekly executive meeting to antiracism initiatives, and we report on progress via quarterly residency-wide open meetings with time for resident feedback.

Reflections and Lessons Learned

While developing the strategic plan, we were forced to balance priorities that at face value often felt like competing interests. We urge programs to consider these not false dichotomies but rather dual critical concepts.

Value Antiracism and Program Diversity

Historically, our program's EDI work largely focused on increasing the racial diversity among residents. Although program diversity is an important goal related to antiracism, the concepts are not synonymous. Antiracism is a practice of actively opposing and disrupting systems of racial oppression. Thus, the path to becoming antiracist cannot stop at hiring more UIM trainees. Instead, it requires critical inspection of climate and practices and how these may perpetuate racist views; for example, "How are people of color treated, evaluated, and promoted—or not—at our institutions?" In our experience, advancing introspection along these ideals was best accomplished when the ideals were supported and communicated openly and consistently by our leaders. Those in positions of power, including program leaders and department chairs, can take visible steps to role model qualities of introspection and self-awareness and acknowledge their own privileges, potential biases, and assumptions. Leaders also must be involved and seek opportunities to engage with trainees, employees, and the community they serve to best recognize systems of oppression. Self-awareness and broad engagement allow leaders to best position themselves to be effective sponsors and leaders of antiracism efforts.

At our program, some examples of department chair sponsorship already in place or put into place during this time included partial support of 2 APD salaries, protecting a department-wide grand rounds educational space for a health equity rounds series, and a commitment to hiring and promoting a diverse workforce. Other examples of department chair leadership included ensuring that departmental mission statements emphasized values of EDI and antiracism, supporting department-wide upstander training, and starting department meetings with a group agreement statement grounded in values of EDI. Given the nature of our combined training program, antiracism initiatives varied at each institution, but many of the strategic initiatives identified were achievable specifically because of the financial and cultural support of our respective department chairs.

Recognize Prior Work and Critical Gaps

We realized that the language around gaps in our program was dismissive of long-standing antiracism work by trainees and faculty who had worked in this space for many years. For example, generalizations like "there is no focus on diversity in recruitment" was hurtful to those who were deeply dedicated and involved in the past. Instead, an appreciation for these contributions was needed alongside acknowledgment of the continued barriers faced, including inadequate funding and institutional support. Appropriate recognition for work focused on antiracism and EDI more generally was a priority in implementing our strategic plan. Residency program directors created an EDI "honor roll" and wrote individualized notes of recognition to faculty leaders with department chairs and division chiefs included to adequately value and credit their contributions. Finally, we continued to dedicate the Darryl Powell Social Justice Award annually for a resident

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dedicated to eliminating racial disparities in medicine and advancing UIMs in healthcare.

Address Minority Tax and Foster Allyship

Historically, the overwhelming burden of antiracism work has fallen on residents of color. Minority tax, defined as the process of overburdening minorities with additional responsibilities to improve diversity, is a concern in academic medicine.[13] Accordingly, there was concern that minority tax would be increased. However, in seeking to mitigate the minority tax, we ran the risk of reducing representation, scholarship, and leadership opportunities for UIM trainees. Similarly, in trying to reduce resident workload, there was a risk of reducing residents' voices. What we found most effective was maximizing opt-in opportunities for residents to participate and lead initiatives while offering meaningful administrative support. For example, in the development of a UIM-focused mentorship pilot, self-selected resident leaders shaped the focus and scholarly evaluation of the program with committed programmatic funding, institutional technical resources from the GME office, and administrative logistics support.

Fostering allyship is an additional component of addressing the minority tax by expanding and diversifying the group of people passionate about and dedicated to antiracism. Allyship is the process of building relationships based on trust, consistency, and accountability with marginalized individuals.[14]

Given the limited racial diversity of our residency program leadership and antiracism leaders, allyship was essential to trainee trust and programmatic change. Our guiding principle for allyship was that self-awareness leads to better service and requires both acknowledgment of privilege and strategic and purposeful use of that privilege to dismantle discriminatory practices and policies. To foster allyship among leaders and educators, department chairs supported us in hosting a mandatory antiracism retreat for residency program leadership, rotation directors, Clinical Competency Committee members, and Selection Committee members. The retreat included didactics on the impact of structural racism on medical education and workforce diversity and included facilitated small groups for individual reflection and goal-setting. We continued these diversity-informed practices in creating inclusive and facilitated spaces for residents and faculty throughout strategic plan development and implementation to teach and build allyship. These combined efforts resulted in a better-supported UIM workforce and a more robust community of allies to support, lead, and sustain antiracism work.

Prioritize Recruitment and Retention

In 2022, our program comprises 154 residents, of whom 66% identify as White/Caucasian, 9% as Black/African American, and 7% as Hispanic/Latinx using Electronic Residency Application Service self-reported data. Although this composition mirrors the national average among all medical trainees, our goal remains to train a diverse group of physicians that mirrors the diverse communities we serve.

We historically have invested more resources into intern recruitment compared with retention, which has resulted in attrition of a disproportionate number of UIM residents to other institutions. Work to improve learning climate, mentorship, and professional development must be pursued in parallel. Furthermore, when trainees of color are disproportionately not retained, representation among faculty is further limited. This may propagate implicit institutional beliefs that people of color do not belong.

Ensure Immediate Action and Sustainable Change

There is a need for both immediate action and sustainable change in antiracism. Even with a year-long plan, we did not accomplish every goal. In particular, goals with larger numbers of stakeholders and collaborators were more challenging (eg, expansion of health equity rounds across institutions and implementing antiracism curricula in all rotations). Pandemic-specific challenges, such as hiring freezes, created additional logistical barriers to increasing diverse representation in leadership. Finally, financial limitations significantly impacted the feasibility and selection of action items included in our strategic plan. Although we are fortunate to have relatively substantial financial and resource support, disparities remain in the allocation of funding and resources to antiracism efforts. We would expect these challenges to be significantly exacerbated in programs with fewer baseline resources, both financial and otherwise.

These challenges informed reflection and planning for the coming year. Weekly review of immediate and short-, medium-, and long-term goals helped maintain urgency in areas while remaining focused on a larger programmatic vision. Our most feasible goals were those with stakeholders within the residency program that required limited additional resource support. Examples of these included improving the program's existing visibility and transparency, creating and modifying residency-specific education efforts, requiring free and brief training in uniform inclusive curriculum for educators,[15] and creating safe spaces for trainees. Other less resource-intensive action items were those that reevaluated existing contracts or reallocated already protected time. Although we celebrate these quick wins, we remain committed to long-term and more resource-intensive goals involving institutional partners and have scheduled protected time to review items not included in the initial plan. Although we began with a focus on education and climate given our scope within one residency program, we cannot and will not lose sight of ideas involving direct patient care, legislative advocacy, and wider hospital systems.

Ensuring sustainable investment of resources and measurement of indirect costs is another necessary step in sustainability. We mobilized both short- and long-term

funding sources. Short-term investments included a hospital Alumni Association gift for Juneteenth programming and use of GME Office mentorship software. Long-term examples included residency budget line items for salary support, resident reimbursement for recruitment-related activities, and a fully funded second-look event for UIM applicants. Indirect costs included time and curriculum changes in which dedicating more time to antiracism meant less time for other program objectives; this transition was embraced and prioritized by our leadership. Although financial support is necessary, our greatest asset for ensuring sustainability is our people. We will continue to professionally recognize and reward antiracism leaders and foster allyship.

Finally, alignment of program-specific and institutional initiatives was critical for efficient and effective work. In our experience, improved leadership structure and relationships with institutional offices such as GME and Health EDI were paramount in streamlining efforts on shared goals rather than competing goals, particularly related to recruitment and retention initiatives.

Conclusion

The work of becoming an antiracist organization is challenging, requiring introspection, shared accountability, and institutional investment of time, resources, and people. Efforts must recognize existing work while increasing the transparency of programmatic shortcomings. Mitigation of minority tax must be met with shared responsibility through fostering allyship and recognition of individuals leading these efforts. Investment must be equal in both recruitment and retention. Finally, all of these efforts must reflect a program's commitment to both immediate action and sustainable change. Substantive change is difficult but must remain the priority for the sake of our trainees, our patients, and society. ■

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Table. Selected action items from antiracism strategic plan for the Boston combined residency program, academic year 2020-21

Domain	Action item	Description	Timeline*
Program	Contract with Black-owned businesses*	Review vendor contracts and increase contracts with local Black-owned businesses (eg, catering).	Immediate
	Antiracism retreat for program leadership*	Create a virtual 3-hour retreat consisting of didactics on the impact of structural racism on medical education and workforce diversity and facilitate small groups for individual reflection and goal setting for residency program leadership, rotation directors, clinical competency committee members, selection committee members, and department chairs.	Short-term
	Honor Juneteenth as a residency holiday	Provide clinical coverage for all Black resident trainees for Juneteenth and plan residency-wide education and celebration in collaboration with the Graduate Medical Education Office.	Medium-term
	Executive leadership representation	Increase racial representation within program leadership.	Long-term
	Intersectional institutional events	Collaborate with affiliated institutions to highlight and participate in EDI events that offer opportunity for intersectionality of antiracism in addition to other diverse and marginalized identities, including Latinx Heritage Month, Migration Is Beautiful Week, Trans Health Week, National LGBTQ Health Week, and Asian American and Pacific Islander History Month.	Long-term
Education	Rising intern orientation: antiracism curriculum*	Ensure early introduction to the history of racism in medicine, implicit bias curriculum, and bystander/upstander training.	Immediate
	Shared antiracism education resources*	Centralize antiracism education resources to internal website for self-directed learning	Immediate
	Antiracism advocacy*	Prioritize and share antiracism advocacy opportunities in weekly residency-wide communication	Immediate
	Uniform inclusive curriculum*	Require all educators to review the program statement on antiracism and an inclusive curriculum training video[15] to ensure content in alignment with program antiracism values and standards	Immediate
	Advocacy curriculum orientation: antiracism*	Revise curriculum to include clear connections among racism, policy, economic exclusion, disinheritance, and poverty; provide recommended antiracism reading and facilitate discussion.	Short-term
	Longitudinal implicit bias curriculum	Support and expand the resident program Diversity Council Education Working Group's longitudinal implicit bias curriculum for residents (eg, documentation and racial bias, recruitment and selection bias, racial bias in clinical decision tools)	Medium-term
	Educator diversity and representation*	Measure current educator and speaker demographics and improve diversity and representation of residency program didactic educators and invited speakers	Medium-term
	Biannual house staff retreat antiracism integration	Review and incorporate antiracism ideals into existing curricula, for example, leadership curriculum to include understanding bias in job searches and salary inequities and improving communication and negotiation skills. Extend antiracism transformation to academy sessions including "global health decolonization," "understanding bias in medical education," and "clinical investigation: how to appropriately use race in clinical research."	Medium-term
	Health equity rounds expansion*	Expand existing grand rounds case-based series on impact of structural racism and implicit bias in patient care shared across institutions for increased resident attendance.[6]	Long-term
	Rotation-specific antiracism initiative*	Engage rotation directors and APD/PDs in review of curricular content and identification of at least one place where antiracism content or discussion can be sustainably added to each rotation.	Long-term
Recruitment and retention	Program visibility and transparency*	Update the program website to reflect ongoing commitment to and plans for antiracism work.	Immediate
	Program accessibility and engagement*	Increase accessibility to and engagement with program for UIM applicants in collaboration with Offices of Health Equity and through existing pipelines (eg, SNMA, LMSA, visiting clerkship programs), existing programs (eg, Diversity Council Connect buddy program, diversity dinners), and new modalities (eg, NextGen Peds, social media, virtual forums).	Short-term
	Bias in recruitment and selection*	Provide education to intern and chief selection committee members on impact of implicit bias and structural racism on medical education and workforce diversity. Implement changes to application review that systematically deemphasize portions of applications known to contain bias.	Medium-term
	UIM mentorship pilot program	Establish and evaluate a structured career mentorship program for UIM trainees.	Long-term
	UIM fellowship program collaboration	Cultivate partnership with fellowship programs through participation in inaugural UIM Second Look experience, GME Juneteenth Event, and inclusion of fellows as near-peer mentors in the UIM mentorship pilot program.	Long-term

(*Continued*)

Table. Continued

Domain	Action item	Description	Timeline*
Climate and culture	Safe spaces*	Create regular spaces for debriefing, listening, self-reflection, and community building.	Immediate
	Resident evaluation review for bias*	Provide an avenue for eliciting trainee concerns about bias in faculty and peer evaluations. Establish a committee to routinely review and facilitate addressing concerns about bias to individual evaluators.	Medium-term
	Upstander training*	Mandate attendance at skills-based upstander training for all house staff to improve comfort in addressing microaggressions and instances of bias in the workplace.	Long-term
	Bias reporting system and Review Committee	Establish mechanism for reporting bias and climate concerns.	Long-term
	Quality improvement*	Practice systematic and continuous actions to measure the impact of strategic plan elements, gather feedback, critically reflect, and improve as a residency program (eg, open resident forums, collated data from weekly bias reporting meetings, the Diversity Council climate survey, and recruitment and retention metrics).	Long-term

Timeline: Immediate, 1 month; short-term, 1-3 months; medium-term, 3-6 months; long-term, 6-12 months.
*Low financial cost initiatives.