Belonging, Respectful Inclusion, and Diversity in Medical Education

Belonging is the experience of being accepted, included, and valued by others. A fundamental human motivation, belonging positively influences an individual’s health, abilities, relationships, and overall well-being.1 Belonging is an interpretation of cues that suggests that one fits in and is welcome in a given context; it is an inference based on observations, interactions, values, and past events that define the culture and environment.2 Encountering discrimination, exclusionary practices, bias, and microaggressions interferes with the experience of belonging. Uncertainty about belonging, or worse, certainty of not belonging can contribute to isolation, diminished capacity for trust, emotional distress, lessened effectiveness, exhaustion, and serious health issues.2–5 Individuals who identify as members of underrepresented groups can be profoundly and disproportionately affected by these concerns.3

Respectful inclusion in the health professions of individuals with a wide range of backgrounds, identities, and life experience is increasingly understood for its primacy in preparing an innovative and representative workforce, addressing health disparities, advancing science, and serving the needs of the public.6,7 Respectful inclusion is vital to the future of medicine and requires new ideas and new practices, as illustrated very thoughtfully in several articles4–7 appearing in this issue of Academic Medicine. Committing to a more diverse and vibrant future requires self-honesty, creativity, and courage in tackling aspects of the culture of medicine that may interfere with people from all backgrounds feeling welcomed, included, and valued—namely, feeling that they truly belong.

Belonging Cues

Individuals may experience certain aspects of medical education as threats to a secure sense of belonging. For example, the populations of students and faculty of U.S. medical schools do not reflect our country’s general population. Poor representation or nonrepresentation may suggest that some people are valued over others in the culture of medicine. This year, for the first time, women outnumber men enrolled in medical school,9 with a gender balance that more closely matches that of the general population. And yet, individuals enrolled in medical school in 2019–2020 identify as 50% white, 22% Asian, 7% black or African American, and 7% Hispanic, Latino, or of Spanish origin,18 while the U.S. population identifies as 60% non-Hispanic white, 6% Asian, 13% black or African American, and 18% Hispanic or Latino.19

Decades of effort to promote diversity in admissions have led to uneven results. To illustrate, between 1980 and 2016, the proportion of black or African American medical school matriculants rose only slightly, from 6% to 7%, and the proportion of Hispanic matriculants rose from 5% to 6%. American Indian/Alaska Native matriculants declined to 0.3% in 2016 from 0.4% in 1980, despite increasing year after year in the general population.20 In 2018–2019, 24 of 53 applicants who identified as Native Hawaiian or other Pacific Islander were accepted to medical schools, and 44 of 109 who identified as Alaska Native/American Indian became accepted.21 Postgraduate medical education overall tends to be more diverse, especially in primary care fields, although certain fields of training are very narrow in terms of demographic characteristics. Bringing greater representation to all specialty fields poses challenges. In 2019, for example, there were more black or African American and Hispanic applicants to family medicine programs than to dermatology, neurology, orthopedic surgery, otolaryngology, pathology, physical medicine and rehabilitation, radiation oncology, and urology combined.22

The composition of medical school faculty is evolving, with greater numbers and proportions of women and individuals who identify as traditionally underrepresented in medicine (URiM), especially among earlier career faculty members.24,25 That said, in a recent survey26 inquiring about the major professional activity of medical school faculty members, only 516 individuals who identified as black or African American reported medical teaching as their primary focus, and only 294 reported research. In this survey, only 2 Native Hawaiian or other Pacific Islander individuals reported administration as their main professional activity.

Persistent underrepresentation of some groups in medical schools may lead to the perception that some groups are less welcome and their presence less supported, impeding the experience of belonging. As noted by Walton et al.,27 this perception should not be denied or dismissed, as it is not unjustified: “it reflects the external world, and the risks a person faces” when a group that has been historically excluded encounters stereotype threat or, for whatever reason, experiences disadvantage or negative repercussions in a given context. In her essay entitled “A Dark Spot on a White Canvas,” Dr. Lia Thomas describes this inner experience from when she was a medical student:

The thought was there, gnawing in the back of my mind, whispering at me when gross anatomy got tough. . . . “You do not really belong here; you took someone else’s spot.” I would not dare voice these feelings to my friends or to my advisors. A part of me was afraid that they would think less of me for feeling inadequate; another part of me knew that they already knew I was inadequate.28(p456)

As Dr. Thomas assumed leadership roles as a faculty member, she felt paradoxically both visible and invisible. When stressed, she found that the voice of lonely self-doubt returned. Did I not know my place? Had my reach exceeded my grasp? . . . And, most importantly, where would I belong?29(p456)

Baumeister and Leary4(p521) have cautioned that “cultures use social inclusion to
reward, and exclusion to punish, their members as a way of enforcing their values. It is no wonder, then, that feeling out of place causes self-critique, isolation, and feelings of being an “imposter” in academic medicine. Moreover, in the presence of other factors, ruptured or thwarted belongingness can contribute to heightened risk for physical health problems as well as emotional distress and self-harmful behaviors. Better understanding of the role of belonging in medical schools may help us to understand the distinct and often very serious health care needs of URiM students, as documented in a number of empirical studies.

Another barrier to feelings of belonging among medical students is the observation that that learning environments are not free from hostility, exploitation, and unequal treatment, despite efforts to ensure otherwise. The 2019 Medical School Graduate Questionnaire, conducted by the Association of American Medical Colleges, documented that many respondents (23%) had been “publicly humiliated” once (13.1%), occasionally (8.8%), or frequently (0.8%) during their undergraduate medical training. Twenty-one percent reported other students being subjected to such behavior. More than 60 respondents reported being asked during medical school to exchange sexual favors for grades or other rewards. Nearly 1,000 respondents reported being denied opportunities for training or rewards based on gender, and more than 1,100 reported receiving lower evaluations or grades based on gender. A total of 8.5% of respondents had personally experienced “racially or ethnically offensive remarks/names” once (4.1%), occasionally (3.9%), or frequently (0.5%) in medical school. More than 500 respondents reported being denied opportunities for training or rewards based on race or ethnicity. A similar number reported receiving lower evaluations or grades based on race or ethnicity. A small proportion of respondents overall reported being subjected to offensive remarks/names (2%) or to unequal treatment (0.7%) at least once related to sexual orientation. It is unclear which students had these experiences, but it should be noted that a total of 7.2% of respondents in the survey self-identified as bisexual, gay, or lesbian, and 0.4% stated that they had a different gender identity from the sex assigned at birth.

Many respondents did not report negative experiences such as these to their institutions because they felt that nothing could be done or because they were fearful of reprisal. Further, demonstrations of respect for diversity by faculty were reported as occurring either never, almost never, or sometimes by 5.4% of respondents. Demonstrations of respect for students by faculty were reported as occurring either never, almost never, or sometimes by 6.5% of respondents. These findings suggest that the learning climate is not yet fully supportive of our students. While some may argue that these percentages have improved over time—and they clearly have—it is important to remember that a trend does not feel wholly relevant for individuals who are directly experiencing humiliation or unequal treatment.

Beyond these threats and barriers, the experience of belonging may be affected, positively or negatively, by rituals and signs of recognition and status in the culture of medicine (e.g., honors, awards, invitations, opportunities). Whether evaluations and letters of recommendation predominantly describe personal attributes (as is more common for women and members of groups traditionally underrepresented in medicine) as opposed to strengths and areas of competence (as is more common for men and members of majority groups in medicine) is a cultural signal that influences opportunities for students and reinforces either belonging or exclusion. Students who identify as members of underrepresented minority groups in some settings may carry greater financial debt, may encounter structural barriers to performance on standardized examinations, and may be at risk for slower progression and greater attrition.

How such disparities are addressed will affect students’ sense of affiliation, safety, and feelings of either being out of place or “at home.” The presence of leaders, mentors, and near-peers who identify as members of underrepresented groups, along with perceptions of their scope of responsibility, power, and control or access to resources, can serve as cultural indicators that augment or lessen feelings of belonging. Whether individuals who identify with underrepresented groups are asked to carry disproportionate burdens of service and representation (the “minority tax”) can be another environmental cue for students.

The presence of meaningful and relevant policies, along with evidence of their faithful implementation, can serve to communicate a commitment to respectful inclusivity in a given context. For instance, the Liaison Committee on Medical Education has 2 standards pertaining to diversity and inclusion. The first states that each medical school must develop programs or partnerships aimed at broadening diversity among qualified applicants for medical school admission.

The second states that each medical school must have policies and practices to achieve appropriate diversity among its students, faculty, staff, and other members of its academic community, and must engage in ongoing, systematic, and focused efforts to attract and retain students, faculty, staff, and others from demographically diverse backgrounds.

The existence of concrete manifestations of such ideals is very important, including, for example, intentional curriculum design; adequacy of knowledgeable, sensitive, and well-prepared faculty; the existence of all-gender facilities; and the dedication of spaces for individuals with religious and spiritual beliefs or distinct backgrounds. Opportunities to receive specialized resources, financial assistance, career counseling, and culturally attuned health services, along with the absence of physical symbols that are experienced as objectifying certain groups, further fortify the message of respectful inclusion for medical students.

**Toward a Culture of Belonging, Respectful Inclusion, and Diversity**

In this issue of *Academic Medicine*, our authors take on some of the most difficult challenges that pertain to belonging, respectful inclusion, and diversity in medical education. Several articles offer insights into experiential and cultural issues, and some also offer strategies and practical approaches for implementation.

Three articles relate to the selection of students for Alpha Omega Alpha (AOA), a prestigious national honors society in medicine. Byyny et al of the AOA Honor Medical Society articulate their society’s commitment to diversity, inclusion,
and equity, emphasizing humility as expressed in the organization’s ideal that its members “Be Worthy to Serve the Suffering.” The authors acknowledge that the AOA has certain restrictions (e.g., no more than 16% of a medical school’s graduating class can be selected) and yet make clear that each of the 132 AOA chapters at medical schools in the United States, Puerto Rico, and Lebanon have the ability to develop and enact selection criteria for medical students, residents, and physicians at different career stages.

In a second article, Teherani et al describe how the University of California, San Francisco School of Medicine examined and changed selection processes for the school’s AOA honor society, adopting holistic review, as one effort among many, to dismantle existing inequitable educational structures.

Arguing that selection to the AOA reinforces structural biases and social privilege in medical education and runs counter to core tenets of equity and wellness, a third article by Lynch et al describes what many will consider a courageous decision to suspend student selection to the AOA at the Icahn School of Medicine at Mount Sinai. The authors state that a return to selection of students for the AOA at Icahn will only occur when all students are treated equitably in medicine. The cultural symbolism and influence of the AOA, and of similar honors, are reflected in these 3 articles.

In a remarkable qualitative study performed by Ackerman-Barger et al at the University of California Davis School of Medicine and Yale University School of Medicine, medical students and nursing students who identified as members of underrepresented groups were interviewed to better understand the role and effects of racial microaggressions in health professions education. This research report is exceptional for its clarity and thematic organization, its engagement of students in 2 health domains, and its sensitive selection of narrative examples to convey, movingly and richly, students’ experiences. This project follows on the past work by Orom et al documenting, for example, that URiM students face distinct challenges socially and academically, experience their learning environments as less positive, encounter discrimination and racial harassment, and are more likely to see race as negatively affecting their education. An important contribution of the study by Ackerman-Barger et al is the set of recommendations offered by the students themselves related to diversity and allyship, curriculum change, open conversations, and safe spaces. The insights of trainees in bringing forward respectful inclusion practices in the culture of medicine are invaluable, as seen in the example described elsewhere of the innovative adoption of 2 new chief resident roles for diversity and inclusion in one clinical department at Yale University School of Medicine.

Cook et al consider key issues and relevant resources and provide a set of thoughtful recommendations to help academic institutions develop more respectful, supportive, and attuned approaches to trainees who identify as transgender and nonbinary. The authors comment on administrative challenges and recommendations, touching upon culture, policies, data collection, health and wellness, and gendered spaces, and on educational challenges and opportunities in the classroom, clinical teaching, mentorship, and evaluation activities. The AM Last Page in this issue of the journal, entitled “Creating Affirming Health Care Environments for Patients Who Are Gender Diverse,” complements the valuable contribution by Cook et al and builds on the relatively small literature base on this emerging topic.

In their careful review of 89 published articles, Brottman et al sought to understand how health care professionals and medical students learn about topics such as implicit bias, health disparities, and the needs of diverse patient populations. Eleven educational strategies for fostering cultural competence were identified in the articles. Few of the published projects demonstrated favorable outcomes. Similar results have been found in studies of college students, in which some strategies for inclusion resulted in feelings of inauthenticity and exclusion among certain groups, despite their opposite intent. The review by Brottman et al highlights the important role of faculty expertise and skill and states that the adoption of more clearly articulated goals and refinement of best practices are needed. That review also serves as a reminder of the value of empirical work in informing curricular innovation and campus interventions. In another article in this issue’s collection, Sukhra et al suggest that transformational learning theory may serve as a useful lens for advancing education on implicit bias and related topics.

Focusing on graduate medical education, Gonzaga et al propose an approach for meeting Accreditation Council for Graduate Medical Education standards on creating a diverse and inclusive workforce. The approach features 5 interrelated components: setting diversity as a priority, seeking out candidates, implementing inclusive recruitment practices, investing in trainee success, and building the pipeline. Gardner et al describe the use of a new tool, the Situational Judgment Test, in addition to a scoring algorithm, to identify candidates for residency interviews in 7 residency programs. A number of candidates selected in this manner had United States Medical Licensing Examination Step 1 scores that previously would not have reached a “cutoff” threshold, and the candidates invited for interviews were more diverse than in the past.

Respectful inclusion and diversity in health professions education are essential to the learning, well-being, and effectiveness of our early-career colleagues. Respectful inclusion and diversity, furthermore, are essential to the health of the people and populations we are entrusted with serving, now and in the future. The role of belonging in health education, systems, and workforce is also essential, even though that role has thus far been underrecognized. Greater understanding of belonging, Dear Reader, is the key to respectful inclusion and diversity in the health professions. Such understanding will allow us to tackle the hardest issues we together face related to equity and well-being.

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Editor’s Note: The opinions expressed in this editorial do not necessarily reflect the opinions of the AAMC or its members.

References
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