Distribution Agreement:

In presenting this thesis or dissertation as partial fulfillment of the requirements for an advanced degree from Emory University, I hereby grant to Emory University and its agents the non-exclusive license to archive, make accessible, and display my thesis or dissertation in whole or in part in all forms of media, now or hereafter known, including display on the world wide web. I understand that I may select some access restrictions as part of the online submission of this thesis or dissertation. I retain all ownership rights to the copyright of the thesis or dissertation. I also retain the right to use in future works (such as articles or books) all or part of this thesis or dissertation.

Signature:

__________________________________ ________________________

Erika Heard Date

Investigating Perspectives about Diversity, Equity, Inclusion Curriculum of Psychiatry Residents, a Qualitative Analysis

By: Erika Heard, MD

The degree to be Awarded: MPH

Executive MPH

___________________________________ [Chair's signature]

___________________________________ [Member's signature]

___________________________________ [EMPH signature]

Laurie Gaydos, PhD

Associate Chair for Academic Affairs, Executive MPH

Investigating Perspectives about Diversity, Equity, Inclusion Curriculum of Psychiatry Residents, a Qualitative Analysis

By

Erika Heard, MD

Bachelor of Arts

Spelman College 2006

Doctor of Medicine

Duke University School of Medicine, 2011

Thesis Committee Chair: Rebecca L. Upton, Ph.D., MPH

A thesis submitted to the Faculty of the Rollins School of Public Health of Emory University in partial fulfillment of the requirements for the degree of Master of Public Health in Prevention Science 2022

Abstract:

Investigating Perspectives about Diversity, Equity, Inclusion Curriculum of Psychiatry Residents, a Qualitative Analysis

By: Erika Heard

Introduction: Health disparities have continued to persist despite efforts made by healthcare organizations to address them. Recently, many organizations have implemented diversity, equity, and inclusion (DEI) programs to address health inequality against the backdrop of the pandemic and the deaths of Black Americans at the hands of law enforcement. The medical community has a complex connection in developing and remaining complicit in upholding the systems of racism that infiltrates all facets of Black life. This is particularly true of psychiatry. Thus, the historical context of scientific racism must be acknowledged and dismantled.

Objective: As DEI programs and curricula have become a mainstay in addressing health disparities in healthcare, their effectiveness in addressing disparate health outcomes has not been proven. Thus, it is essential to understand how learners absorb this curriculum. The study investigates the perspectives of psychiatry residents participating in the DEI curriculum to understand motivations for participation, strengths and weaknesses of the program, and beliefs about areas for further growth and development. Based on these assessments, recommendations were developed to improve the program and increase engagement.

Methods: The primary researcher used qualitative methods to assess residents' beliefs and perspectives. The researcher used quantitative methods to conceptualize the resident participants. The data collected underwent thematic data analysis, and codes were then applied. The codes developed were then used to create a codebook.

Results: Participants highlighted the need for systemic implementation of DEI work with the integration of the work throughout the duration of their program and their clinical encounters. Residents highlighted that one of the main reasons for applying to Emory is because of Grady Hospital, and as such, they expect to receive training that will help them best care for their patients. DEI is an aspect of training they expect to help them treat their patients. Lastly, evidence-based DEI work is needed to equip residents with proven tools to address health outcome inequity adequately.

Conclusions: The findings of this study move the conversation forward by recommending bolder, more systemic change. To reduce health disparities, it will be important to develop a DEI curriculum based on structural competency and utilize evidence-based methods to assess the difference in health outcomes for those who participate in the DEI curriculum versus those who do not participate in this curriculum. This study highlights that this work is necessary not only for patient outcomes but also because residents expect to do it when attending Emory due to the patients they know they will serve. Thus, it is seen as a strength and a value that residency programs are doing this work.

Acknowledgments:

I want to thank my thesis committee members, Dr. Upton and Dr. White, for their guidance, support, advice, and patience while completing my thesis. I would also like to thank the Emory residents who agreed to participate in the focus groups. As residency is quite hectic, I genuinely appreciate the time they took from their schedules to assist in evaluating the curriculum and providing feedback. Lastly, I would like to thank my family and friends for their support and patience over the past two years of working on completing my Executive MPH.

Table of Contents

Definitions and Common Terms **7**
Introduction **9**
  Problem Statement 9
Background 9
  Historical Context 10
  Education 12
  Criminal Justice 14
  Black Wealth 15
  Black Health 17
Literature Review 19
  Diversity Training 20
  Current Practice 21
  Challenges 25
  Specific Aims 26
Methodology **27**
  Population and Sample 28
  Research Design and Analysis 28
Results **29**
  Qualitative Analysis 29
  Recommendations from participants 35
Discussion **36**
  Structural Competency 40
  Limitations 42
  Strengths 42
  Significant to Public Health 43
  Conclusions 43
References **45**
Appendices **52**
  Appendix A Focus Group Questions 52
  Appendix B Lectures 53
  Appendix C Codebook 54

Definitions of Common Terms:

Race: the social classification of people based on phenotype

Ethnicity: the historical, cultural, contextual, and geographic experiences of a defined population

Racism: a system of structuring opportunity and assigning value based on phenotype that unfairly disadvantages some individuals and communities while unfairly advantages other individuals and communities and undermines the realization of the full potential of the whole society through the waste of human resources.

Eugenics: the scientifically inaccurate theory that humans can be improved through selective breeding of populations.

Scientific Racism: a historical pattern of ideologies that generate pseudoscientific racist beliefs that perpetually influence racial bias and discrimination in science and research.

Implicit Bias: beliefs that are based in the subconscious, thus, making it difficult to acknowledge and control

Redlining: a pattern of discrimination in which financial institutions refuse to make mortgage loans, regardless of the applicant's credit record properties in specified areas because of alleged deteriorating conditions.

Institutionalized racism: the structures, policies, practices, and norms resulting in differential access to the goods, services, and opportunities of society by "race."

Equity: an approach that ensures that everyone has access to the same opportunities

Inclusion: the intentional, ongoing effort to ensure that diverse people with different identities are able to fully participate in all aspects of the work of an organization, including leadership positions and decision-making processes. It is an unconditional sense of belonging in a group or an organization.

Diversity: the range of individual and group differences, including but not limited to race, ethnicity, socioeconomic status, country of origin, culture, age, physical and mental ability, spiritual/religious beliefs, gender identity, and sexual orientation

Structural competency: the trained ability to discern how a host of issues defined clinically as symptoms, attitudes, or diseases represent the downstream implications of a number of upstream decisions about such matters of healthcare and food delivery systems, zoning laws, urban and rural infrastructures, medicalization, or the definition of illness and health

Microaggressions: commonplace, daily verbal, behavioral, or environmental indignities, whether intentional or unintentional, that communicate hostile, derogatory, or negative racial slights and insults towards people of color

"But race is the child of racism, not the father. And the process of naming "the people" has never been a matter of genealogy and physiognomy so much as one of hierarchy. Difference in hue and hair is old. But the belief in the preeminence of hue and hair, the notion that these factors can correctly organize a society and that they signify deeper attributes, which are indelible—this is the new idea at the heart of these new people who have been brought up hopelessly, tragically, deceitfully, to believe that they are white."

- Ta-Nehisi Coates, Between the World and Me

Introduction:

Problem Statement: Many studies have demonstrated that racial health disparities persist in the United States (US) and continue to adversely impact the health outcomes of minority communities (Hall et al., 2015). Addressing implicit bias is essential to dismantling structural racism to improve health disparities (Jones, 2002). Many organizations in business and healthcare have implemented Diversity, Equity, and Inclusion (DEI) curricula to address this bias and inequities. However, its sustained effectiveness in outcomes has not been demonstrated (Chang et al., 2019 and Fernandez, 2020). Despite their limited effectiveness, these curricula continue to be implemented in medical schools and residencies. To improve the DEI curriculum, speaking to learners who receive training is necessary to understand their views of the curriculum. Furthermore, few studies explicitly assessing psychiatry residents have been done. Psychiatry/psychology are disciplines closely connected to the justification of racism in the US (Warner, 2021). Thus, it is imperative to speak with residents in this program.

Purpose: This project aims to understand possible limitations and challenges in developing and implementing a DEI curriculum that resonates with the intended audience. The group being assessed is psychiatry residents in a large academic medical center.

Background

Understanding the historical context of how psychiatry was used to justify the system of racism that is impactful still to this day on the lives of Black Americans is necessary to rectify this system. Moving forward and building upon what we know is crucial to developing the framework by which to conceptualize programs for maximum effectiveness.

Historical Context

Slavery as an institution was the law of the land until the Emancipation Proclamation in 1863 (National Archives, n.d.). Beliefs about Black inhumanity contributed to the beginning and sustaining of slavery. Furthermore, the action of keeping individuals as slaves perpetuated the belief of Black inhumanity that permeates through all US institutions and persists today (Painter, 2006). Racism has impacted all facets of Black and White life, leading to disparities in housing, criminal justice, education, wealth, employment, and healthcare (Matthew et al., 2016).

In the US, the history of racism is complex, and the impacts of racism have been durable (Matthew et al., 2016). Interestingly, race was rarely used before the 1500s. It was used to identify individuals based on kinship or shared connection. It was not until the advent of the US capitalist system, built upon free labor from the enslavement of Africans, that race was used to discriminate against people based on their physical features. Thus, race was developed as a social construct to justify the use of free labor (National Museum of African American History and Culture, n.d.). Moreover, the scientific community, particularly psychiatry, was intimately entwined in using science to justify the inferiority of Blacks.

Benjamin Rush, the father of psychiatry, though an abolitionist, was an enslaver. He developed the theory of "negritude". Negritude is defined as a mild form of leprosy, and the only cure is to become White (Moffic et al., 2020). With the development of asylums, Blacks and Whites were segregated, being the first institutions in the United States to be segregated. The American Psychiatric Association supported this manner of treatment. The prongs of racism were also seen in differing diagnoses for Blacks and Whites. Dr. John Galt helped establish the asylum system and believed that Blacks were too primitive to have a complex life; thus, they were immune to insanity. In fact, for the census in 1840, there was a category for the insane or

idiotic, and Blacks in the North were diagnosed far more often than Blacks in the South with this disorder (D'Arrigo, 2020). This was used to justify the need for slavery. John C. Calhoun, the US vice president, stated that this was proof that slavery was a necessity. Without slavery, Blacks would go insane (Warren, 2016).

Samuel Morton, a physician and natural scientist, used research to inaccurately prove that Blacks' skulls were smaller than Whites', demonstrating that he believed Blacks were of lower intelligence than Whites (Penn Museum, n.d.). Other physicians such as Josiah Nott and Louis Agassiz supported this theory and believed in polygenism which proposed that Blacks were an entirely separate species from Whites (Harvard Library, n.d.). Dr. Rush's protegee Dr. Samuel Cartwright developed the diagnosis of *dysaesthesia aethipica* to explain his perception that Blacks are lazy and lack work ethic. He also created the diagnosis of *drapetomania* to explain the reason for slaves fleeing captivity. He believed that God programmed Blacks to be enslaved. The American Psychiatric Association did not refute these diagnoses. Psychiatry was complicit in maintaining the belief that Blacks are inferior to Whites (D'Arrigo, 2020).

According to Ruane, scientific racism is defined as the "spread of bogus theories of supposed Black inferiority to rationalize slavery and centuries of social and economic domination and blunder" (Ruane, 2019). This theory was used to justify the enactment of laws supporting Black dehumanization and the characterization of Blacks as property (National Museum of African American History and Culture, n.d.). Despite genome sequencing proving that 99.9% of DNA is shared among all humans, these false beliefs persist even today. These beliefs about the inferiority of non-White populations based on a now-defunct scientific theory have continued to cause harm in many aspects of Black life (Ruane, 2019).

The fields of psychology and psychiatry were complicit in using scientific racism and, at times, were explicit in their support of Black inferiority. As described above, psychiatric diagnoses can be contextualized within the framework of one's own preconceptions. This highlights the need for cultural understanding and sensitivity not to misdiagnose or assign psychopathology when there is none (Schwartz and Blakenship, 2014). The unfamiliarity with cultural norms and biases is believed to contribute to the disproportionate diagnosis of psychotic disorders in Black and Hispanic Americans compared to White Americans. Psychiatrists utilize the biopsychosocial model to conceptualize patients presenting with psychiatric symptoms. This framework encourages clinicians to evaluate patients through the lens of the biological, psychological, and social factors that influence how a patient presents and helps develop a treatment plan. This model aims to provide a more holistic and comprehensive patient review. Traditionally, this model does not include racism/bias as a construct that should be considered (Sanders and Fiscella, 2021). Dr. Metzl recommends moving beyond cultural competency and conceptualizing patients through the prism of structural competency (Metzl and Petty, 2017). Thus, using the biopsychosocial model with the context of racism and bias impacting the lives of people of color would be a more informative method to understand a patient's lived experience (Sanders and Fiscella, 2021). Understanding these connections and their impact is crucial as racism is a rot that festers in all facets of Black life.

Education

Within the psychology community, an extensive amount of work was dedicated to using scientific racism to develop theories regarding the inferior intelligence of Blacks compared to Whites. Intelligence Quotient (IQ) testing was used to support the cause of eugenics. Psychologist Henry Goddard (The "father of intelligence testing") translated the initial IQ test

developed by Alfred Binet from French to English. The initial goal of the test was to assess children with learning disabilities to provide appropriate educational support. However, once utilized in the US, results from IQ testing were extrapolated to justify the practice of eugenics for new immigrants (Reddy, 2008). According to the National Human Genome Research Institute, eugenics is defined as the scientifically erroneous and immoral theory of “racial improvement” and “planned breeding” (National Institute of Health, n.d.). As desegregation was enforced more, Black women became the target of forced sterilization, with 100,000 Black, Latino, and Indigenous women sterilized (Stern, 2020).

Psychologist, Carl Brigham, created the Scholastic Aptitude Test (SAT) which has been used for many years to assess students’ preparedness for college. Thus, the use of testing to limit Black life persists. Carl Brigham wrote the book *A Study of American Intelligence* which theorized that Blacks were inferior to other races/ethnicities and warned against integration within the educational system. The ticket to college admissions throughout the US was based upon a test created by a man who believed that certain races/ethnicities are inferior to the White, Nordic race. These aptitude tests, which do not measure innate intelligence but instead learned scholastic aptitude and cultural conditioning, have far-reaching consequences (Walker, n.d.). For example, many who supported eugenics advocated that sterilization was needed because there was a genetic link between low intelligence, crime, and poverty (Reddy, 2008). Furthermore, this continues to have an impact as research has shown that Black males are disproportionately placed or misplaced in special education programs (Walker, n.d.). As colleges use testing as a means of access, testing rooted in racist theories has implications on who attends college and, ultimately, one’s employment and earning potential. According to the Social Security Administration, those who complete a bachelor’s degree earn approximately $900,000 (men) and

$630,000 (women) more in median lifetime earnings than those who are high school graduates (Social Security Administration, 2015). What one earns impacts where one lives and their ability to accumulate wealth and pass it down to the next generation.

Criminal Justice

It must not be lost upon us that the beliefs of Black criminality influenced the criminal justice sphere. The fields of psychiatry and psychology supported the myth of Black criminality (Medlock et al., 2017 and Woods, 2020). Before the Civil War, the penal system was nearly entirely composed of White inmates as Blacks were enslaved, and any criminal penalty was enacted outside the penal system. After Emancipation, throughout the South, prisons were quickly filled by Black and Brown people. This was particularly striking in Alabama. In 1850, only 1% of the prison population was Black; by 1855, the Black population increased to 75%, and by the late 1880s, it was 85%. Due to a clause in the 14th Amendment, those convicted of a crime could not vote, leading to disparities in Black and White males voting (Thompson, 2019). Often the law was not applied evenly. While multiple race riots occurred throughout the US, with Whites committing offenses against Blacks, rarely was anyone held accountable. Meanwhile, Blacks were over-policed, and often acts such as loitering were criminalized or only enforced in Black neighborhoods. Not only was there a difference in the enforcement of laws and arrests, but how Black and Brown people were treated within the penal system was also very different. These actions have led to disproportionate imprisonment of Black and Brown people based on their proportion of the population that persists today (Thompson, 2019). While 29% of the US population is comprised of Black and Latinos, they comprise 56% of the prison population, with blacks being 48% of the people serving a life sentence (The Sentencing Project, 2018).

Echoes of scientific racism within the criminal justice system are heard today. The three white men convicted of murdering Ahmaud Arbery in February 2020 were not initially arrested (Fausset, 2022). Similar to how White terrorism against Blacks in the past was not considered a crime, these individuals were allowed to live freely after murdering a Black man they were convinced had engaged in criminal activity. Their use of words such as "monkey" and "subhuman savage" to describe Black people are the exact words that were used and, in the past, supported by physicians and others in healthcare to justify the treatment of Blacks (Mckay and Brooks, 2022 and Ruane, 2019). Their defense was their suspicion of criminality in Ahmaud Aubery (Fausset, 2022). The belief in Blacks' inherent criminality has been used to maintain the US social order and demonstrate the lasting effects of these racist theories (Thompson, 2019).

Black Wealth

Crime in Black communities is not only a result of disparate policing practices but also intentional disinvestment in these communities. The government-backed practice of redlining is rooted in the eugenic beliefs of Black inferiority (Szto, 2013). Redlining came into practice during the 1930s after the Great Depression due to the rising cost of owning a house. According to Szto, there were three assumptions of the federal housing programs: people could be divided by race, only White communities held property values, and segregation by race was necessary to protect White property values. Essentially, only Whites could receive federally insured mortgages in certain areas. Racial covenants were developed and led to the exclusion of Blacks in certain neighborhoods. The Federal Home Owner's Loan Corporation developed a secret map that divided and labeled neighborhoods based on desirability. Neighborhood desirability was based on the beliefs of eugenicists at the time that Whites were elevated above all races; thus, their neighborhoods were coded green. Jewish people were seen as less desirable with the blue

and yellow coding; lastly, Blacks were rated the lowest, and their neighborhoods were coded red. These beliefs were continued by the Federal Housing Authority and Veteran's Administration when these programs developed their regulations for mortgage loaning (Szto, 2013).

Due to this disinvestment in Black communities, there is a significant disparity between the value of homes in Black vs. White communities. According to the Brookings Institute, while 73% of White families own their home, only 42% of Black families do. Moreover, the value of homes owned by Whites was $230,000 compared to $150,000 for homes owned by Blacks. As the house is a significant source of wealth for families, this has impacted overall wealth and the ability to leave an inheritance. This culminates in less money being held within the Black community—with White households having $94 trillion (84%) of household wealth despite being 60% of the population. In comparison, Black families hold $4.6 trillion (4%) despite being 13.4% of the population (Moss et al., 2020). Ultimately, the damaging legacy of scientific racism is far-reaching and pernicious as the disinvestment in black neighborhoods has generational consequences.

Wealth in the Black community is not only affected by homeownership but also by employment and job retention, and promotion. Past studies have shown that even when controlling for confounders, race was a factor in the different employment outcomes for Blacks and Whites (Pager and Shepherd, 2008). Quillian et al. completed a meta-analysis of field experiments that assessed racial discrimination in hiring practices over 25 years. The study found that White applicants were called back 36% more frequently than equally qualified Blacks, which has not improved with time. It is highlighted that despite the decrease in the expression of explicit racism, there remain high levels of discrimination at the point of job entry (Quillian et al., 2017). Studies have demonstrated that employers identify Blacks as being "lazy" and

"unreliable" (Pager and Shepherd, 2008). Thus, stereotypes persist when there are considerations for hiring. The disparities in homeownership and employment are two facets that impact wealth building within a community and are likely what has led to the Black/White wealth gap, with the average White wealth being 6-10 times that of average Black wealth (McIntosh et al., 2020, and Bhutta et al., 2020).

Black Health

The impact of redlining has also impacted the health of community members. Studies have shown the statistically significant impact of disinvestment in certain communities leading to a higher prevalence of poor mental health and lower life expectancy at birth. These effects were felt even more acutely during the COVID19 pandemic, as low-income minority communities bore the greater burden (Richardson et al., 2020). In addition to redlining, the Federal Aid Highway Act of 1949 contributed to the destruction of minority communities by deeming these communities "unhealthy slums" and allowing for the development of highways in these communities (Nardone et al., 2020). These government-sponsored disadvantages have impacted the health of the community.

A study by Nardone and colleagues looked specifically at eight cities and found differing effects of redlining on the health of each community. Overall, there was an association between historically redlined neighborhoods and lack of health insurance, those diagnosed with non-dermatologic cancers, and self-reported 14 days of poor mental health. This is consistent with previous studies that have demonstrated a correlation between redlining and other health indicators such as severe asthma, birth outcomes, and cancer stage at diagnosis. (Santos et al., 2021). Additionally, past studies have shown a link between racial segregation and cardiovascular disease, hypertension, obesity, diabetes, and asthma. Overall, where one lives

impacts exposure to health-promoting opportunities such as access to quality food, safe recreation, and healthcare (Richardson et al., 2020).

Within the healthcare system, numerous studies continue to show disparities in health outcomes when comparing Whites and Blacks, primarily due to bias and racism (Jones, 2002). When delving deeper, the inequity is attributed to differential care within the healthcare system, differing access to healthcare, and exposure to life circumstances and opportunities that create differences in health outcomes (Jones, 2002). A litany of studies has demonstrated disparities in care for Blacks regarding pain management, treatment of prostate cancer, screening and treatment of breast cancer, and treatment for acute coronary syndrome (Esnaola and Ford, 2012, Nelson, 2020, and Chapman et al., 2013). Research has also demonstrated that physicians' could accurately assess patients' pain levels but were less likely to give adequate treatment for pain in Black patients with severe injuries (Chapman et al., 2013). Additional studies have shown that medical students, residents, and physicians believe Blacks are different from Whites because Blacks feel less pain, have blood that coagulates more quickly, and have thicker skin (Hardeman, 2016 and Hoffman et al., 2016). These beliefs are not too dissimilar to physicians' practices in the past. Much has been written about the father of gynecology, Dr. Marion Sims, and his use of slave women to correct surgical procedures for vesicovaginal fistulas. He perfected performing this procedure on Black women without anesthesia before performing the procedure on White women (Taylor, 2020).

Within psychiatry, there are disparities in the diagnosis of schizophrenia, with Blacks being more likely to receive this diagnosis and to be treated with antipsychotics compared to Whites (Medlock et al., 2017 and Metzl et al., 2018). Dr. Metzl's research found that until the 1960s, schizophrenia was an illness that affected those who were considered nonviolent, petty

White criminals, mostly rural White women. However, by the mid-1970s, this diagnosis was disproportionately given to Black men from Detroit who were now medicated rather than given recommendations for relaxing activities (Fernando, 2010, Metzl et al., 2018, and Hazin, 2011). Drs. Bromberg and Simon coined the term protest psychosis in 1968 to describe the protest of Blacks against racial discrimination. Literally, the efforts of Black people to highlight the inhumanity and injustice that was placed upon them became pathologized. Schizophrenia became synonymous with “angry Black masculinity” (Hazin, 2011). There was a paradigm shift in how the medical community viewed schizophrenia, and Black men became disproportionally diagnosed with schizophrenia. Psychotropic drug advertisements showed “angry” Black men in front of looted cities needing to be medicated (Hazin, 2011). Thus, this is a reminder of how these beliefs can become embedded in society and possibly impact medical practice today (Taylor, 2020). Moreover, Blacks are less likely to be treated for depression despite having higher rates of severe depression than Whites. Black patients are also less likely to be able to access and receive psychotherapy, having to rely more on emergency room services (Medlock et al., 2017).

Literature Review

With the death of George Floyd and the coronavirus pandemic, the glaring disparities in health outcomes for Black communities due to racism could no longer be ignored (Argueza et al., 2021). Many companies committed to implementing a culture of acknowledging and tackling racism within their systems (CEOAction, n.d.). The healthcare sector was included in these declarations. As a result, many organizations developed curricula/programs for Diversity, Equity, and Inclusion (DEI) to combat the persistent effects of past and ongoing racism (Argueza et al., 2021).

Diversity Training

In its initial iteration, diversity training was developed in the 1960s for community organizations, government programs, and higher education to help integrate places previously segregated and with active discriminatory practices (Dong, 2021). The training was eventually utilized to protect companies from civil rights lawsuits. The concept of inclusion developed in the 1990s to include other oppressed communities (Vaughn, 2007). These programs have increased exponentially in the workplace in the wake of the Black Lives Matter reckoning (Dong, 2021). In healthcare, programs have addressed implicit bias in patient interactions. Despite these efforts over the years, disparities in health outcomes persist, and evidence that these programs directly impact patient health outcomes is sparse (bHardeman et al., 2016 and Metzl et al., 2018).

Multiple studies have looked at implementing these programs in medical school, residency, and once physicians enter their profession. Studies have found several common themes in regards to these programs: a belief that the bias is more of a perception of the patient rather than actual behaviors exhibited by the clinician, mandatory participation in these programs can be problematic, discomfort about discussing this topic, a lack of specific tools to target these issues, difficulty about how to address the problem, expressed resistance towards these programs, beliefs that these programs are irrelevant, and an ability to recognize explicit bias but not implicit bias (Clark-Hitt et al., 2010, Gonzalez et al., 2018, Gonzalez, et al., 2019, Chapman, et al., 2013, Bright and Nokes, 2019, and Acholonu et al., 2020). Addressing these challenges is imperative for developing effective programs. Thus, developing programs that confront these concerns is necessary to see forward movement. Not only is there a moral motivation to address health disparities, but also a financial motivation. In a study by King and Redwood, the estimated

excess health care cost attributed to racial disparities is $35 billion and an additional $10 billion in illness-related lost productivity (King and Redwood, 2016).

Current Health Practice

The role medical providers play in this system is rooted in the historical precedence and legacy of how providers practiced in the past. Despite the decrease in overt or explicit racism, the disparities in health outcomes persist. This persistence is believed to be attributed to systemic and structural racism. This form of racism is described by Braveman et al. as pervasive and deeply embedded into our systems, laws, written and unwritten policies leading to disparate outcomes between Whites and people of color. Structural racism condones, produces, and perpetuates unjust and oppressive treatment of people of color (Braveman et al., 2022).

To make progress in addressing health inequities, the system must tackle three areas that impact care. Jones drew attention to the need to address healthcare quality by acknowledging and setting specific goals to deal with the differential care within the system.

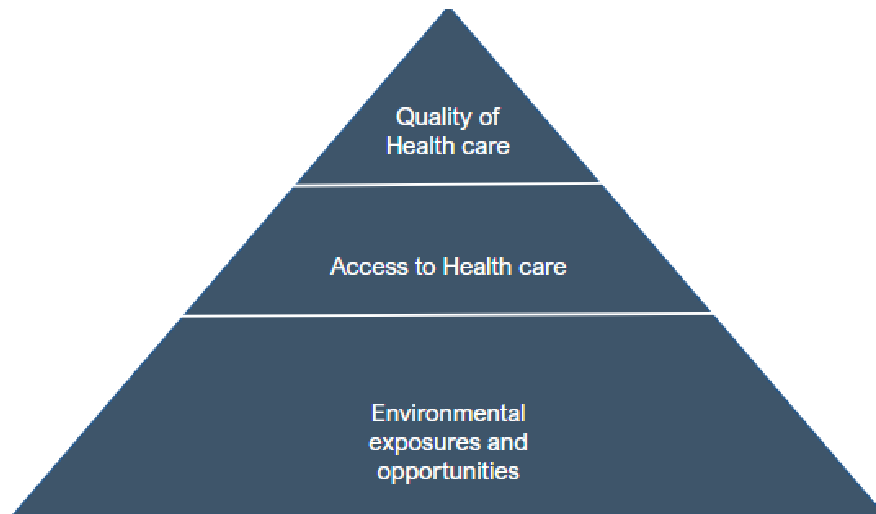

Figure 1. Ideas for addressing the different levels at which "racial" health disparities are produced.

Differential care within the health care system:

- Monitoring of physician practice
- Implementation of provider reminder systems
- Adherence to treatment protocols
- Training of a more racially, economically, and linguistically diverse health workforce at all levels
- Provision of "cultural competency" or antiracism training to health providers
- Community oversight of health care institutions
- Adequate numbers and training for translators

Figure 1. Jones, pylon 2002

Implicit bias is rooted in this system and described as subconscious beliefs, thus making it difficult to acknowledge and control (Hall et al., 2015). This bias can develop early on in life—studies have demonstrated that even 3-year-olds have a pro-White implicit bias which can impact behavioral interactions with the stereotyped groups. A pro-White implicit bias has been found in all physicians except Black physicians, with women having less bias than men and Latino doctors having less pro-White bias but not neutral (Chapman et al., 2013). In a study by Gollust et al., a qualitative analysis of Veterans' Administration (VA) physicians demonstrated that clinicians are less likely to acknowledge that racism is a factor in health disparities, instead attributing the differences more to patient factors. Moreover, they found that clinicians were less likely to believe that racism is a current issue and more likely to assign the breakdown of the

patient-provider relationship to patient sensitivity towards racism than the act of bias or racism (Gollust et al., 2018). Not accepting the historical context of racism rooted in medicine or only accepting certain historical events such as the Tuskegee experiments allows one to ignore the present. Current episodes of implicit bias and racism impacting Black patients must be addressed. Clinicians who operate in a framework of focusing on patient factors that lead to health inequity are less likely to acknowledge that racism exists within healthcare (Gollust et al., 2018). Additionally, within medicine, much of what is published in medical journals regarding racism is written in the context of race rather than racism and from the viewpoint of the majority (Hall et al., 2015). What impetus is there for the system to change, grow, and improve?

Studies have shown that approximately two-thirds of residents did not feel adequately trained to address race and racialized health disparities (Adelekun et al., 2019). These findings were further supported by a study by Marshall et al., which found that internal medicine residents lacked knowledge about healthcare disparity-related concepts (Marshall et al., 2017). This is despite the 2017 Accreditation Council for Graduate Medical Education (ACGME) mandate that all residency programs include curricula to address healthcare disparities in residency training (Song et al., 2021). Thus, programs are being motivated to enact this curriculum.

As this has become mandated, relatively few studies review the quality of the curricula. Even fewer studies examined DEI work implemented in a psychiatry residency program. The mandate, in addition to the racial awakening of the 2010s/2020s, has helped propel this work to the consciousness of many academic institutions. In the past, most work focused on cultural competency, which has not led to significant changes in health inequity. As a result, moving towards a focus on antiracism and structural competency/cultural humility framework for

teaching should be considered (Metzl et al., 2017). One of the barriers to implementing this work has been a concern for learners' discomfort and reaction to discussing this subject matter (Bright and Nokes, 2019). The literature demonstrates that this fear is unwarranted as residents desire this in their training (Dupras et al., 2020).

Not only is it necessary to implement these curricula due to systemic changes forcing an emphasis on DEI work, but residents and students also find this work meaningful. Multiple studies that have reviewed the implementation of DEI subject matter curricula have demonstrated that residents and medical students appreciate and find this work meaningful (Acholonu et al., 2020, Adelekun et al., 2019, Bright and Nokes, 2019, Medlock et al., 2017). Studies have found that residents and medical students find this curriculum to be helpful for them to gain an understanding of the intersection of racism and healthcare, feel more confident in addressing these issues, increase confidence in discussing race with patients, and increase empathy (Adelekun et al., 2019, Acholonu et al., 2020, Neff et al., 2020, Simpson et al., 2022). Even more impactful is that training in structural competency led to clinicians feeling reconnected to the "why" of entering this profession and helping them to feel more empowered (Neff et al., 2020). Additionally, implementing curricula that focus on empowering and providing tools for effective allyship and confronting bias is desired by residents (Martinez et al., 2021, Crites et al., 2022). Not only is it essential to provide knowledge, but likewise to provide actual tools/skills to help residents feel more effective in addressing systemic bias/racism. Furthermore, studies have also found that residents, medical students, and attendings desire this work to be more interactive, iterative, and ongoing (Simpson et al., 2022). Perdomo et al. highlighted that participants preferred more discussion and brainstorming activities to develop solutions to address structural racism and implicit bias (Perdomo et al., 2019). The vast majority

of the literature is focused on curricula implemented as a series over a few weeks or as a one-time conference/lecture (Simpson et al., 2022, Acholonu et al., 2020, Adelekun et al., 2019). Thus, future work in this area must assess the impact of these limited courses versus sustained investment in teaching and integration throughout both the explicit and hidden curricula.

The more recent literature demonstrates an evolution from cultural competency to structural competency. Cultural competency implies an ability to master the understanding of culture; thus, as evidenced by Marshall et al., there can be a gap between perceived competency and actual knowledge (Medlock et al., 2017, Marshall et al.,2017). Understanding how to move past cultural competency and encourage participation in deconstructing these systems is essential to address the differences in quality of care. This manner of thinking must begin from those at the institution's top to permeate all sectors and establish a new culture of recognizing and destroying these systems. Thereby fostering commitment at all levels to making this change.

Challenges

My literature review found several challenges with implementing this work. One is that no studies demonstrate that participating in these programs leads to improved healthcare outcomes. Much of the literature involves implementing a curriculum and gauging improvement in attitudes or understanding of racism and implicit bias. How this can be translated to decrease health inequity remains to be seen. Additionally, much of the literature demonstrates that these curricula are being developed as modules and lecture/conference series. Thus, it is unclear how this will lead to sustained impact as residents progress through their training. As this is relatively new, there has not been much information in the literature comparing one curriculum to another in terms of effectiveness. This may help determine how to implement programs across diverse programs. One goal Medlock et al. highlighted as essential for effective racism education is

interracial contact (Medlock et al., 2017, Onyeador et al., 2017). This is defined as the interaction of people from different racial backgrounds. My literature review did not see this as being described as an outcome for many of the curricula implemented. Studies have found that the quality of this contact is more important than quantity. During a time of training, this can be effective in decreasing both explicit and implicit bias. Making this an objective is necessary as interactions with those from diverse backgrounds help to break down harmful biases/stereotypes (Onyeador et al., 2017). Lastly, my literature review did not demonstrate any randomized control trials comparing the patient health outcomes or patient satisfaction ratings of those physicians who participate in DEI curricula versus those who do not. This may be challenging to implement but vital to demonstrating effectiveness in addressing health inequity.

More specifically, there have not been many studies looking at psychiatry residents and their beliefs regarding DEI training. I aim to understand their knowledge about this topic and what they believe would be effective in developing this program. The formal DEI curriculum for the Emory psychiatry residents consists of a series of lectures during residency training. The list of the topics covered is provided in Appendix B. I believe that for change to occur, those for whom the program is developed must have a voice. Their input is valuable to help engage those who are already inclined to participate in these programs and determine how to engage those less inclined to participate. Engagement from everyone who provides patient care is essential to make inroads in addressing structural racism/bias.

Specific Aims:

I. Explore the opinions and motivations of residents about the current DEI program.

II. Develop recommendations to be implemented into the program to help improve engagement.

Significance statement:

Addressing systemic racism is crucial to eliminating health disparities. As much of the introduction highlights, the long-term effects of systemic racism against Blacks have been rooted and supported by scientific racism. The consequences have been far-reaching in Black life. To combat continued structural racism in healthcare, it is critical to acknowledge its past and educate providers about its impact on Black life and health. Curricula to address these issues are needed; however, determining how best to engage providers is crucial. Exploring the beliefs, motivations, and opinions of those participating in these programs is essential. Based on this information, developing more effective programs to engage clinicians, specifically resident physicians, can be achieved. Ultimately, this will be one vital tool in addressing systemic racism in healthcare.

Methodology

Due to the field of psychiatry's long history of supporting racist ideology and the desire to understand the limitations of the effectiveness of DEI programs in addressing racial disparities in healthcare, I desired to speak with psychiatry residents. I utilized qualitative analysis in the form of in-depth interviews in a focus group setting to understand psychiatry residents' baseline knowledge about this topic, their beliefs, and goals for DEI programs. I also recommended improvements based on their experience with the current curriculum. The Emory Internal Review Board (IRB) did not require approval as this was an internal program analysis to determine its effectiveness and would not be used for external purposes. All information was de-identified.

I received approval from the residency program to complete the program analysis. I also conducted a quantitative analysis of the participants for demographic characteristics. Residents in their post-graduate years 1-4 were contacted via e-mail with assistance from the Residency Program Directors. There was a total of seven residents from the program who participated. A focus group was conducted via Zoom conference call on two separate occasions. Demographic information was collected using Survey Monkey (Momentive Inc. 2022). Residents were informed about the intended use of the data from the focus groups and consented to have the focus groups recorded. The recording of focus groups was needed to transcribe the data and extract themes from the data. The residents were de-identified when completing the focus group. The information collected from the focus group was analyzed using the software MAXQDA 2022. I was able to glean themes common in both focus groups. Based on these themes and recommendations, I was able to provide feedback about methods to develop the curriculum and engage the residents more effectively.

Population and Sample

Seven of the 45 residents in the Emory University Psychiatry program agreed to participate in the in-depth interview about the DEI curricula sponsored by their program. The only inclusion criteria was being a current resident in the Emory psychiatry program. We collected demographic data about age, self-identified gender, race/ethnicity, post-graduate year, and state/country of origin.

Research Design

Two focus groups were conducted with four residents in the initial and three in the second. The questions developed were to glean information about baseline knowledge of the

curriculum, strengths/weaknesses, improvements needed, and motivations to participate in the developed program. The specific questions are provided in the index. Due to the COVID19 pandemic, the focus groups were conducted via Zoom.

Research Analysis

The recordings from the focus groups were transcribed verbatim. All personally identifiable information was removed for each participant. The transcripts contained information about why residents chose Emory, their introduction and baseline knowledge about the DEI curriculum, the strengths and weaknesses of the program, and recommendations for improvement.

The interviews were reviewed multiple times in-depth to glean themes that arose. Next, the transcripts were uploaded into MAXQDA 2022, a qualitative and mixed methods data analysis software program. Codes were assigned to specific portions of the transcript based on initial themes collected from the initial readings. Inductive and deductive codes were developed related to diversity, integrated, interactive methods, strengths/weaknesses, and improvements, and the codebook can be referenced in Appendix C.

Results

Quantitative Analysis

All the residents had been exposed to the DEI curriculum. The level of exposure depended on the year of residency. There was a total of seven residents who participated in two focus groups over two separate sessions. Of the total group, two were women, four were people of color, and six were between the ages of 25-34. Four were from the Midwest. There was three post-graduate year (PG-Y) 2, one PGY-3, two PGY-4, and one PGY-5.

Table 1: Resident Demographics

Demographic Table:	
Gender:	Male: 5 (71.4%)
	Female: 2 (28.6%)
Age:	25-34: 6 (85.7%)
	35-44: 1 (14.3%)
Race/Ethnicity:	Asian: 2 (28.6%)
	Black: 2 (28.6%)
	White: 3 (42.9%)
Region of Origin:	West Coast: 1 (14.3%)
	East Coast: 2 (28.6%)
	Midwest: 4 (57.1%)
Year in Training:	PG-Y 2: 3 (42.9%)
	PG-Y 3: 1 (14.3%)
	PG-Y 4: 2 (28.6%)
	PG-Y 5: 1 (14.3%)

Qualitative Analysis:

Participants were clear about their intentions for choosing Emory to attend for residency. Every participant highlighted that diversity was a significant reason for choosing Emory. Diversity with patient population, cultural diversity, clinical exposure, the Atlanta community, underserved populations, and global health experiences. One resident highlighted "…public hospital, private, and the VA (Veterans Administration), so I will be well trained after

graduation”. Moreover, Grady was mentioned as a reason that they chose Emory. Emory University School of Medicine is synonymous with Grady. Those interested in attending Emory know that a large portion of their experience will entail working at the associated safety-net hospital in the inner city. Residents are aware of the patients that Grady serves—the underserved. Thus, they know there will be challenges in helping patients access care. This again highlights the type of resident coming to Emory expects to work with an underserved and diverse community. “Grady was a big reason why I came down here to train at Emory”. Moreover, residents were aware of the challenges posed by social determinants of health which they felt more acutely at Grady compared to other hospitals where they rotate.

As residents come to Emory due to Grady, they expressed the need to conceptualize a patient comprehensively. This includes the biopsychosocial factors that impact a patient’s ability to access care. Even though they did not specifically name it, they were cognizant of structural systems that challenge patients accessing care, leading to disparate health outcomes. They acknowledged the need to formulate patients through the lens of social determinants of health but also felt defeated, overwhelmed, and burned out by how to address these issues.

Residents reported a lack of formal introduction to the DEI curriculum.

“When you’re asking about DEI curriculum, and I’m trying to think back on lectures that are like labeled DEI, none of them like really stuck out to me. I don’t remember”.

Furthermore, they emphasized that there is no continuity with the curriculum, and the sequencing of the lecture series does not align with their rotations. “And sometimes the order of them doesn’t make as much sense to me. Like we spend most of our first year at Grady, and then at least, what I’m seeing here is that one of the second-year lectures is Grady and gun violence.

Like that lecture seemed like it would be more powerful if it were given when we are in the space when they are most relevant". Another resident expressed uncertainty about what lectures they had received constituted DEI curriculum. "It's not as though we know like, okay, on these days, at this time, this is going to be like the diversity series. They're just kind of peppered into the didactics calendar. So you know, depending on whether we're present that day, whether we're taking a wellness day or whether we're working, we may or may not have encountered those lectures. I wouldn't be able to tell you what the sequence is, you know, in terms of like one topic being continuous with the next. I don't think there is any continuity. It's just sort of like these one-off lectures that we get throughout our training".

Residents highlighted that there were no expectations, goals, or objectives for the curriculum's existence and how to integrate it into their practice. Resident participants also recognized the importance of the lectures that were presented. For example, one resident highlighted "…a discussion on looking at the historical kind of racist roots of psychiatry, and kind of like aspects where psychiatry was very biased, discriminatory, sexist, racist in certain ways. Like the concept of protest psychosis and hysteria and those kinds of things, and I thought it was a valuable discussion. I think it is important to understand the roots of the field that we're practicing in and understand issues that are in the field in the past and continue".

Regarding the curriculum itself, residents found that providing the curriculum as a lecture series does not resonate in a way that would make a sustained impact. It was challenging for them to recall what they had learned, but the lectures that did stand out were interactive. "I don't know that like, teaching-wise, I've had any that I can think of off the top of my head whose lectures have impacted during my time in residency. I don't know".

"DEI curriculum is a particularly challenging thing to do in a didactic format, just because I think that part of it is a lived experience". The female residents were more vocal about how the curriculum was delivered. Both noted the need for a non-lecture format that was more interactive, explorative, experiential, and conversational to help teach this information in a way that would be more impactful and insightful. They also recommended that utilizing this format would help to increase participation from those less inclined to participate in DEI work. Both made mention of the lack of participation from all residents within the department. Both were also aware of the lack of diversity within the department and how this impacts resident learning.

When questioned about the strengths of the DEI curriculum, residents highlighted that just having a curriculum to focus on these topics is in and of itself a strength. The residents also expressed that the residency program allow for an evaluation of the program as a strength. Another strength of the program is the addition of DEI resident chairs. Implementing this helped the residents feel they could provide input about the curriculum. The residents feel supported by having this position because they have been given time and funding support and dedicated time.

Residents expressed multiple weaknesses of the program.

1. *The curriculum is not as impactful because it is heavily lecture-based*

   "I feel that a lot of, sort of like social justice, and you know, disparities work…and so psychiatry in terms of the education needs to be more experiential and more through conversation and exploration rather than lectures. So, you know, I think like really learning from our peers, learning and questioning our perspectives individually and as a group and like challenging ourselves to sort of grapple with our beliefs, our thoughts, our behaviors, I think that's going to make the most difference. So while I

do feel like the lectures have been good, I still feel like you can come out of this program with a very big missed opportunity".

2. *The program does not provide tools/recommendations about how to address these issues*

   "I don't know about you, but sometimes I feel that they do a good job of talking about the first step, like the discrepancies of schizophrenia diagnoses, for example, in black versus non-black populations. Um, but sometimes I feel like it kind of stops with that and there's less discussion about how to address those discrepancies or how to think differently. We've had a number of lectures where the bulk of it is the prevalence of these discrepancies and less so the discussing of interventions".

3. *The program has a lack of evidence-based literature presented*

   "…there is a dichotomy between research and DEI. Like for example, you know even with grand rounds, they are separated into the research grand rounds, or this is the DEI, you know, but like I'm hoping to have the two together. Why can't we have DEI curriculum that is informed by evidence-based research? But you know, more along the lines of what the literature is saying and having guidance, and how do we read the literature with the scope and the lens of considering DEI."

4. *The program has a lack of clarity about goals, purpose, and expectations*

   "I think that one of the things that you brought up that got me thinking is the question about the introduction to the DEI curriculum. And being clear about what like the mission or the goals are. Well, I like don't really have a clear sense of what this is. I mean diversity is a very broad topic and different people interpret it in a different way. I certainly don't want to presume that what I think is DEI is what others think is

DEI. So I think there is some ambiguity". One resident highlighted how prospective psychiatry residents ask about the DEI work at Emory and felt ill-equipped to answer these questions during interview season.

Interestingly, residents noted that the informal DEI curriculum was more impactful. Residents indicated that clinical work where these topics are discussed resonated with them more. Efforts made by attendings to incorporate these topics during rounds or rotations were noticed and appreciated. The residents also emphasized that working in a team with other members providing a diverse perspective and clinical engagement with patients, was very helpful in learning about this topic.

Based on the weaknesses, residents suggested the following improvements to the DEI curriculum:

1. Early consistent focus on and integration of DEI issues when in the clinical setting
2. Attendings modeling this work more consistently
3. More interactive and explorative small group work
4. Clear organization, goals/objectives of the curriculum
5. Equip residents to feel empowered about skills they learn to address these issues
6. Highlight the value of DEI work
7. Strong programmatic support
8. Widen the view of what DEI work encompasses
9. Make more significant efforts to increase diversity within the department

Discussion

Addressing systemic racism and its impact on the health outcomes of people of color is essential to the well-being of these populations and the country's overall health. One component contributing to persistent health inequalities is the patient-clinician interaction. Medicine is making significant strides in finally identifying racism instead of race as the cause of these disparities. Healthcare organizations from hospital systems, medical schools, national professional organizations, and research organizations and journals made proclamations committing to significant action to address racism and its harm to minority communities. Addressing racism at the organizational level must incorporate conscious policies to truly effect change.

As noted by the resident participants, Emory is recognized for the diversity of clinical training sites. Residents come to Emory for diversity in patient population, diversity in the types of illness presentation, cultural diversity, and diversity in healthcare systems. This is seen as a positive and a strength for Emory. Additionally, Emory is recognized for its connection and work with the Centers for Disease Control and Prevention (CDC). As diversity is a strength of Emory, this is an expectation for residents; thus, acknowledging and emphasizing a commitment to issues pertinent to serving a diverse community should be highlighted and prioritized. Therefore, an organizational focus on making meaningful and sustained efforts to address systemic bias is an expectation.

Residents were also very clear about Grady being a significant factor in coming to Emory. Grady is the public hospital serving Fulton and Dekalb counties. Most patients served by Grady identify as Black (Grady Community Needs Assessment, 2019). As such, there would be an expectation that residents coming to train at Emory would interact with a diverse patient

population. Furthermore, residents know before coming to Emory that Grady is a safety net hospital that serves an underserved population. An underserved patient population lacks access to adequate medical care due to locality, age, literacy level, and socioeconomic status. These characteristics can encompass minority populations (National Institute of Health, n.d.). While the definition of safety net hospitals can vary, a commonality for hospitals described in this manner is that they are often located in poor and underserved communities. Additionally, many do serve large populations of racial and ethnic minorities (Hefner et al., 2021). As such, residents have expectations about diversity and understanding of how to serve this patient population best. Thus, learning about structural systems that impede access to care is more than anticipation but rather an expectation. There is an expectation that they will be taught about social determinants of health and equipped to address them.

Connecting with one's patients is essential to the clinician-patient relationship. Studies have shown that patients who endorse experiencing racism when interacting with the healthcare system are less likely to adhere to treatment adherence (Hall et al., 2015, Cuffee et al., 2013). Residents must understand the complexities of their patient's lived experience and how it influences their overall health. Commitment to providing resident education in this arena is vital in helping to train physicians who can care for all patients. Not only is it necessary for the residency program to highlight the need for this work to benefit patients, but also how it benefits residents. Underscoring how this work will aid residents in their careers is imperative. During the first year of medical school, one takes the Hippocratic Oath. The central tenet taught is "First, do no harm" (Retsas, 2013). One motivator to commit to this work is highlighting the commitment to treating diverse patient populations that are needed to uphold this tenet. It is important to work within diverse patient populations and commit to empowering oneself to provide the best patient

care possible. The main component of excellent patient care is striving for health equity (Bathija and Reynolds, 2019). We all must do our part to make this a reality. Thus, there is a moral motivation for residents to be involved in DEI work. Moreover, addressing the importance of this work in relation to the resident's humanity is essential (Shiffer, 2013). In a system rooted in the belief that certain people are inferior and thought of as less than subhuman, how does that impact the humanity of those in positions of power and whose past is connected to those who have always maintained power?

Moving past blame and guilt is necessary for the residency program to frame this work not as cultural competency but instead through structural competency. It is essential to practice integrating anti-racism throughout all systems and policies to develop all those who are part of the system, particularly residents. Reflecting on one's privilege and power can be empowering and help one understand how to best address social injustice rather than feeling shame and overwhelmed. Work in this area highlights that White supremacy depends on numbing, violence, and silence. Working to dismantle it can help restore one's humanity and live a more enriched and empowered life (Shiffer, 2013). Moreover, one needs to confront these power dynamics and acknowledge how it impacts not only those othered but also themselves. Implementing a fully encompassing curriculum that focuses on structural competency is necessary to allow residents to understand the complexities of power and privilege. Only with consistent reinforcement of these realities will one begin to feel discomfort. As Shiffer noted, discomfort is needed to motivate change. To move one from the pre-contemplative stage to the action phase in the Stages of Change Theory, one must feel discomfort (Loma Linda University School of Medicine, n.d.). As an organization, Emory psychiatry underscoring the cost of systemic racism/bias not only to

oppressed communities but also to those with power and privilege is necessary. It is important to press this point as this system has harmed not only the powerless but also the powerful.

Diversity, equity, and inclusion work benefits the organization at the organizational level by fostering innovation and productivity. Targeting this level is essential to help establish the cultural norm of anti-racism. Organizational emphasis on diversity, equity, and inclusion helps improve patient care and attract and retain top talent (Lingras et al., 2021).

Based on resident feedback, it would be beneficial for Emory to take a strong stand from an organizational perspective about its commitment to DEI and make clear the goals and objectives of this work. There was a lack of clarity about the purpose. Residents expressed significant burnout and feeling inadequate in being able to address these issues. Taking a top-down approach with this work is essential. Firstly, it helps to focus on the mission, which allows for goal development. This makes it clear to everyone in the organization that this work is important and necessary. Thus, creating this environment can help to get buy-in from all within the organization. Residents highlight the importance of attending influence on their careers. As such, diversity within the department for attendings is critical. Residents highlighted the lack of diversity in their attendings and mentors. Likewise, residents observe and model their patient care from the attendings that supervise and train them—taking a firm stance with a clear mission about antiracism work and a commitment to increasing attending diversity will signal to attendings that this work is also important.

I recommend that Emory implement training and education for attendings regarding the DEI curriculum so they can model the clinical care model of working with diverse patient populations. Additionally, residents evaluate attendings; one of the metrics could encompass their ability to implement the curricula's mission in patient care. I believe that attendings

displaying these interactions can help residents feel empowered to address systemic bias and racism. Secondly, organizational emphasis on this work can help residents see that systemic change is possible and help to ease the burden of burnout and feeling helpless.

Thirdly, the program must emphasize what residents can control to address resident burnout and feeling helpless. Providing them with tools and the ability to handle confidently treating a diverse patient population will be empowering. Focusing on implementing a program through a structural competency lens will help empower residents in their clinical interactions with patients. Focusing on how one's daily interactions are meaningful to patients despite whatever challenges a patient may have before their interactions with their clinician can be impactful.

Structural Competency

Structural competency redirects the focus from the individual's choices and behaviors to societal systems that impact health equity. This deviates from cultural competency used in many healthcare settings to address bias and racism. Cultural competency implies the ability to achieve a goal of understanding culture to the level of mastery. With this framework, clinicians in positions of power and privilege view their diverse patients through the prism of how their culture can act as a barrier to them being able to comply or access treatment. Utilizing a structural competency framework views the structural inequities within society that impacts one's ability to access care or comply with treatment. This moves from solely blaming the patient to reviewing how to address inequity and help improve health outcomes (Metzl and Petty, 2017). In his work developing curricula that focus on structural competency, Metzel and colleagues demonstrated that students majoring in curriculum focused on structural competency versus those who have majored in other subjects can approach clinical scenarios through the

more complex prism of the structural factors that impact patient care. The students were more mindful of the challenges of systems in place that make it more challenging to achieve health equity. This is necessary because health inequity remains despite the considerable focus on cultural competence for many years. To progress in this arena, we must first learn and acknowledge these systems and, in many ways, their unconscious impact on our lives (Metzel et al., 2018).

Moreover, cultural competence "others" those of a different culture. However, culture is difficult to define and can be based on factors other than race/ethnicity. There may be a shared culture between the clinician and patient based on different factors. For example, culture can be based on region, and finding areas of overlap and connectivity can help to reduce othering. Additionally, cultural competency can imply that there is a culture that is the norm while other cultures would be the opposite. In this vein, the dominant culture is what one should conform/assimilate. Thus, shifting the emphasis from cultural competency to cultural humility and structural competency is necessary to begin a systemic change (Metzel, 2016).

Research has shown that physicians express burnout and feel helpless to deal with the challenges of patient care while dealing with complex social issues. Reframing how we view health may help address the issue of burnout. Using this framework is not enough, but it is a start to developing a foundation for how to assess and begin to formulate interventions to serve patients better and address these inequities. Without first recognizing and then having the language to analyze these barriers, we will be unable to eliminate health inequity (Metzel et al., 2018).

Not only is it important to reassess the framework we use to do this work, but it is also important to reassess the most effective methods to incorporate this work in resident training.

Residents highlight the challenges of discussing topics of diversity. It was noted during the focus group the lack of willingness to participate in how to improve the curriculum as there were only seven residents. Resident participants highlighted the discomfort with confronting these issues and the lack of language to discuss these topics. Previous studies have shown a positive effect on implicit racial bias when racism is directly addressed in medical training (Medlock et al., 2018). Finding a method to tackle these complex subjects will be an iterative process. To make it an inclusive and non-judgmental experience, it will be necessary to highlight what diversity means. Many of the residents mentioned the focus of diversity as being embedded in cultural/ethnic/racial concepts. However, this does not fully encompass the breadth of what diversity means. This includes diversity in ability, religious/spiritual practices, language, gender/sexuality, socioeconomic status, etc. Recognizing all these facets of diversity could help enhance the richness of the experience.

Limitations

My study was limited by the number of residents who agreed to participate in the focus group. While participants were diverse, there were seven of a total of 45 residents who participated. Additionally, as the residents mentioned, those who participated in the focus group are already committed to this work. Two of the residents chose to serve as the resident chairs for DEI. Thus, I may not have been able to gather the perspectives of those who may have been less inclined to participate or engage more actively in DEI work.

Strengths

My study was a qualitative analysis of the DEI program, which adds contextual richness to the assessment of the program. The residents were very open about the limitations of the

curriculum and gave a unique perspective on what they wanted for their program. I believe this will be very useful for restructuring the curriculum and developing a more structured program to address health inequity. My study focused on a discipline in medicine steeply entrenched in the formation of scientific racism. I believe that increased knowledge about psychiatry's role is crucial for those entering this profession. Thus, focusing on this group is a strength. Lastly, my study provides concrete methods to help develop these DEI programs that may be applied to other residency programs.

Significance to Public Health

The work of decreasing health disparities is not only a commitment made by those working in healthcare but also those in public health. All institutions have a vested interest in helping to improve the health of all citizens. This is a core foundational principle of public health. In this realm, the CDC has made the elimination of health disparities a central goal of its Healthy People 2030 campaign (Office of Disease Prevention and Health Promotion, n.d.). Those of us in healthcare have been trained in a system entrenched in racism, and we need to do the work to deconstruct and rebuild on a more equitable foundation. Thus, doing the work of DEI that is more than simple platitudes to check a box will take more than pledges but actual work. The work is challenging but necessary for the health of all. Racism has stained many institutions in our country, and with healthcare, it can be a matter of life or death. Sustained, rigorous efforts to research and develop effective DEI programs are just one method to address health inequity and deliver on the government's commitment to ensuring good health for all.

Conclusions:

I undertook a qualitative analysis to gain perspective from the learners participating in DEI curricula. This was helpful for me to make recommendations to continue to develop the curricula and hopefully develop a program. As the ACGME now mandates these programs to address health inequity, many are being created to educate in order to employ interventions to address this healthcare priority. While this has been an incredible step forward, it has yet to demonstrate significant, meaningful change in eliminating healthcare disparities. Thus, continued evaluation of these programs is necessary. This is just the initial phase of program evaluation. As much of the literature demonstrates, analyzing if these programs will lead to an effective, sustained decrease or elimination of systemic bias has not been studied. Furthermore, additional analysis is needed to investigate how these programs impact patient care and health outcomes. Using randomized control trials to evaluate these programs to compare those who undergo this training versus those who do not and whether there is a difference in the outcome of their patients will be imperative in the future.

References:

Abbasi K. (2019). First do no harm: the impossible oath. *BMJ,* 366, l4734. doi:10.1136/bmj.l4734

Acholonu R., Cook T., Roswell R., & Greene R. (2020). Interrupting microaggressions in health care settings: a guide for teaching medical students. *MedEdPORTAL.* 16:10969. https://doi.org/10.15766/mep_2374-8265.10969

Adelekun, A., Beltrán, S., Carney, J., Lett, E., Orji, W., Rider-Longmaid, E., Stokes, D. C., Teeple, S., & Aysola, J. (2019). Recognizing racism in medicine: a student-organized and community-engaged health professional conference. *Health Equity*, *3*(1), 395–402. https://doi.org/10.1089/heq.2019.0015

A History of Craniology in Race Science and Physical Anthropology. (n.d.). Penn Museum. Retrieved from https://www.penn.museum/sites/morton/craniology.php

Argueza, B., Saenz, S., & McBride, D. (2021). From diversity and inclusion to antiracism in medical training institutions. *Academic Medicine: Journal of the Association of American Medical Colleges*, *96*(6), 798–801. https://doi.org/10.1097/ACM.0000000000004017

Bathija, P. & Reynolds, D. (2019, December 18). *How equity impacts the patient experience.* American Hospital Association. Retrieved from https://www.aha.org/news/blog/2019-12-17-how-equity-impacts-patient-experience

Bhutta, N., Chang, A., Dettling, L., & Hsu, J. (2020, September 8). *Disparities in Wealth by Race and Ethnicity in the 2019 Survey of Consumer Finances.* Board of Governors of the Federal Reserve System. Retrieved from https://www.federalreserve.gov/econres/notes/feds-notes/disparities-in-wealth-by-race-and-ethnicity-in-the-2019-survey-of-consumer-finances-20200928.htm

Braveman, P., Arkin, E., Proctor, D., Kauh, T., & Holm, N. (2022). Systemic and structural racism: definitions, examples, health damages and approaches to dismantling. *Health Affairs*, 41(2), 171-178. https://doi.org/10.1377/hlthaff.2021.01394

Bright, H., & Nokes, K. (2019). Impact of a discussion series on race on medical student perceptions of bias in health care. *PRiMER*, *3*, 29. https://doi.org/10.22454/PRiMER.2019.142917

CEOAction for Diversity and Inclusion. (n.d.). *Business can Act on Making Change Happen.* Retrieved from https://www.ceoaction.com/purpose/

Chang, E., Milkman, K., Gromet, D., Rebele, R., & Massey, C. et al. (2019). The mixed effects of online diversity training. *PNAS*, 116(16) 7778-7783. https://doi.org/10.1073/pnas.1816076116

Chapman, E., Kaatz, A., & Carnes, M. (2013). Physicians and implicit bias: how doctors may unwittingly perpetuate health care disparities. *J Gen Intern Med*, 28(11):1504-1510. doi: 10.1007/s11606-013-2441-1

Clark-Hitt, R., Malat, J., Burgess, D., & Friedemann-Sanchez, G. (2010). Doctors' and nurses' explanations for racial disparities in medical treatment. *Journal of health care for the poor and underserved*, 21(1), 386–400. https://doi.org/10.1353/hpu.0.0275

Coates, T. (2015). *Between the World and Me.* First edition. New York: Spiegel & Grau.

Crites, K., Johnson, J., Scott, N., & Shanks, A. (2022). Increasing diversity in residency training programs. *Cureus*, 14(6), e25962. https://doi.org/10.7759/cureus.25962

Cuffee, Y., Hargraves, J., Rosal, M., Briesacher, B., Schoenthaler, A., Person, S., Hullett, S., & Allison, J. (2013). Reported racial discrimination, trust in physicians, and medication adherence among inner-city African Americans with hypertension. *American Journal of Public Health*, 103(11), e55–e62. https://doi.org/10.2105/AJPH.2013.301554

D'Arrigo, T. (2020). Black psychiatrists call on White colleagues to dismantle racism in profession. *Psychiatric News*, 55(13). https://psychnews.psychiatryonline.org/doi/pdf/10.1176/pn.2020.55.issue-13

De los Santos, H., Jiang, K., Bernardi, J., & Okechukwu, C. (2021, May 26). *From redlining to gentrification: The policy of the past that affects health outcomes today*. Primary Care Review. Retrieved from http://info.primarycare.hms.harvard.edu/review/redlining-gentrification-health-outcomes

Dong, S. (2021, June 2). *The History and Growth of the Diversity, Equity, and Inclusion Profession.* Global Research and Consulting Group. Retrieved from https://insights.grcglobalgroup.com/the-history-and-growth-of-the-diversity-equity-and-inclusion-profession/

Dupras, D., Wieland, M., Halvorsen, A., Maldonado, M., Willett, L., & Harris, L. (2020). Assessment of training in health disparities in US Internal Medicine Residency Programs. *JAMA network open*, *3*(8), e2012757. https://doi.org/10.1001/jamanetworkopen.2020.12757

Esnaola, N. & Ford, M. (2012). Racial differences and disparities in cancer care and outcomes: where's the rub?. *Surgical oncology clinics of North America*, 21(3), 417–442. doi:10.1016/j.soc.2012.03.012

Eugenics and Scientific Racism. (n.d.). National Human Genome Research Institute. Retrieved from https://www.genome.gov/about-genomics/fact-sheets/Eugenics-and-Scientific-Racism

Fausset, R. (2022, February 7). What we know about the shooting death of Ahmaud Arbery. *The New York Times.* Retrieved from https://www.nytimes.com/article/ahmaud-arbery-shooting-georgia.html

Fernandez, A. (2020). The unacceptable pace of progress in health disparities education in residency programs. *JAMA Netw Open,* 3(8), 1-3. doi:10.1001/jamanetworkopen.2020.13097

Gollust, S., Cunningham, B., Bokhour, B., Gordon, H., & Pope, C., et al. (2018). What causes racial health care disparities? A mixed-methods study reveals variability in how health care providers perceive causal attributions. *Inquiry*, 55, 1-11. doi: 10.1177/0046958018762840

Gonzalez, C., Deno, M., Kintzer, E., Marantz, P., Lypson, M., & McKee, M. (2019). A qualitative study of New York medical student views on implicit bias instruction: implications for curriculum development. *Journal of General Internal Medicine*, 34(5), 692–698. https://doi.org/10.1007/s11606-019-04891-1

Gonzalez, C., Garba, R., Liguori, A., Marantz, P., McKee, M., & Lypson, M. (2018). How to make or break implicit bias instruction: implications for curriculum development. *Academic Medicine: Journal of the Association of American Medical Colleges*, 93(11S), S74-S81. https://doi.org/10.1097/ACM.0000000000002386

Grady Hospital. (n.d.). *Grady Community Needs Assessment 2019.* Retrieved from https://www.gradyhealth.org/wp-content/uploads/Grady-2019-CHNA_FINAL_12.6.2019.pdf

Hall, W., Chapman, M., Lee, K., Merino, Y., & Thomas, T., et al. (2015). Implicit racial/ethnic bias among health care professionals and its influence on health care outcomes: a systematic review. *American Journal of Public Health*, 105(12), 60-76. doi:10.2105/AJPH.2015.302903

Hansen, H. & Metzl, J. (2016). Structural competency in the U.S. healthcare crisis: putting social and policy interventions into clinical practice. *Journal of bioethical inquiry*, 13(2), 179–183. https://doi.org/10.1007/s11673-016-9719-z

Hardeman, R., Medina, E., & Kozhimannil, K. (2016). Structural racism and supporting Black lives—the role of health professionals. *N Engl J Med*, 375(22), 2113-2115. doi: 10.1056/NEJMp1609535

Hazin, R. (2011). The protest psychosis: how schizophrenia became a Black disease. *Journal of the National Medical Association*, 103(4): 375. Retrieved January 13, 2022, from https://ur.booksc.eu/book/49851890/66ff57

Hefner, J., Hogan, T., & Opoku-Agyeman, W. *et al.* Defining safety net hospitals in the health services research literature: a systematic review and critical appraisal. *BMC Health Serv Res,* 21(278), 1-8. https://doi.org/10.1186/s12913-021-06292-9

Hoffman, K., Trawalter, S., Axt, J., & Oliver, M. (2016). Racial bias in pain assessment and treatment recommendations, and false beliefs about biological differences between blacks and whites. *Proceedings of the National Academy of Sciences of the United States of America*, 113(16), 4296–4301. https://doi.org/10.1073/pnas.1516047113

Jones, C. (2002). Confronting institutionalized racism. *Phylon*, 50(1/2), 7-22. https://doi.org/10.2307/4149999

King, C. & Redwood, Y. (2016). The health care institution, population health, and Black lives. *Journal of the National Medical Association*, 108(2), 131-136. https://doi.org/10.1016/j.jnma.2016.04.002

Lingras, K., Alexander, M. & Vrieze, D. (2021). Diversity, equity, and inclusion efforts at a departmental level: building a committee as a vehicle for advancing progress. *J Clin Psychol Med Settings,* 1-24. https://doi.org/10.1007/s10880-021-09809-w

Marshall, J., Cooper, L., Green, A., Bertram, A., Wright, L., Matusko, N., McCullough, W., & Sisson, S. (2017). Residents' attitude, knowledge, and perceived preparedness toward caring for patients from diverse sociocultural backgrounds. *Health equity*, 1(1), 43–49. https://doi.org/10.1089/heq.2016.0010

Martinez, S., Araj, J., Reid, S., Rodriguez, J., & Nguyen, M., et al. (2021). Allyship in residency: an introductory module on medical allyship for graduate medical trainees. *MedEdPORTAL*, 17:11200, 1-8. https://doi.org/10.15766/mep_2374-8265.11200

Matthew, D., Rodrigue, E., & Reeves, R. (2016, October 19). *Time for justice: Tackling race inequalities in health and housing.* The Brookings Institute. Retrieved from https://www.brookings.edu/research/time-for-justice-tackling-race-inequalities-in-health-and-housing/

McIntosh, K., Moss, E., Nunn, R., & Shambaugh, J. (2020, February7). *Examining the Black-White wealth gap.* The Brookings Institute. Retrieved from https://www.brookings.edu/blog/up-front/2020/02/27/examining-the-black-white-wealth-gap/

Mckay, R & Brooks, B. (2022, February 15). *Ahmaud Arbery's murderers used litany of racist slurs, hate-crimes trial hears.* Reuters. Retrieved from https://www.reuters.com/world/us/prosecutors-will-need-show-mindset-arbery-killers-hate-crimes-trial-2022-02-14/

Medlock, M., Weissman, A., Wong, S., Carlo, A., & Zeng, M., et al. (2017). Racism as a unique social determinant of mental health: development of a didactic curriculum for psychiatry residents. *Journal of Teaching and Learning Resources*, *13,* 10618. https://doi.org/10.15766/mep_2374-8265.10618

Metzl, J.& Petty, J. (2017). Integrating and assessing structural competency in an innovative prehealth curriculum at Vanderbilt University. *Acad Med*, 92(3): 354-359. doi: 10.1097/ACM.0000000000001477

Metzl, J., Petty, J., & Olowojoba, O. (2018). Using a structural competency framework to teach structural racism in pre-health education. *Social Science & Medicine,* 199, 189-201. http://dx.doi.org/10.1016/j.socscimed.2017.06.029

Moffic, H., Bailey, R, Clark, F., Cohen, C., & Friedman, C., et al. (2020). Dismantle racism in psychiatry and society. *Psychiatric Times*, 37(8). Retrieved January, 13, 2022, from https://www.psychiatrictimes.com/view/dismantle-racism-in-psychiatry-society

Moss, E., McIntosh, K., Edelberg, W., and Broady, K. (2020, December 8). The Black-White wealth gap left Black households more vulnerable. The Brookings Institute. Retrieved from https://www.brookings.edu/blog/up-front/2020/12/08/the-black-white-wealth-gap-left-black-households-more-vulnerable/

Nardone, A., Chiang, J., & Corburn, J. (2020). Historic redlining and urban health today in US cities. *Environmental Justice*, 13, 110-119. DOI: 10.1089/env.2020.0011

National Museum of African American History and Culture, Smithsonian. (n.d.). *Historical Foundations of Race.* Retrieved from https://nmaahc.si.edu/learn/talking-about-race/topics/historical-foundations-race

Neff, J., Holmes, S., Knight, K., Strong, S., & Thompson-Lastad, A., et al. (2020). Structural competency: curriculum for medical students, residents, and interprofessional teams on the structural factors that produce health disparities. *MedEdPORTAL*, 16:10888, 1-10. https://doi.org/10.15766/mep_2374-8265.10888

Nelson, B. (2020). How structural racism can kill cancer patients. *Cancer Cytopathol, 128(2),* 83–84. https://doi.org/10.1002/cncy.22247

Office of Disease Prevention and Health Promotion. (n.d.). *Health People 2030 Questions and Answers.* Retrieved from https://health.gov/our-work/national-health-initiatives/healthy-people/healthy-people-2030/questions-answers#:~:text=Similar%20to%20Healthy%20People%202020,Provides%20data%20monitoring%20tools

Onyeador, I., Wittlin, N., Burke, S., Dovidio, J., & Perry, S., et al. (2020). The value of interracial contact for reducing anti-Black bias among non-Black physicians: a cognitive habits and growth evaluation (CHANGE) study report. *Psychological Science*, *31*(1), 18–30. https://doi.org/10.1177/0956797619879139

Pager, D. & Shepherd, H. (2008). The sociology of discrimination: racial discrimination in employment, housing, credit, and consumer markets. *Annu Rev Sociol,* 34, 181-209. https://doi.org/10.1146/annurev.soc.33.040406.131740

Painter, N. (2006, February 14). Slaver: A Dehumanizing Institution. *Oxford University Press blog*. Retrieved from https://blog.oup.com/2006/02/slavery_a_dehum/.

Perdomo, J., Tolliver, D., Hsu, H., He, Y., & Nash, K., et al. (2019). Health equity rounds: an interdisciplinary case conference to address implicit bias and structural racism for faculty and trainees. *MedEdPORTAL,* 15(10858), 1-9. https://doi.org/10.15766/mep_2374-8265.10858

Quillian, L., Pager, D., Hexel, O., & Midtboen, A. (2017). Meta-analysis of field experiments shows no change in racial discrimination in hiring over time. *PNAS*, 114(41), 10870-10875. https://doi.org/10.1073/pnas.1706255114

Reddy, A. (2008). The eugenic origins of IQ testing: implications for Post-Atkins Litigation. *DePaul Law Review*, 57(5), 667-678. https://via.library.depaul.edu/law-review/vol57/iss3/5

Richardson, J., Mitchell, B., Edlebi, J., Meier, H., & Lynch, E. (2020). *The Lasting Impact of Historic "Redlining" on Neighborhood Health: Higher Prevalence of COVID-19 Risk Factors.* National Community Reinvestment Coalition. Retrieved from https://ncrc.org/holc-health/

Ruane, M. (2019, April 30). A brief history of the enduring phony science that perpetuates white supremacy. *The Washington Post*, Retrieved from https://www.washingtonpost.com/local/a-brief-history-of-the-enduring-phony-science-that-perpetuates-white-supremacy/2019/04/29/20e6aef0-5aeb-11e9-a00e-050dc7b82693_story.html

Sanders, M. & Fiscella, K. (2021). Anti-racism training using the biopsychosocial model: Frederick Douglas' earthquake, whirlwind, storm and fire. *Frontiers in psychiatry*, 12(711966), 1-6. https://doi.org/10.3389/fpsyt.2021.711966

Schwartz, R. & Blankenship, D. (2014). Racial disparities in psychotic disorder diagnosis: A review of empirical literature. *World journal of psychiatry*, *4*(4), 133–140. https://doi.org/10.5498/wjp.v4.i4.133

Scientific racism. (n.d.). Retrieved May 4, 2022, from https://library.harvard.edu/confronting-anti-black-racism/scientific-racism

Shiffer, Bronwyn R., "An exploratory study of motivations of White people engaged in antiracism work" (2013). Masters Thesis, Smith College, Northampton, MA. https://scholarworks.smith.edu/theses/977

Simpson, T., Evans, J., Goepfert, A., & Elopre, L. (2022). Implementing a graduate medical education anti-racism workshop at an academic university in the Southern USA. *Medical Education Online*, 27(1), 1-5. https://doi.org/10.1080/10872981.2021.1981803

Social Security Administration search. (2015, November). *Research, Statistics, and Policy Analysis. Social Security Administration.* Retrieved from https://www.ssa.gov/policy/docs/research-summaries/education-earnings.html#:~:text=Men%20with%20bachelor's%20degrees%20earn,earnings%20than%20high%20school%20graduates

Song, A., Americo, L., Myers, H., DeBenedectis, C., Slanetz, P. J., & Sarkany, D. (2021). Addressing the ACGME mandate for healthcare disparities education in residency programs: a needs assessment. *Academic radiology*, *28*(7), 930–937. https://doi.org/10.1016/j.acra.2021.05.003

Stages of Change Model. (n.d.). Loma Linda University School of Medicine. Retrieved from https://medicine.llu.edu/academics/resources/stages-change-model

Stern, A. (2020, September 23). *Forced Sterilization Policies in the US targeted minorities and those with disabilities- and lasted into the 21st century.* University of Michigan Institute for healthcare policy and innovation. Retrieved from https://ihpi.umich.edu/news/forced-sterilization-policies-us-targeted-minorities-and-those-disabilities-and-lasted-21st

SurveyMonkey, Momentive Inc. www.momentive.ai. San Mateo, California, USA (not sure how to cite)

Szto, M. (2013). Real estate agents as agents of social change: redlining, reverse redlining, and Greenlining. *Seattle Journal for Social Justice*, 12(1): 1-60. https://digitalcommons.law.seattleu.edu/sjsj/vol12/iss1/2

Taylor, J. (2020). Structural racism and maternal health among Black women. *The Journal of Law, Medicine, and Ethics*, 48(3), 506-517.

The Sentencing Project. (2018, March 19). *Report of the sentencing project to the United Nations special rapporteur on contemporary forms of racism, racial discrimination, xenophobia, and related intolerance.* Retrieved from https://www.sentencingproject.org/publications/un-report-on-racial-disparities/

The U.S. National Archives and Records Administration. (n.d.). *The emancipation proclamation.* Retrieved from https://www.archives.gov/exhibits/featured-documents/emancipation-proclamation#:~:text=President%20Abraham%20Lincoln%20issued%20the,and%20henceforward%20shall%20be%20free.%22

Thompson, H. (2019). The racial history of criminal justice in America. *DuBois Review*, 16(10), 221-241. doi:10.1017/S1742058X19000183

National Institutes of Health. (n.d.). *Toolkit for patient-focused therapy development.* Retrieved from https://toolkit.ncats.nih.gov/glossary/underserved-

group/#:~:text=Underserved%20groups%20refer%20to%20populations,more%20or%20the%20included%20categories.

Vaughn, B. (2007). The history of diversity training and its pioneers. *Strategic Diversity and Inclusion Management Magazine*, 1(1), 11-16. Retrieved from https://diversityofficermagazine.com/diversity-inclusion/the-history-of-diversity-training-its-pioneers/

Walker, J. (n.d.). *The racist beginnings of standardized testing.* National Education Association. Retrieved from https://www.nea.org/advocating-for-change/new-from-nea/racist-beginnings-standardized-testing

Warner, J. (2021, April 30). Psychiatry Confronts Its Racist Past, and Tries to Make Amends. *The New York Times*. Retrieved from https://www.nytimes.com/2021/04/30/health/psychiatry-racism-black-americans.html

Warren, C. (2016). Black interiority, freedom, and the impossibility of living. *Nineteenth-Century Contexts*, 38(2), 107-121. http://dx.doi.org/10.1080/08905495.2016.1135769

Woods, K. (2020, June 25). *The Crime and Illness of Being Black: Past and Present.* Psychology Today. Retrieved from https://www.psychologytoday.com/us/blog/outside-the-box/202006/the-crime-and-illness-being-black-past-and-present

Appendix A.

Focus Group Questions:

Questions	
1.	Introduction—name, year in residency?
2.	Why did you choose Emory for a general psychiatry residency?
3.	What was your introduction to the residency's DEI curriculum?
4.	What has been your experience with the DEI curriculum thus far?
5.	What are the strengths of the curriculum?
6.	What are areas for improvement in the DEI curriculum? Are there any gaps in the content?
7.	What additional comments or takeaways do you think are important for the next steps in developing the program's DEI curriculum?
Supplemental Questions	
1.	What changes has the curriculum prompted you to make in your personal life and/or professional life?
2.	Have your views of society changed from participating in the curriculum? If so, how?
3.	What do you think can be done to reach those who are less inclined to participate in this work?
4.	Do you believe that this work can lead to systemic, impactful change? If so, how?

Appendix B:

Emory Psychiatry Residency DEI Curriculum Lecture Titles

Hours	PGY Year	Title
1	1	Introduction to Cultural Psychiatry: Cultural Formulation and Humility
1	1	Cultural Identity
1	1	Power and Privilege
1	1	Expanding Our Reach: Working with Underserved Populations
1	1	State of MH in GA and Tour of Georgia Regional
1	1	Religion, Spirituality, and Psychiatry
1	1	Health Disparities and Social Determinants in SMI
1	1	Introduction to Global Mental Health
1	2	Payer Sources
1	2	Working with Immigrants/Refugees
1	2	Grady and Gun Violence
1	2	Ethics in Global Health Training
1	2	LGBTQ Case Conference
1	2	Black Americans and Psychiatry: An Exploration of its Historical Underpinnings in the Contiguous United States
1	3	Where I'm from exercise
1	3	Child and Family Therapy: A Cultural Perspective
1	3	Racial disparities in the assessment and treatment of psychosis
1	3	Culturally Competent Interactions
1	3	Mental Health in Humanitarian Emergencies
1	4	Structual Racism
1	4	Structural Racism II
1	4	Culturally based case presentation (resident presenter)
1	4	Racial disparities in the assessment and treatment of psychosis
1	4	DSM-5 cultural formulation interview (Francis Lu webinar)

Appendix C

Qualitative Codebook Themes

#	Theme	Definition	Sub-theme	Code Type	Example quote
1	Diverse Clinical Sites	Reason for choosing Emory	-Atlanta -Inner city -Grady -Public safety net hospital	Inductive	"…primarily, I did most of my clinical training at a county like public safety net hospital. So, I wanted that to be, also part of my residency experience, um, and hopefully to work with kind of the population that the public system works with, at some point in the future." "To get to work at a public hospital, private, and VA, and so, I will be well trained after graduation. For me, I think I was very interested in the underserved population, and Grady was a big reason why I came down to train at Emory."
2	Diverse Training	Reason for choosing Emory	-Rotate at multiple hospitals -Reputable institution	Inductive	"Emory is a great reputable institution, lots of diverse clinical sites, the training". "I think that for me the breadth of experience that you would get like specifically, ECT and some of the more procedural aspects are not available outside of places with pretty big department". "…probably the biggest thing was the diversity of the clinical sites like Grady versus a Wesley Woods, like a very, very wide variety of patient populations. Probably the biggest thing that drew me here."
3	Introduction to DEI	How you were introduced to DEI	-No intro to DEI -Integrated into clinical work -Lack of formal curriculum	Deductive	"So I don't know if there was a formal introduction at Emory that I missed it, I don't recall actively formal introduction. I feel like its integrated into a lot of our clinical experiences, which perhaps is great and maybe even a goal better rather than an hour lecture of here's an introduction". "Not just limited to didactics. It seems throughout a lot of my attendings, talking about diversity issues, cultural issues, you know here I've been not

			-Lack of clarity in sequence of lectures		only trained in the biopsychosocial model but also the cultural component as well. So it's very well integrated throughout my clinical experience inpatient and outpatient". "I think like really learning from our peers, learning and questioning our perspectives individually and as a group and like challenging ourselves to sort of grapple with our beliefs, our thoughts, our behaviors, I think that's going to make the most difference. Um, and so while I do feel like the lectures have been good, um, I still feel like you can come out of this program with like with a very big, missed opportunity". "We've had a number of lectures where the bulk of it is the prevalence of these discrepancies and less, so the discussing interventions". "Sometimes the order of [lectures] doesn't make as much sense to me. Like we spend most of our first year at Grady and then at least that I am seeing here is that one of the second year lectures is Grady and gun violence. That lecture seems like it'd be more powerful if it was given when we were in the space when it was most relevant".
4	Systemic issues	Challenges residents face	-Resistance to change -Lack of patient resources -Burnout	Inductive	"I would have to say I've found my experiences to be frustrating when I didn't understand some of the social determinants of health and kinda struggling with dealing with burn out first year but learning more about and hearing more about, I learn these are much bigger issues of what I'm capable of doing. This is my role as a clinician, you know I'm appreciating and understanding some of the structural issues has been helpful in understanding why I'm feeling the way I'm feeling and the frustration".
5	Curriculum	Strengths of DEI curriculum	-Integrated with clinical practice -Discussion and interactive teaching -Focus on social determinants of	Deductive	"I think my supervisor like brings that in, and that's where I learn a lot about different perspectives, not as much about in didactics unfortunately. I think it's hard, I think that a lot of the DEI classes were about discussions about very particular patient encounters and may apply to specific cases…very multi-layered and there are a lot of different aspects

			health and structural racism		that contribute to a patient’s presentation that gets a little more nuanced and complex”. “[One attending] gave us one about power and privilege which I remember this one because she made it much more interactive and I remember reflecting on our own backgrounds. The other lectures are more power point based I think are harder to recall”. “A lot on culture, disparities, social determinants, lectures related to racial disparities and in particular structural racism. So a lot of the topics in and of themselves, I think are really important. Feels like there could always be more”.
		Weaknesses of DEI curriculum	-Heavily lecture-based/ didactic format not good -Not equipped with tools -Lack of attending buy-in -Fully encompassing all facets of diversity -Lack of diverse faculty/staff	Deductive	“DEI curriculum is a particularly challenging thing to do in a didactic format just because, I think that part of it is a lived experience. You know everyone is so diverse, everyone has their own lived experience. Everyone has their own, you know, everybody is coming to it from a different perspective”. “I personally haven't experienced much in that realm in terms of attendings incorporating like relevant teaching on the subject area. There's only, I think outside of like a lecture context, that I can think of like one attending, only one attending that comes to mind that I specifically addressed topics related to DEI. I think about our patient encounters and our approach and our interviews and things like that” “I feel that they do a good job of talking about the, the first step, like the discrepancies of schizophrenia diagnoses, for example, in black versus non-black populations. But sometimes I feel like it kind of stops with that and there's less discussion about how to address those discrepancies or how to think differently. We've had a number of lectures where the bulk of it is the prevalence of these discrepancies and less, so the discussing interventions”.

6	Improvements	Areas for curriculum improvement	-Evidence based DEI -Lecture sequence -Early, consistent integration of cultural formulation -Programmatic support -Incorporate those less inclined to participate in DEI work -More interactive and experiential	Deductive	"In the age where much doctoring is evidenced based, psychiatry is a little different for many reasons. And I would say that if we want to be part of this evidenced based community, then we sorta need evidence and having evidence from papers that are peer reviewed and published to help guide us may be useful. That's wildly needed when we talk about DEI". "I feel like having more of a willingness to have these complicated conversations, especially intern year at Grady would be really helpful with the inpatient unit and the psych ER. One thing I think just looking at the curriculum is interesting, so much of it almost all of it is centered around our patients but nothing really about diversity and value of it academia or in residency programs". "What is the vision? And what are we trying to accomplish? Because of course you know, clearly there is going to be a couple of years of trying to gain ground on what do you want this position to look like because it's so new. We really try to hone in on what ideal, for example, I have a clinical chief position". "In July we will see what people's actual expectations and support of us will be. I'm optimistic but also recognize that there have been a lot of issues in the past". "And being clear about what like the mission or the goals are. Well, I like don't really have a clear sense of what this is. I mean diversity is a very broad topic and different people interpret it in a different way. I certainly don't want to presume that what I think is DEI is what others think is DEI. So, I think there is some ambiguity, in terms of what is even the roles, I think we have a chief role for diversity and I think that fell through". (addressing how to get more buy-in) "Psychiatry, in terms of the education needs to be more experiential and more through conversation and exploration rather than lecture".