In August 2020, the editors of JAMA Network Open put forth a Call for Papers on Prevention and the Effects of Systemic Racism on Health, acknowledging systemic racism as one of the strongest factors driving health disparities among individuals who belong to historically marginalized racial and ethnic groups and/or socioeconomically disadvantaged groups in the United States. The call referenced numerous publications from the journal that collectively provide irrefutable evidence for the adverse health outcomes associated with systemic racism at all levels of health care, extending to the physician training pipeline. To address systemic racism, the Accreditation Council for Graduate Medical Education (ACGME) has set as one of its highest priorities the expansion and support of a diverse physician workforce to match US demographic characteristics and provide greater opportunities for racial congruence between clinicians and patients. The ACGME Committee on Diversity further notes that physicians who are underrepresented in medicine (URM) create culturally inclusive clinical environments and choose to practice and innovate in marginalized communities, which subsequently improves physician-patient communication and trust, adherence to medical advice, follow-up rates, and therapeutic success. Accordingly, ACGME accreditation requires that all residency training programs implement and report on policies and procedures to recruit and retain URM physicians and medical leadership. To maintain accountability for developing a diverse physician workforce, the American Medical Association and the Association of American Medical Colleges administer the National Graduate Medical Education Census (GMEC) to track demographic trends among residents across medical specialties and over time.

The cross-sectional analysis of GMEC data by López et al that appears elsewhere in JAMA Network Open draws attention to racial disparities in the composition of residency training programs and suggests that existing efforts to recruit URM candidates have been insufficient to expand diversity across ACGME-accredited residency programs. Specifically, the authors identified a consecutively declining proportion (10.2% to 7.9%) of Black residents entering obstetrics and gynecology (OBGYN) from 2014 to 2019, accompanied by a plateau in the proportion of Hispanic (9.6% to 10.1%) and Native American or Alaska Native (0.2% to 0.1%) OBGYN residents, although there has been an increase in those who identify as multiracial or other race/ethnicity. Comparatively, the proportion of Black residents entering surgical and nonsurgical residencies remained stagnant.

With Black OBGYN physicians accounting for 13.2% of active OBGYN physicians in the United States as of 2014, and the national proportion of URM physicians expected to grow, the goal of developing a racially congruent OBGYN physician workforce remains elusive unless the number of Black OBGYN residents significantly increases.

The declining proportion of Black OBGYN residents represents a failure of the medical education system to adapt to the changing demographic needs of its patients and cultivate diversity within the academic pipeline. Female residents account for 81.8% of OBGYN residents (according to 2019 AAMC data); they experience microaggressions and/or overt discrimination on account of their gender as well as their race, compounding the emotional and physical demands of postgraduate medical training. As URM residents are further mistreated and marginalized in their careers, regardless of specialty, they are frequently driven away from academic medicine.

URM physicians who take academic faculty positions are subject to the socioemotional stresses of concurrent isolation and hypervisibility because of their race. URM faculty face isolation from the dearth of colleagues with similar backgrounds and anxiety from having to code switch or adjust their appearance, speech, and/or behavior to optimize the comfort of white and other non-URM physicians.

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colleagues in anticipation of fair treatment and equal opportunity. Their hypervisibility in academia
creates the threat of stereotyping that pressures achievement beyond levels expected of their peers,
tokenism that highlights their race rather than their qualifications and achievements as faculty, and
uncompensated obligations to support institutional diversity initiatives and mentor URM students or
trainees. These factors cumulatively contribute to academic burnout and the departure of URM
faculty from academia, leaving URM residents without racially congruent role models and sources
of support in a cycle of racial inequity.

The findings by López et al additionally reveal consistently low proportions of URM physicians
from other racial and ethnic minority groups, although nonsurgical specialties experienced increases
in the proportion of Hispanic residents entering those programs. The study’s findings support best
practice recommendations for residency programs to improve diversity in the medical field by:
1. cultivating a diverse medical workforce starting from its earliest points of influence (eg, facilitating
health care and research experiences at the high school and undergraduate levels);
2. identifying, tracking, and mentoring medical students and residents toward academic careers,
medical leadership, and public health advocacy (eg, creating pipeline programs);
3. creating inclusive and supportive workforce environments for URM students and physicians (eg,
promoting allyship to promote inclusivity, address implicit bias, and provide antiracism/antisexism
training; creating diversity committees and initiatives);
4. holding unprofessional and discriminatory behaviors accountable (eg, identifying implicit bias and
discriminatory behavior and applying standards for professionalism to the entire academic and
medical workforce, inclusive of established faculty and staff); and
5. investing in the equitable compensation and promotion of URM faculty (eg, funding and
protecting administrative time for diversity work; providing leadership training, mentorship, and
research support).

Increasing the proportion of URM physicians will not occur without academic medical
institutions recognizing their role in the perpetuation of systemic racism and health care disparities
and taking bold and intentional steps to promote equity over equality via antiracist,
antidiscriminatory initiatives. The failure to recruit, train, and mentor URM physicians will reinforce
racial inequity in the academic pipeline that supplies the physician workforce, academic medicine,
and medical leadership for years to come.

ARTICLE INFORMATION
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