JRMC Journal of Regional Medical Campuses

Seeking Education, Equity, and Diversity (SEED): The Learning Experience, Cultural Humility, and Intention To Effect Change

Crystal R. Ackles, M.Ed. and Michael E. Anders, Ph.D.

DOI: *https://doi.org/10.24926/jrmc.v6i3.5099*
Journal of Regional Medical Campuses, Vol. *6*, Issue 3 (2023)

Published by University of Minnesota Libraries Publishing

Seeking Education, Equity, and Diversity (SEED): The Learning Experience, Cultural Humility, and Intention To Effect Change

Crystal R. Ackles, M.Ed. and Michael E. Anders, Ph.D.

Abstract

Introduction

Health care work cultures that embrace diversity, equity, and inclusion (DEI) foster innovations, synergy, and appreciation for differences. To promote DEI, health care systems have encouraged professional development on cultural humility, which is awareness of one's values, beliefs, and social position, given the current cultural context while mindful of history. The national SEED Project (Seeking Educational Equity and Diversity) is a professional development program that prompts reflection and perspective shifting about workplace culture and systemic change. However, reports that examine the SEED learning experience and the participants' intention for behavior change are lacking. The purpose of our study was to examine: (a) the SEED learning experience, (b) how personal views can foster cultural humility, and (c) the impact of SEED on intentions to effect change.

Methods

A purposive sample of eight (N = 8) faculty and staff from a SEED cohort at an academic health science center, with regional programs, participated in in-depth interviews to explore their personal views of how to foster cultural humility in health care and the impact of SEED to prompt intentions for behavior change. The investigators conducted a thematic analysis using an inductive, iterative method. Independently, they read each transcript and created codes for each comment. Subsequently, they compared findings, developed a coding frame, and grouped codes into potential themes. They then individually applied the coding frame to the data and considered themes. Finally, they built consensus on codes and synthesized codes into themes.

Results

Thematic analysis indicated the participants had a profound learning experience, which prompted them to develop cultural humility by reframing cultural experiences and resolving to become more proactive about DEI in the workplace. They found small group discussions were insightful and provocative. These discussions led to new perspectives and behavior change or intentions for behavior change. Our analysis generated three themes: (1) Connecting with diverse perspectives, (2) Developing new perspectives, and (3) Being proactive with advocacy and new strategies.

Conclusion

Health care professionals and organizations can use our findings to encourage professional development that potentially stimulates behavior change, the ultimate goal of professional development, related to DEI. Future studies should examine the impact of this professional development within their organization and in the delivery of health care.

Introduction

It is vital for diverse people to work together effectively in health professions. A work culture that embraces diversity, equity, and inclusion (DEI) fosters innovations, synergy, and appreciation for differences.[1] Diversity is the presence of differences, while equity is systemic fairness, and inclusion occurs when diverse people fully participate in organizational decisions and development. When a sense of connection exists between people in a diverse workplace, there is a sense of belonging and people strive to meet common goals. Building foundational awareness of multiculturism, inclusive of diverse groups who maintain their identities, leads to knowledge about related institutional structures, policies, and practices.[2]

Crystal R. Ackles, M.Ed.; Program Manager, Chief Medical Office, University of Pittsburgh Medical Center
Michael E. Anders, Ph.D.; Educational Development, Academic Affairs, University of Arkansas for Medical Sciences
Corresponding author: Crystal Ackles, M.Ed. AcklesCR@upmc.edu 412-647-0505

Professional development can potentially shape norms, values, beliefs and common practices among health professions faculty and staff.[3,4] In light of ongoing appalling social injustices and health disparities in the U.S., a pressing need exists for professional development that prompts health care professionals, educators, and staff to reflect on and have meaningful discussions about DEI and, ultimately, change their behavior.[5,6] Health care systems are one of the largest community assets and can serve as agents for change to address systemic biases, which are unfair health organization policies and practices that adversely affect underrepresented or marginalized groups.[7,8] For example, health care teams may lack the diversity of the patients they serve, therefore, their cross-cultural communication may suffer. Health care systems can also encourage professional development on cultural competencies to promote knowledge about the values, beliefs, and behaviors of certain cultural groups, and tailoring professional and clinical encounters accordingly.[9,10]

The national SEED Project (Seeking Educational Equity and Diversity) is a professional development program that provides an educational framework for reflection and perspective shifting about workplace culture and systemic change.[11] SEED explores cultural humility and DEI in communities, institutions, and schools. Cultural humility is awareness of one's values, beliefs, and social position, given the current cultural context while mindful of history.[12] However, published reports that examine the learning experience in SEED and the participants' intention to change their behavior are lacking. Therefore, the purpose of our study was to examine the following: (a) the learning experience in the SEED program from the lens of health care faculty and staff, (b) perspectives of participants and how their personal views can foster cultural humility in health care settings, and (c) the impact of SEED on the participants' intentions for implementing strategies to affect change in their setting.

Methods

Setting: The setting was an academic health science center, with regional programs (Area Health Education Centers), in a rural, southern state.

Participants: A cohort of 32 faculty and staff, including some (three faculty, one staff) from the regional programs (Area Health Education Centers), participated in the SEED seminar series. To recruit a purposive sample, all participants received an invitation asking them to volunteer to participate in a semi-structured interview at the conclusion of the seminar series.

Procedures: The SEED program consisted of eight monthly professional development peer-led seminars in the fall, 2020 – spring, 2021. Due to the COVID-19 pandemic, SEED used a virtual videoconferencing platform (Zoom Video Communications, Inc.). SEED seminars featured large group forums combined with small group breakout sessions, which offered an opportunity for engaging dialogue. Under the auspices of the Division of DEI at our institution, SEED facilitators consisted of four trained faculty and staff from Family and Preventative Medicine, Veterinary Medicine, and the Center for Health Literacy.

The principal investigator (CA), with training in qualitative research, conducted in-depth, semi-structured interviews, each approximately one-hour long, via video conferencing (Zoom Video Communications, Inc.). The video conferencing software generated transcriptions of recordings of the interviews. The investigators took steps to minimize biasing the participants during the interview. The pre-interview briefing sought to create a safe environment for and emphasized the importance of the participants being candid by saying, "What you truly think is important. Feel free to speak your mind. There are no right or wrong answers. All your comments, positive or negative, are helpful. Not everyone sees things the same way. It is good to have many points of view." Moreover, the facilitator (CA) maintained a neutral outlook during the interviews.

Measures: The investigators developed an interview guide with open-ended questions for in-depth exploration of how the personal views of the participants can foster cultural humility in health care settings, and the impact of SEED to prompt their intentions for change management at our institution and the SEED facilitators. See Table 1. Along with input from the Division of DEI at our institution, the

theory of planned behavior, which served as the basis for the social injustice scale, served as conceptual frameworks for many of the questions.[13,14] The central concept of the theory of planned behavior is that one's stated intention to act predicts future behavior.[13]

Qualitative analysis: We conducted a thematic analysis using an inductive, iterative method outlined by Braun and Clarke.[15] The two investigators independently read each transcript and created codes for each of the participants' comments. Subsequently, the investigators compared findings, developed a coding frame, grouped the codes into potential themes, and assessed data saturation.[16] The investigators then individually applied the coding frame for the data, and considered themes.[17] Next, the investigators met to build consensus on codes, synthesized codes into themes, and identified illustrative quotes. Finally, we conducted respondent validation, in which some respondents assessed whether the analysis was representative of their views. Throughout, the investigators used analytical memos to record decision points.[18]

To address the potential influence of the views and beliefs of the first author (CA), who was a participant in the SEED cohort, on the analysis, the second reviewer (MA) was a neutral investigator from the Educational Development department who prompted CA to objectively examine her assumptions about SEED.

Table 1: Interview Guide

- Tell me about your experience in the SEED program.
- Please discuss the most helpful aspects of the SEED program.
- Please discuss any suggestions you have for improving the program.
- Self-reflection welcomes awareness to learning and understanding different experiences. What have you learned about yourself through the SEED experience?
- Tell me about an experience when you felt your rights to something or someone were oppressed? Can you share a time you experienced a 'privilege moment'?
- How has SEED influenced the way you envision social injustices? How has the SEED experience challenged you?
- From your SEED experience, discuss how you are more proactive, the same, or less proactive in challenging inequality, social injustice, inequities? Why?
- Based on your experiences with others' views of oppression, privilege, or social injustices, how did you receive or struggle with different perspectives?
- The word diversity can take on many definitions, depending on the context in which it is used. How do you define diversity, inclusion, and equity?
- How has diversity, equity and inclusion showed up in your workplace?
- How has systemic oppression or privilege shaped your identity?
- After your SEEDS experience, would you recommend this program for new employees? Why or Why not?
- Tell me about your SEED project experience and its effect on your future professional practice.

Ethics: Our Institutional Review Board determined this study was not human subject research.

Results

Eight (N = 8) faculty and staff volunteered to participate in an interview. See Table 2. Review of the participants' responses revealed similar themes. The investigators were confident they achieved a thorough understanding of the participants' experiences in SEED, because analysis revealed data saturation or a close approximation of it was evident in redundant themes.[16]

Table 2: Characteristics of the Participants (N = 8)

Characteristic	n	Percentage
College of Medicine		62
Neurosurgery	1	
General surgery	1	
Pediatrics	1	
Anatomy	1	
Graduate Medical Education	1	
College of Health Professions		13
Sonography	1	
Other		25
Translational research	1	
Domestic violence	1	
Faculty		
Associate Professor	1	13
Assistant Professor	3	37
Staff	4	50
Practice location		
Main campus	8	100
Regional campus	0	0
Age		
< 40	2	25
> 40	6	75
Gender		
Male	1	12
Female	7	88
Race		
African American	1	12.5
Caucasian	6	75
Indian American	1	12.5

Thematic analysis of the transcribed interviews revealed three predominant themes: (1) Connecting with diverse perspectives, (2) Developing new perspectives, and (3) Being proactive with advocacy and new strategies (Table 3). See Table 4 for illustrative quotes of each theme.

Table 3: Themes and Codes

Theme	Codes
Connecting with diverse perspectives	• Develop knowledge base of social injustices • Sharing experiences and moral belief systems • Relating to fellow workers in the workplace environment • Understanding how one's culture shows up in the workplace • Distinction between diversity, equity, and inclusion • Small breakout sessions create intimate space for engagement • Smaller cohorts would be conducive for more in-depth discussion
Developing new perspectives	• Recognize differences and commonalities • Challenge of self-reflection • Difference between equity and equality • Difference between acceptance and experience • Privilege versus oppression • Accepting uncertainty about how to answer some questions
Being proactive with advocacy and new strategies	• Use SEED as an onboarding tool • Speak against social injustices, micro aggressions, and biases • Encourage self-reflection • Intentionally seek diversity

Table 4: Representative Quotes of Themes

Theme	Illustrative Quotes
Connecting with diverse perspectives	"The most helpful part about SEED is meeting people from various backgrounds. I have learned from others' life experience and gained better insight. I should not be judgmental or assume anything while speaking to somebody of a certain race, gender, or ethnicity or that it is a given they are going to behave a certain way."
	"I spent more time ruminating and reflecting on perspectives different from mine, not just trying to figure out why there is a difference, but what can I take from those differences that will shape my future."
Developing new perspectives	"[I have] not come to terms with many things that have set me up in life that other people do not experience."
	"I learned to see the whole story and not be narrow minded about how I view people who get angry about social injustices. SEED opened my eyes and challenged the way I think. I now consider the whole person by asking myself, 'Why is this hurtful to them, why do we say the things we say and do the things we do?' I am more empathetic and learn from others' experiences."
	"Diversity can be many different things. We have more women than men. Some residents who are LGBTQ are leaders in our program. We have residents who had careers before surgery, with different life experiences. Some are parents, married, or single. We have some residents that grew up in the city and some that grew up on a rural farm and gave birth to farm animals. I am proud of these aspects of our diversity."
Being proactive with advocacy and new strategies	"I'm becoming more proactive in the classroom with my students and not feeling like I have to shy away from challenging conversations. I want to try to do for my students what SEED has done for me - create a safe space for self-reflection. I am encouraging students to be more comfortable with self-reflection and be more self-aware."
	"I'm a lot more proactive in increasing diversity in our residency and fellowship programs. I met with our residents who were helping me conduct the interviews. We actually talked about ways the candidates would make our program more diverse."
	"I feel more empowered to speak up when I see social injustices and inequities. I think being empowered is a big thing, in relation to my colleagues and our patients, too."

Discussion

Qualitative analysis of the interviews indicated the participants had a profound learning experience, which prompted them to develop cultural humility by reframing cultural experiences and resolving to become more proactive about DEI in the workplace. In particular, they found small group discussions were insightful and provocative, even "intense," and desired more of this format. These discussions often led to new perspectives and intentions for behavior change. Our analysis generated three themes: (1) Connecting with diverse perspectives, (2) Developing new perspectives, and (3) Being proactive with advocacy and new strategies.

The first theme was connecting with diverse perspectives. Participants were faculty and staff from diverse health care professions and work settings as well as diverse ethnicity, race, gender, sexual orientation, and religious views. The SEED curriculum challenged each of these participants to cultivate his or her perspective and knowledge about social injustice through stirring poetry, mini-documentaries, TEDx talks (www.ted.com), videos, and music. Participants then related their unique perspectives

and knowledge to their workplace environment, including normal day-to-day work routines, interpersonal dynamics, how one's culture shows up in the workplace, and an expanded definition of diversity. Differences and commonalities surfaced, as participants examined diversity, equity, and inclusion through the lens of peer discovery. Virtual breakout rooms provided a space for small groups, with six to eight participants each, in which participants were able to engage with the curriculum and each other emotionally, behaviorally, and cognitively. There, they were able to candidly express opinions, reflect, and formulate strategies for behavior change. The participants valued the intimate, in-depth connection with people who had diverse perspectives.

Connecting with diverse perspectives led to the second theme, developing new perspectives. Participants recognized differences and commonalities with each other and colleagues as well as patients in their work settings. Many participants exhibited cultural awareness, or understanding differences between people from other backgrounds. Through historical social context in the curriculum, SEED enhanced their awareness of implicit or unconscious bias, which had manifested with race, gender, and cultural differences. Participants also embraced the challenge of self-reflection, which SEED identified as the "4 Ws": (1) What is it that I am feeling? (2) Why do I feel this way? (3) When does this feeling occur? and (4) Where does this feeling occur? Some expressed an understanding of the difference between equality, giving people the same resources and opportunities, and equity, allocating resources and opportunities needed for equal outcomes. Others recognized the difference between acceptances of imposing social injustice, because it is consistent with a social convention, versus hardened perspectives developed by previously experiencing the brunt of social injustice. They shared childhood and parental guidance leading up to adult experiences. For the first time, some participants looked at oppression with a privilege lens, based on demographics and socioeconomic status. The "ah huh" moment occurred when participants recognized life experiences had shaped their perspectives about privilege versus oppression. Indeed, because their life experiences differed, some participants accepted uncertainty about how to respond to them. Rather, they resolved to try to listen and try to understand them.

The last theme was being proactive with advocacy and new strategies. Upon reflection about diverse backgrounds and experiences of people in their workplace, they resolved to speak against social injustices, micro aggressions, and biases that arise in day-to-day activities. Faculty expressed motivation to embrace difficult conversations with students and prompt them to self-reflect. Self-reflection on the part of future health care professionals could lead to advocacy and change to strengthen diversity, equity, and inclusion in health care. Some even spoke of action they were already taking to build diversity in their workplace.

While our study findings support that of others, our methods and findings are novel in important ways. Hutchins, *et. al*, conducted a qualitative analysis in faculty from outside of health care who participated in an online course that focused on cultural competence.[19] Cultural competence largely involves promoting knowledge about the values, beliefs, and behaviors of certain cultural groups, and tailoring professional and clinical encounters accordingly. In contrast, cultural humility, the focus of SEED, is both an interpersonal and intrapersonal approach, because it calls for individuals to learn from others' experiences, while being aware of their own engrained enculturation. Nevertheless, their findings revealed themes similar to those of our study. These themes were learning through dialog, heightened self-awareness, empathy, and improved self-efficacy to be proactive against unconscious bias, micro aggressions, and privilege.[19] Unlike our study, both their course discussion and their qualitative data came from asynchronous online discussion forums, which may have limited responsive exchanges between participants. An interdisciplinary workshop for health professions faculty, too, focused on cultural competency.[20] Their study findings demonstrated improved knowledge, skills, and attitudes. Themes from a qualitative analysis of field notes taken during the workshop related to improving clinical practice and teaching.[20] Another faculty development course for medical school faculty sought to raise their awareness of unconscious bias and, thereby, prompt self-discovery and future behavior change.[21] Based on

a qualitative analysis of in-depth interviews of the participants, the investigators concluded the course was moderately successful.[21] Kumagai, *et. al*. used interactive theater.[22] Similar to SEED, the intervention featured small group discussions focused on social justice. At long-term follow-up, participants reported behavior changes. In an educational intervention that featured movie clips to prompt discussion and reflective writing, participants' evaluations demonstrated the discussions helped them reflect on their own attitudes about race and diversity.[23] O'Connor, *et. al*, targeted only nursing educators, but similar to the SEED approach and our study findings, their DEI educational intervention featured small group activities, and participants perceived an improvement in self-efficacy.[24] Other studies addressed implicit bias and racism in clinical practice, which differed from the broader target group in SEED and our study.[25,26,27] Our study was novel, because it provided an in-depth qualitative evaluation of a DEI educational intervention for both faculty and staff at a health science university.

Our study has several limitations. In the analysis, the investigators thought they had a thorough understanding of the perspectives of the study participants, reaching data saturation or close to it. However, it is possible interviewing more participants could have further enhanced their understanding and expanded the themes. Further, most of the participants were female. Their perspectives may have differed from that of males in the SEED cohort and in health care settings. The ratio of females (n = 7, 88%) to males (n = 1, 12%) who participated in an interview was similar to that of the SEED cohort, which had 27 females (84%) and five males (16%). However, compared to medicine faculty nationally, in which females make up 45% of Assistant Professors and 35% of Associate Professors, our study had overrepresentation of females.[28] Our study also had overrepresentation of African Americans (12.5%) compared to the proportion of African American faculty at the University of Arkansas for Medical Sciences faculty (5%) and medical faculty nationally (3.6%), but the sample size was small.[29,30] Another limitation was the primary investigator was a participant in the SEED program and facilitated the interviews as well as participated in the analysis. To minimize biasing the participants' responses, the investigator took great care to create a safe environment for them to speak freely, as outlined in the Methods section. To offset this investigator's potential bias in the analysis, the second reviewer was a neutral investigator who strived to ensure objectivity. Further, the virtual format of the SEED program may have inhibited the participants' engagement. However, many of them highly favored the small group discussions, which the breakout rooms in the platform made possible. Further, their responses were rich. Finally, the participants' expressed intentions for behavior change, including advocacy, being proactive in the face of social injustice, and prompting students to self-reflect, may not translate to real future behavior change. Still, some participants described significant behavior changes they already made.

Conclusion

Health care professionals and organizations can use our findings to encourage professional development that stimulates behavior change, the ultimate goal of professional development, related to DEI. Future studies should examine the impact of this professional development within their organization and in the delivery of health care using quantitative methods and a comparison group.

Acknowledgements

We are grateful to the Division of Diversity, Equity, and Inclusion at the University of Arkansas for Medical Sciences (UAMS) for support and feedback, and we are grateful to Tricia Edstrom, Director of Education for Graduate Medical Education in Regional Programs at UAMS for her support and guidance.

References

1. Shaw-Taylor Y, Benesch B. Workforce Diversity and cultural competence in health care. Journal of Cultural Diversity. 1998; 5(4):138-140.
2. Sotto-Santiago, S. , Poll-Hunter, N. , Trice, T. , Buenconsejo-Lum, L. , Golden, S. , Howell, J. , Jacobs, N. , Lee, W. , Mason, H. , Ogunyemi, D. , Crespo, W. & Lamba, S. (2022). A Framework for developing antiracist medical educators and practitioner–scholars. Academic

Medicine, 97 (1), 41-47. doi: 10.1097/ACM.0000000000004385.
3. Hutchins D, Hode Goldstein M. Exploring faculty and staff development of cultural competence through communicative learning in an online diversity course. Journal of Diversity in Higher Education. 2021; 14(4):468-479. DOI: http://dx.doi.org/10.1037/dhe0000162
4. Grant S. Diversity in health care: Driven by leadership. Frontiers of Health Services Management. 2010; 26(3):41-44.
5. Lewis LD, Steinert Y. How culture is understood in faculty development in the health professions: A Scoping Review. Acad Med. 2020;95(2):310-319. doi: 10.1097/ACM.0000000000003024. PMID: 31599755.
6. Sabatello M. Cultivating inclusivity in precision medicine research: disability, diversity, and cultural competence. Journal of Community Genetics. 2019; 10:363-371.
7. Betancourt JR. Organizational Change Management for Health Equity: Perspectives from the Disparities Leadership Program. Health Affairs. 2017; 36(6):1095-1101.
8. Brown University. Understanding the Impact of Unconscious Bias in a University Setting: A Module for Faculty and Staff at Brown. https://www.brown.edu/about/administration/institutional-diversity/sites/oidi/files/Unconscious%20Bias%20Discussion%20Guide.pdf. Accessed October 3, 2022.
9. Shepherd SM, Willis-Esqueda C, Newton D, Sivasubramaniam D, Paradies Y. The challenge of cultural competence in the workplace: perspectives of healthcare providers. BMC Health Serv Res. 2019;19(1):135. doi: 10.1186/s12913-019-3959-7.
10. Carnevale FA, Macdonald ME, Razack S, Steinert Y. Promoting cultural awareness: A faculty development workshop on cultural competency. Can J Nurs Res. 2015; 47(2):18-40. English, French. doi: 10.1177/084456211504700203.
11. Nelson CL. The National SEED Project. Educational Leadership. 1991; 49(4):66-67.
12. Tervalon M, Murray-Garcia J. Cultural humility versus cultural competence: A critical distinction in defining physician training outcomes in multicultural education. Journal of Health Care for the Poor and Underserved. 1998;9(2):117–125. http://dx.doi.org/10.1353/hpu.2010.0233
13. Ajen I. The theory of planned behavior. Organizational Behavior and Human Decision Processes, 1991; 50, 179-211.
14. Torres-Harding SR, Siers B, Olson BD. Development and psychometric evaluation of the Social Justice Scale (SJS). Am J Community Psychol. 2012; 50:78-81.
15. Braun V, Clarke V. Using thematic analysis in psychology. Qualitative Research in Psychology. 2006; 3(2):77-101. DOI: 10.1191/1478088706qp063oa
16. LaDonna KA, Artino AR, Balmer DF. Beyond the guise of saturation: Rigor and qualitative interview data. Journal of Graduate Medical Education. 2021; 13(5):607-611. DOI:10.4300/JGME-D-21-00752.1
17. Sargeant J. Qualitative Research Part II: Participants, analysis, and quality assurance. Journal of Graduate Medical Education. 2012. DOI: http://dx.doi.org/10.4300/JGME-D-11-00307.1
18. Grady P. Qualitative and Action Research: A Practitioner Handbook. Phi Delta Kappa Educational Foundation, Bloomington. 1998.
19. Hutchins D, Hode MG. Exploring Faculty and Staff Development of Cultural Competence through Communicative Learning in an Online Diversity Course. Journal of Diversity in Higher Education. 2021 14;468-479. http://dx.doi.org/10.1037/dhe0000162.
20. Hanna SD, Carpenter-Song E. Patrolling Your Blind Spots: Introspection and Public Catharsis in a Medical School Faculty Development Course to Reduce Unconscious Bias in Medicine. Cult Med Psychiatry. 2013; 37:314-339.
21. Enders FT, Golembiewski EH, Pacheco-Spann LM, Allyse M, Mielke MM, Balls-Berry JE. Building a framework for inclusion in health

services research: Development of and pre-implementation faculty and staff attitudes toward the Diversity, Equity, and Inclusion (DEI) plan at Mayo Clinic. J Clin Transl Sci. 2021;5(1):e88. doi: 10.1017/cts.2020.575.
22. Kumagai AK, White CB, Ross PT, Purkiss JA, O'Neal CM, Steiger JA. Use of interactive theater for faculty development in multicultural medical education. Med Teach. 2007;29(4):335-40. doi: 10.1080/01421590701378662.
23. Ross PT, Kumagai AK, Joiner TA, Lypson ML. Using film in multicultural and social justice faculty development: scenes from Crash. J Contin Educ Health Prof. 2011;31(3):188-95. doi: 10.1002/chp.20126.
24. O'Connor MR, Barrington WE, Buchanan DT, Bustillos D, Eagen-Torkko M, Kalkbrenner A, Laing SS, Reding KW, de Castro AB. Short-term outcomes of a diversity, equity, and inclusion institute for nursing faculty. J Nurs Educ. 2019;58(11):633-640. doi: 10.3928/01484834-20191021-04.
25. Watt SK, Curtis GC, Drummond J, Kellogg AH, Lozano A, Nicoli GT, Rosas M. Privileged identity exploration: Examining counselor trainees' reactions to Difficult Dialogues. Counselor Education and Supervision. 2009; 49(2):86-105. DOI: 10.1002/j.1556-6978.2009.tb00090.x
26. Perdomo J, Tolliver D, Hsu H, He Y, Nash KA, Donatelli S, Mateo C, Akagbosu C, Alizadeh F, Power-Hays A, Rainer T, Zheng DJ, Kistin CJ, Vinci RJ, Michelson CD. Health equity rounds: An interdisciplinary case conference to address implicit bias and structural racism for faculty and trainees. MedEdPORTAL. 2019;15:10858. doi: 10.15766/mep_2374-8265.10858.
DOI: 10.15766/mep_2374-8265.10858
27. White-Davis T, Edgoose J, Brown Speights JS, Fraser K, Ring JM, Guh J, Saba GW. Addressing racism in medical education: An interactive training module. Fam Med. 2018 May;50(5):364-368. doi: 10.22454/FamMed.2018.875510.
28. Xierali IM, Fair MA, Nivet MA. Faculty diversity in U.S. Medical Schools: Progress and Gaps Coexist. Association of American Medical Colleges 2016; 16 (6).
29. University of Arkansas for Medical Sciences, Division for Diversity, Equity and Inclusion. 2020-2021 Annual Report. https://ddei.uams.edu/about-us/annual-report/. Accessed on October 3, 2022.
30. American Association of Medical Colleges. Data and Reports. https://www.aamc.org/data-reports. Accessed on October 3, 2022.