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The Role of the Chief Resident in Promoting Health Equity

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ABSTRACT

Drawing on recent experiences as a Chief Resident, the author proposes several strategies for promoting health equity. Challenges to this task are highlighted. The Chief Resident's ability to bypass these obstacles and construct experiences that promote long-term change is explored through the framework of the formal, informal, and hidden curricula. The strategic use of didactic conferences, role-modeling, and personnel decisions are emphasized.

Keywords:

cultural diversity; change management; racism; healthcare disparities; medical education

INTRODUCTION: EFFECTIVE ACTION AND HIDDEN CURRICULUM

Protests triggered by the killing of George Floyd and disparities in coronavirus disease (COVID-19) mortality (1) have prompted a broad reconsideration of race in American institutions. Physicians are no less touched by this zeitgeist than their fellow citizens, creating a unique opportunity to address long-running inequity in American health care (2). But to

realize this potential, those of such passions must be prepared to connect this apparently singular moment in history to a broader tapestry of sustainable efforts. This is one implication of civil rights organizers' axiom that "the arc of the moral universe is long, but it bends toward justice" (3). It finds parallels in medical education's increasing emphasis on longitudinal assessment and medicine's renewed attention to preventative care (4, 5).

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In medical education, Chief Residency exemplifies the challenge of balancing short-term impact and long-term progress. Considering its particularities thus offers valuable lessons to all those who care about the work of achieving health equity.

The Chief Resident occupies a unique niche. The role varies depending on program characteristics such as size, culture, and specialty. Among its universalities are an increased share of educational and administrative responsibilities. Lacking budget, permanence, or independent authority, efficacy in this role is not always intuitive. This is especially true when addressing efforts such as diversity that may be lesser institutional priorities. A recent survey of residencies found that almost two-thirds of chief residents perceived no institutional priority in the recruitment or retention of trainees from underrepresented populations (6). Chief residents interested in promoting health equity must instead understand how the hidden curriculum operates in their position and against their cause.

Efficacy requires purposefully accessing the power of the hidden curriculum. Beside their syllabi and milestones, trainees also absorb the humor and interaction style of their environment. The overall impression that emerges from the aforementioned formal and informal curricular elements are the core of customs and biases called the “hidden curriculum” of medical education, which can perpetuate injustice even where more overt bigotry has declined (7). An uncommon primary language does not inherently marginalize patients—attendings do, by deciding a case’s teaching value is less than the hassle of a translator. “Frequent flyer” jokes may orient learners away from systemic causes for health outcomes and toward perceived personal defects. These are precisely the early experiences expected in a healthcare system in

which non-white individuals report lower satisfaction, and inequality costs us almost \$250 billion annually (8, 9). The heavy symbolism invested in the Chief Resident’s post is ideal for addressing these conceptual, emergent properties of medical education. One of the earliest descriptions of the role described a “revered [...] person who had considerable authority over matters of concern to the house staff [...] whose medical acumen was not infrequently second only to that of the departmental chairman” (10). Formalized postgraduate education and evolving norms around trainee supervision have changed many particulars in that description. Nonetheless, taken as an urtext, the reader grasps how this role was intended as a visible expression of institutional ideals and priorities: an embodiment of its hidden curriculum. This tension is bidirectional, with perceptions not only restraining but also being shaped by a Chief’s actions.

This orientation finds parallels in other positions that sharply contrast between ceremonial importance and formal authority. A paradox is observed among diplomatic corps spouses, wherein their lack of formal authority “made it easier to connect with people and break down barriers” while their symbolic role simultaneously allowed such private action to acquire outsized official consequence (11). Medical literature also suggests the productivity of this approach. A longitudinal study on implicit bias among medical students investigated the influence of educational experiences. Though multiple experiences of the hidden curriculum, such as hearing disparaging comments about minorities, had a statistically significant impact on the measured bias, among formal curricular experiences such as lectures, only taking implicit association tests changed outcomes (12). Similarly, a recent study found that the

impact of formal curricular interventions on diversity and inclusion was mediated by the school's broader diversity climate (13). By targeting the hidden curriculum through positive role-modeling, highlighting health disparities regularly in structured didactics, and actively engaging in recruitment initiatives, the Chief Resident can maximally augment the health equity mission of his or her institution.

PROMOTING HEALTH EQUITY THROUGH FORMAL CURRICULA

Most Chief Residents have some voice in shaping the structured didactic program of their residency. Even if this is only by merit of their access to the Program Director and Chairman, this influence is a unique, valuable tool for health equity. By encouraging speakers to embed health equity concerns into clinical presentations, they can offer their trainees exposure to these topics without potentially arduous bureaucratic battles for dedicated lectures. Speakers with an interest in health equity should be preferred. However, whether soliciting faculty or assigning trainees to participate in didactics, every presenter should be encouraged to include these elements. The Chief Resident should work to identify resources for those that lack the relevant background.

There may also be substantial benefit in reaching outside one's department to experts who have a strong focus on health equity. The ability to fill an unmet educational need may be persuasive to those resistant to an explicit focus on health equity. Moreover, a speaker's strong topical engagement allows them to highlight its relevance to their field of practice during any presentation. At my institution, a special lecture from a Center for Disease Control employee deployed to Liberia during the latest Ebola epidemic received wide support from Infectious Disease,

Emergency Medicine, and Global Health. Content on privilege, understanding local context in the delivery of care, and how cultural practice intersects with health behaviors received significant attention as central elements of the discussion. Through multiple exposures, trainees can thus appreciate the landscape of disparities across many facets of health care. The goal is to foster an atmosphere wherein a lecture that does not address health disparities would be unthinkable. Importantly, in emerging from a trainee, such initiatives may bear an authenticity or lack the coerciveness that can be perceived in institutionally mandated efforts.

THE CHIEF RESIDENT AS ROLE MODEL

The Chief Resident is ideally suited for positive role modeling. Its consciously exemplary aspect lends an imprimatur that is arguably harder to disown than even some faculty. Students are inclined to look to those with greater teaching responsibilities as role models (14). A uniquely high-impact curriculum for indigenous health in New Zealand noted the importance of positive role modeling in their program's success (15). Equally important is the ability to integrate inclusive curricular content applicably and practically. Chiefs should make frequent explicit reference to health equity concerns in daily clinical work. Discussions about treatment plans during teaching rounds should encourage these considerations. Trainees who demonstrate cultural competence in bedside interactions should receive immediate positive feedback. Invite self-reflection where identity-discordant patients are offered more hostile nonverbal cues or less shared decision-making than those like the trainees (16, 17). A recent perspective by Kumagai highlights the way strategically

open-ended questions in clinical settings can prompt learners to confront these issues (18). Liberally applying such tools, the Chief Resident can leverage the informal curriculum to promote health equity. The more present the Chief Resident is on the wards interacting with learners, the greater the chance this behavior may spread as an expectation among the house staff.

Equally, the examples employed in explaining clinical concepts can promote inclusion by highlighting the contributions of underrepresented groups. Such demonstrations not only aid the target learning audience but broaden the exposure of faculty with a more limited historical perspective. Though previous generations might have learned of the contributions of Halstead in general surgery, they may be less familiar with the equally important work of Gertrude Elion in oncology, Emmanuel Rivers in critical care, or Charles Drew in transfusion medicine. This mode of knowledge diffusion caters to physicians' preference for practical, clinical-based learning over more abstract strategies (19). Operating in the informal curriculum, it also offers scant opportunity for objections.

The successful application of these techniques depends on a Chief Resident's familiarity and comfort with the material. One useful strategy for developing a relevant skillset is participation in intergroup dialogues. Centered on facilitated discussions between members of different identity groups, they increase all participants' empathy and inclination to work on social justice (20). Although the content of the activity will improve a prospective Chief's knowledge base, the structure includes several techniques for soliciting learners to engage in serious self-reflection while ensuring a safe environment for discussion. Immersion in the

broader literature of higher education can also identify useful parallel efforts in other fields to integrate social equity. As a secondary benefit, one may see expanded awareness of the pedagogy of learning, enhancing the ability to share content of any kind.

PROMOTING HEALTH EQUITY IN RECRUITMENT AND ADMINISTRATION

Individuals profoundly shape the institutions they inhabit. This insight is the key to every previous intervention discussed and should inform the Chief Resident's selection of administrative emphasis between recruiting, policymaking, and performance initiatives. Of these three, the first is least easily revised after a Chief's tenure. The literature has clearly identified correlates to care for underserved populations (21); these can be used to help identify candidates most beneficial to the school's climate. Each new hire or matriculant represents a multiyear commitment for the institution, guaranteed to outlast the Chief's tenure in an otherwise unparalleled fashion. Such experience may also prove especially enlightening in the quest to understand one's institution. Because hiring is a deliberative process through which the institution builds human capital, its priorities can be perceived in the internal discussions of search and/or hiring committees. By mirroring this language in their health equity proposals, Chief Residents can demonstrate value alignment with senior administrators. Conversely, these recruitment-oriented tasks may also reveal resistance to efforts promoting health equity that the Chief Resident should be cognizant of in developing their plans. Finally, the Chief's activities may be especially welcome here, as such service is generally not credited toward promotion and tenure (22).

THE CHIEF RESIDENT IN TRANSITION

The final test of these dynamics comes at the end of the Chief Resident's tenure. They may be relocating at a significant distance from their home institution or absorbed in adapting to their new role as an attending physician or fellow. However, utilizing the same framework that served them during their tenure can maximize their service to the mission of health equity. In considering the formal curriculum, they can work to transition personal knowledge to institutional knowledge. They can recommend the speakers that were most effective as doubly purposed lecturers for further speaking opportunities, create repositories of the resources used to help address health disparities in presentations, and formalize one's activities into reusable lesson plans. This lowers the activation energy for subsequent efforts. Visiting the institution as a successful former Chief can lend new weight to your role modeling. Lastly, the hidden curriculum can be accessed by defining one's legacy. To the extent the position lacks formal parameters, the outgoing Chief Resident can retrospectively outline their narrative of its most important elements. This can elevate a commitment to health equity in institutions in which there were fewer previous examples or shape the impression of an incoming Chief Resident still undecided on the meaning of their work. In combination with the work already done, these efforts can accumulate to attempt a lasting impact on the institutional ethos.

CONCLUSION

Over a decade ago, the Institute of Medicine identified equity as a core principle of healthcare quality (23). The challenge this presents is immense, and nothing substitutes for a comprehensive diversity plan with robust institutional

support. But the challenge of achieving influence in highly constrained circumstances is not unique. First Spouses face a similar conundrum of prominence on White House organizational charts despite lacking formally prescribed duties. The most effective of them participated in activities that offloaded the President's work while simultaneously advancing personal causes through speech writing and internal advocacy (24). These find parallels in activities such as participation in recruitment committees and building a secondary dimension into didactics—theoretically achievable but often underresourced tasks unless a Chief invests in them. Through the accumulation of such incremental nudges, one may begin to influence the ethos that defines the hidden curriculum.

Much has been written on the ways the informal and hidden curricula can contradict the values we aim to inculcate. Social dominance theory suggests this negative impact depends on an implicit consensus from institutional stakeholders. The transformation of a Chief Resident to a hierarchy-attenuating force through the embrace of health equity will disrupt this dynamic (25). The symbolism of the position can help amplify the effect of these moves. Although the Chief Resident position may encompass a wide variety of circumstances, this mindset is universally applicable. By targeting the informal curriculum through role modeling, the formal curriculum through double-purposed lectures, and strategic engagement in faculty search committees, Chief Residents can serve as effective advocates that affect elements of the hidden curriculum to promote health equity.

Author disclosures are available with the text of this article at www.atsjournals.org.

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