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BRIEF REPORT

Trainee Experience With Racial Affinity Caucusing

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ABSTRACT

Background and Objectives: Racial affinity caucusing (RAC) is a tool wherein participants gather in self-identified racial groups to learn and share experiences around race and racism. While used in many settings, little is known about the experience when used in graduate medical education (GME).

Methods: In this qualitative study, we explored graduate medical trainees' (resident/fellows) experiences participating in RAC. Participants recruited from a regional residency network participated in quarterly RAC during academic year 2021–2022. Of the 30 RAC (19 White, 11 Black, Indigenous, or Person of Color [BIPOC]) participants, 8 (1 White, 7 BIPOC; 27%) agreed to participate in our qualitative study and were interviewed by study team members who shared their BIPOC identity. We used a direct content analysis approach to analyze and compare interview transcripts.

Results: Key themes regarding their experience of RAC included having a safe space and a space for self-reflection.

Conclusions: While our study was limited by its small sample size, results suggest that RAC can be an impactful tool for GME, particularly to address gaps in self-reflection and professional identity formation. Institutes should encourage RAC within their GME curriculum.

INTRODUCTION

In 2003, the Institute of Medicine published *Unequal Treatment,* the landmark report that catalyzed conversations about health disparities and the need for system change.[1] Further research stressed the impacts of racism in academic medicine. Yet the Accreditation Council for Graduate Medical Education (ACGME) did not mandate diversity, equity, and inclusion (DEI) efforts in all residencies until 2020. A lack of evidence on DEI policies and interventions in graduate medical education (GME) has left programs struggling with these requirements.

One intervention, racial affinity caucusing (RAC), invites individuals to separate into self-identified racial groups (eg, Black, Indigenous, or People of Color [BIPOC] or White groups). For White participants, RAC focuses on addressing white privilege and internalized supremacy; in BIPOC RAC, participants engage in deconstructing internalized racism and exploring interracial dynamics.[2]

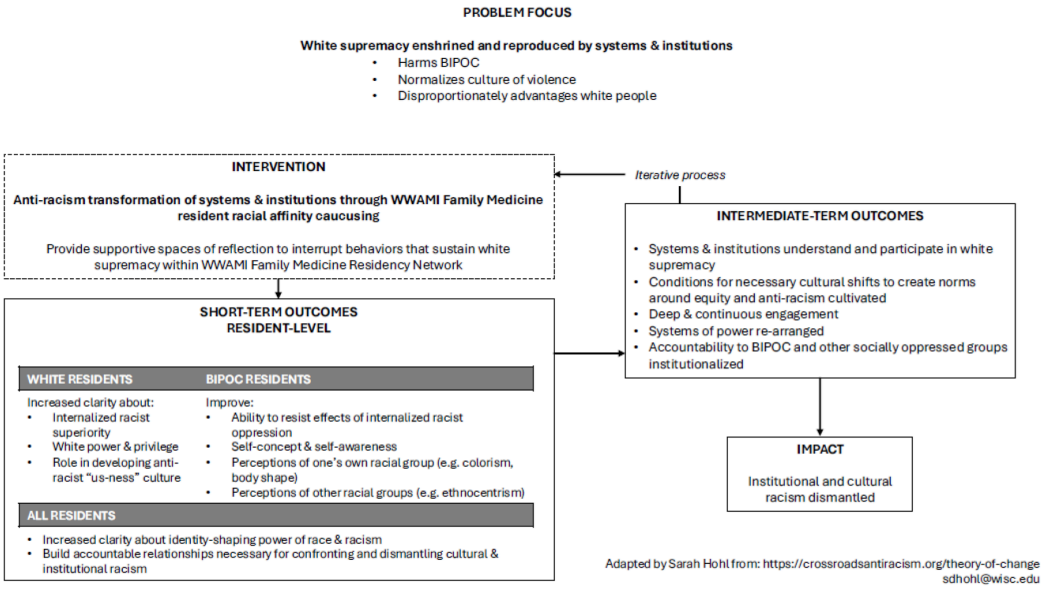
RAC can be traced to social movements and theories of change that emphasize the need for spaces that foster shared learning and healing and is increasingly recognized as a critical component of antiracism curricula in education. We modified the framework of the Crossroads antiracism theory of change (Figure 1) to illustrate RAC's potential role in dismantling institutional and cultural racism.[2-4]

Currently, no known published studies on the experience of RAC for trainees (residents/fellows) exist. The goal of this study was to identify trainee motivations, benefits, and possible unintended harms related to RAC participation in order to contribute to the development of evidence-based DEI practices in GME.

METHODS

This exploratory qualitative study used a constructivist paradigm.[5] Trainee

FIGURE 1. **Modified Framework of the Crossroads Antiracism Theory of Change**



Abbreviations: BIPOC, Black, Indigenous, or Person of Color; WWAMI, University of Washington School of Medicine's multistate medical education program (Washington, Wyoming, Alaska, Montana, Idaho)

participants' experiences were sought using semistructured interviews. We then applied a directed content analysis approach to interview transcripts to discern patterns across participants' experiences.

Setting and Participants

Housed at the University of Washington, the Family Medicine Residency Network (FMRN) comprises 33 family medicine residencies and 10 rural training programs across Washington, Wyoming, Alaska, Montana, and Idaho. From September 2021 to March 2022, four RACs were offered virtually to all 733 FMRN trainees. A total of 30 participants over the 4 sessions included 19 BIPOC and 11 White, with an average of 11 per session. Thirteen attended more than one session (Table 1).

Intervention

RAC sessions were facilitated by FMRN program faculty, some experienced facilitators, and others in training. Facilitators in-training were paired with experienced facilitators to co-lead sessions. Cofacilitators collaborated in advance of each session to select session topics and determine any needed materials or presentations.

A semistructured interview guide was developed to explore (a) motivations, (b) benefits, and (c) unintended harms caused by RAC participation.

In April 2022, audio-recorded Zoom (Zoom Communications, Inc) interviews were conducted with trainee participants, lasting 18 to 29 minutes. To promote trust, BIPOC participants had a BIPOC interviewer, White participants had a White interviewer, and interviewers were not part of the interviewee's residency program. Transcripts were cleaned and deidentified.

Data Analysis

Transcripts were analyzed using Dedoose version 9.0.62 (SocioCultural Research Consultants LLC). The team

TABLE 1. **Racial Affinity Caucusing Program**

Session	RAC	# Participants	# Programs represented	General topic
1 9/14/2021	BIPOC	11	7	Imposter phenomenon
	White	6	5	Race and identity
2 11/10/2021	BIPOC	7	7	Interrupting bias
	White	0	0	Allyship
3 1/20/2022	BIPOC	4	4	Code switching
	White	4	3	Intent and impact
4 3/8/2022	BIPOC	4	4	Code switching
	White	8	3	Power and privilege

Abbreviations: BIPOC, Black, Indigenous, or Person of Color; RAC, racial affinity caucusing

TABLE 2. Illustrative Quotes From FMRN RAC Resident Participants by Theme

Motivations for and perceived benefits of participating in RAC	Illustrative quotes
Create safe spaces	"We want it to be a safe learning environment that manifests, whether that is by having these difficult conversations, and then exploring your own privileges, and exploring your own biases. That is an uncomfortable conversation, but it doesn't necessarily mean it's unsafe, and so I think that overall, those expectations were established as components of the caucuses themselves; it always attempted to reaffirm that safe space." *–White participant #1* "[RAC] gives people permission to speak, really knowing that they have a place to express their intimate and vulnerable emotions around white supremacy and their experiences as BIPOC in historically unjust spaces." *–BIPOC participant #4*
Self-reflection	"This was a very unique space in terms of that intersection between my lived identity and the care that I provide with other folks, with my patients, who are very different racial identities than myself, and so I thought it was a very unique opportunity for us to explore how our own privileges, as White individuals come out and are manifested in the clinical environment." *–White participant #1* "It's up to us what we learn from these [RACs], but I say it helps us be a better physician and a better person." *–BIPOC participant #5*
Others' concept of race/racism	"We are forced to suppress our cultures and to suppress our language and kind of conform to the institutions where we work, and in some of those spaces, we recognize that our leadership does not include BIPOC individuals." *–BIPOC participant #4* "I think it gave me a chance to recognize privilege. Being Asian in medicine means something different than another race of medicine. Being able to appreciate the kind of horrific experiences that other folks have had as being BIPOC in medicine and feeling like I could be more supportive in that environment." *–BIPOC participant #2*
Experience own behavior change	"There are certain things that we learn, that RAC has taught me, like macroaggressions and the microaggressions. Being able to call it out in front an aggressor. That has been something I think that RAC has empowered me to do or I feel like I can do *–BIPOC participant #1* "I can call out acts of racism to my peers, to my faculty, to the people around me. I can engage with learners and talk about these concepts that we learn." *–BIPOC participant #3*
Impact on workplace	"My hope is that these sorts of things continue whether it's in the WWAMI region or in another academic setting where I work, and being able to have these conversations and create safe space, not just for physicians, but also kind of you know our staff and MAs, and other ancillary people." *–BIPOC participant #4* "If you want to be a provider who cares for somebody who is of a different race than yourself, these are crucial elements and crucial conversations, and you know crucial explorations of your own identity that then are relayed into how you interact with patients who are different racial backgrounds from yourself." *–White participant #1*
Unintended harms	"There's always the fear that what [was] said in RAC leaves RAC, or that it comes back around to your leadership." *–BIPOC participant #4* "Before I figured out that it was BIPOC only and the White group separately, I was kind of nervous about what it would look like if they were together. And then my hesitation afterwards was 'Oh, what's being discussed in the non-BIPOC group, White group?'" *–BIPOC participant #1*

Abbreviations: BIPOC, Black, Indigenous, or Person of Color; FMRN, Family Medicine Residency Network; MA, medical assistant; RAC, racial affinity caucusing; WWAMI, University of Washington School of Medicine's multistate medical education program (Washington, Wyoming, Alaska, Montana, Idaho)

developed a start list of codes representative of study aims and constructs of the modified theory of change noted earlier.[6] The start list was applied to a subset of interviews, refined, and finalized. Each interview was independently coded by two team members. Intercoder reliability was assessed subjectively. Discrepancies were resolved during study team meetings. The study was determined exempt from institutional review board review by the University of Washington Human Subjects Division.

RESULTS

Quotes

Out of the 30 trainee participants, 8 (7 BIPOC, 1 White) participated in interviews. Table 2 highlights the themes raised with exemplary quotes. All interviewees expressed several of the themes:

- Safe space: "a place to express their kind of intimate and vulnerable emotions around white supremacy" – *White participant*
- Self-reflection: "the experience has taught me not to keep doubting myself when I have interactions that didn't feel right, or I know [were] wrong." *–BIPOC participant*
- Behavior change: "There are certain things that . . . RAC has taught me, like macroaggressions and microaggressions. Being able to call it out in front of an aggressor. That has been something . . . RAC has empowered me to do." *–BIPOC participant #1*

The themes primarily were centered around the trainee experience of RAC and were tied to the short-term outcomes in the theory of change model.

Beyond the short-term outcomes, some discussed how their RAC experience would impact their patient care. A White participant said, "[RAC] is not for yourself. It is a necessity . . . if you want to be a provider for someone who is of a different race." A BIPOC participant reflected, "[RAC] is a good way to . . . hear about [the] trauma of racism to help get a better perspective, especially as someone who is going to be a doctor taking care of humans from all different backgrounds."

DISCUSSION AND CONCLUSIONS

The themes (Table 2) from this pilot study aligned with our hypothesized short-term outcomes for trainees in our framework (Figure 1), such as safe space, self-reflection, and concept of race/racism. This outcome aligns with existing literature[7] and suggests that RAC may have similar benefits in GME. We observed themes around behavior change, which could be an indication of movement toward intermediate-term RAC outcomes (Figure 1). Specifically, participants reported that RAC gave them language and empowerment, like how to "call out acts of racism to my peers, to my faculty, to the people around me" (BIPOC participant). This finding aligns with other reported experiences as well.[8] We expected to hear more about the link to larger institutions, but that was rarely mentioned during interviews except in the context of RAC changing a trainee's approach to patient care and self-reflection, possibly because our study spanned only 1 year. If RAC is implemented for longer, the impact could be amplified; a previous study with family medicine faculty indicated that increased exposure can improve the perception of RAC.[9]

Our sample was subject to response bias; RAC participation was self-selected, and participants may not represent the general trainee population. In particular, we were not able to reach theoretical saturation in our analysis for the White participants; this is consistent with the lower participation from White trainees. We hypothesize that White trainees who may not have experience examining their own race are more likely to be intimidated by RAC and have less perception of the potential benefit. Further studies could explore how to engage White audiences more effectively.

Our findings underscore the potential of RAC not only for advancing antiracism efforts at an institutional level, but also for the well-being of BIPOC trainees. RAC provides a crucial space for psychological safety and community building, which are vital for the personal and professional development of BIPOC individuals. Given the novel context of multi-institutional RAC in a GME training setting, we believe that our findings build on a theoretical framework for RAC in GME and leave space for future studies.

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