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One Size Does Not Fit All: Implementation of an Equitable and Inclusive Strategic Response to Address Needs of Pediatric Resident Physicians during the Coronavirus Disease 2019 (COVID-19) Crisis

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The coronavirus disease 2019 (COVID-19) crisis has the potential to amplify an already-unequal stress on resident physicians who belong to groups underrepresented in medicine (based on race, ethnicity, socioeconomic status, LGBTQIA+ identity, or disability).[1-3] These groups experience challenges in residency training, including incidences of microaggressions and bias; feelings of isolation; and personal, professional, and financial hardships, all of which may be exacerbated in times of crisis.[3,4] Taking this into account, the residency-wide COVID-19 strategic response was created and reviewed through a lens of equity and inclusion to ensure it addressed the diverse needs of resident physicians in a large pediatric residency program. We describe the creation of this equitable and inclusive strategic response, lessons learned that remain relevant beyond the pandemic, and suggestions for further areas of work.

Approach

As our program worked to develop a residency-wide strategic response to the COVID-19 crisis, a planning committee of program leadership, faculty, and chief residents was convened. Four of 14 of the committee members (29%) were from backgrounds underrepresented in medicine. The aim of this committee was to evaluate and amend the residency-wide crisis response to ensure it explicitly addressed pediatric residents who might be disproportionately affected by the pandemic due to new or exacerbated stresses (personal, financial, and work-related). To better understand the needs of these residents, we solicited input from our hospital's Office of Health Equity and Inclusion and reviewed published resources describing inclusive solutions during times of crisis.[3] We also sought to understand individual needs by encouraging residents to submit requests directly to chief residents, program leaders, or anonymously via an electronic submission system. After identifying these needs, the committee then reviewed the residency-wide COVID-19 response and added specific supports meant to address the unique needs of those who could be disproportionately affected. The final equitable and inclusive COVID-19 strategic response was distributed to all residents electronically to ensure that any resident needing additional support could take advantage of the resources, given specific needs are difficult to predict.

Outcomes to Date

The planning committee found that the residency-wide COVID-19 response contained many comprehensive resources to benefit all residents. It included supports to meet basic needs (eg, providing meals, housing, transportation), mental health services, changes to the staffing model, and the transition to virtual platforms for educational conferences and clinical care. However, 5 domains were identified as needing additional support to adequately meet the unique needs of residents disproportionately affected by the crisis. These 5 domains are detailed in the paragraphs to follow.

1. *Financial assistance.* Recognizing that a crisis can create new or amplify existing financial hardships for residents and their families, we proactively opened 2 emergency funds (one residency and one hospital fund) for residents experiencing financial stress. Three residents applied for and received financial assistance. Moreover, we prioritized continuing access to free lunches for all residents, even as distribution plans needed to change due to social distancing, recognizing that some residents rely on these meals in their budget. Similarly, we advocated for free hospital parking because of limited access to safe methods of public transportation. Free hospital housing also was provided as an option for residents needing to quarantine away from household members at high risk for COVID-19 and its complications.
2. *Additional mental health supports.* We anticipated that the added emotional and physical stress and

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disruptions in access to usual support systems could add stress or exacerbate mental health conditions, especially for marginalized groups. For example, racial and ethnic minorities and members of the LGBTQIA+ community often encounter microaggressions or overt discrimination in the healthcare setting.[5,6] Residents, their families, and partners belonging to these groups may also have increased fears of falling ill from COVID-19 and being subjected to bias by providers or the healthcare system. In addition to ensuring 24/7 access to mental health support via virtual visits and comprehensive health and wellness resources (eg, exercise classes, meditation, and mindfulness guides) for every resident, we also used this time to redistribute institutional and program policies on maltreatment and discrimination to residents and faculty. These policies outline zero tolerance for these behaviors and delineate how residents can report events.

3. *Accessibility.* We reviewed accommodations for residents with disabilities to ensure that this crisis did not impede their access to communication or ability to provide clinical care. For instance, to ensure that residents who are deaf or hard-of-hearing and read lips could communicate with teams wearing personal protective equipment, clear surgical masks were distributed during rounds. In addition, closed-captioning was used for virtual seminars. Furthermore, we asked residents whether they had access to reliable home computers and internet connections required for telemedicine, virtual education, and residency meetings. We committed to supplying these resources if needed, although no resident required them.
4. *Scheduling flexibility.* We created a short-term virtual work option for residents facing extenuating health risks for themselves or loved ones as a result of COVID-19 (eg, older family members in multigenerational homes, chronic health conditions of residents or partners, pregnancy or young infants at home). Seven residents met with program leadership to discuss this short-term virtual work option and 5 opted into the rotation.
5. *Curricular changes.* When longstanding health inequities related to race/ethnicity and socioeconomic status were exposed by COVID-19, three resident-led seminars were created on these topics and prioritized in the existing virtual seminar schedule.

Discussion

Despite many competing interests during COVID-19, we worked to prioritize our commitment to equity, diversity, and inclusion by creating a "one-size-does-not-fit-all" crisis response to serve the needs of our diverse resident community. We believe we were successful in being intentional in our efforts, using creative solutions within our available resources, and eliciting broad perspectives.

It is known that crises often affect marginalized groups disproportionately.[3] Hence, we deliberately set out early in the COVID-19 pandemic to proactively anticipate, solicit, and address residents' needs before they manifested. We focused on creative solutions and the use of available resources. For example, we were able to provide financial assistance to residents by deploying a fund that existed to support work-family balance. To incorporate broad perspectives, we elicited input from residency leaders, chief residents, and our hospital's Office of Health Equity and Inclusion, while also encouraging residents to submit requests for their needs. Obtaining diverse opinions from key stakeholders has been shown to be a successful strategy for creating equitable and inclusive solutions.[3] Razack and Philibert further advocate for using the resident voice in decision-making.[7] They suggested that inclusive medical training programs "display the courage to co-create with their learners" and minimize hierarchical decision-making.[7] In creating our crisis response, the chief residents were directly involved and all residents were encouraged to submit anonymous or nonanonymous requests. This approach allowed individuals, including residents underrepresented in medicine, to express needs we may not have anticipated without the burden of being identified. Further understanding how to successfully incorporate the resident voice into our decision-making remains a work in progress and a priority for our residency program. It is also important not to place an undue burden on residents underrepresented in medicine to be the voice for their entire communities. Our next step is to survey all residents on this crisis response to determine if initiatives were successful in alleviating the stress caused by the pandemic and adjust the crisis response accordingly.

Ultimately, our goal in sharing the development of this strategic response is to encourage other educational leaders to abandon "one-size-fits-all" solutions to residents' needs. This approach has implications beyond the pandemic in creating training environments that are inclusive and equitable. Shore et al defined inclusion as institutional practices, policies, and actions that promote a high sense of belonging among individuals within the organization, and at the same time recognizing and embracing individuals' uniqueness.[8] Consequently, to build an inclusive residency training environment that promotes a culture of belonging, leaders must seek to understand their residents' individual experiences and hardships, while anticipating how additional factors (eg, a crisis) may impact them. Leaders must be especially attuned to the distinct challenges faced by residents underrepresented in medicine. These include, but are not limited to, frequent episodes of microaggressions and bias, being seen as "other," feelings of isolation, difficulties negotiating personal and professional identities, as well as financial hardships.[3,4] Failing to recognize these existing challenges poses a serious threat to creating inclusive solutions to address residents' needs, which must be assessed in the context of their personal, social, cultural, and

institutional environments. In the same way that we cannot expect a treatment plan to work for every patient with diagnosis "X," we cannot expect a "one-size-fits-all" solution to meet every individual resident's needs. Only after adopting a "one-size-does-not-fit-all" framework, can we begin to achieve equity in our training environments, where solutions and opportunities are accessible to all.

Conclusions

Program leaders, as they respond to this crisis, the next, and the seasonal challenges of residency leadership, should work intentionally toward crafting equitable, inclusive, and actionable solutions. Whenever possible, these solutions should be proactive rather than reactive, anticipating residents' needs before they arise. Using this intentional, forward-thinking approach, we can advance our mission of recruiting and training the next generation of diverse physicians, while promoting equitable and inclusive training environments that embrace the principle, "one size does not fit all." ■

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