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Collaborative Model of Listening and Learning Between Trainees and Faculty to Enhance Bias Awareness in Medicine

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Abstract

Introduction: Graduate medical training programs recognize the importance of education and training on how structural factors affect health but often face challenges on how best to develop and implement these curricula. Two Executive Orders implemented in January 2025 impose limitations on federal programs supporting diversity, equity, and inclusion. While many residency programs had health equity curricula that were already in accordance with federal law and institutional policies, some wondered how to maintain open dialogues in these areas.

Methods: We developed a curricular intervention, called Listening and Learning sessions (L&Ls), at a combined internal medicine-pediatrics residency program in 2020 to increase awareness of bias and inequities in healthcare among faculty and trainees. Unique features included a combined faculty and trainee committee and a shared space for facilitated dialogue on structural bias in medicine and health disparities. Residents rated the effectiveness of the L&Ls in achieving eight curricular goals on annual program surveys from 2021 to 2026; responses were analyzed descriptively.

Results: Over six years, the intervention included 21 L&Ls, five community events, and four book clubs. Annual survey response rates ranged from 21% (5/24) to 54% (13/24), totaling 46 surveys. Across all goals and survey years, 96% of resident ratings (286/299) described the L&Ls as somewhat or very effective. Goals most often rated very effective were increasing self-awareness of bias and awareness of systemic bias (82% each); the goal most often rated not effective was building relationships with community advocacy organizations (11%).

Conclusion: A faculty-trainee collaborative model for facilitated discussion of bias awareness and health equity was feasible and consistently well received by residents over six years. This model may be particularly suited to smaller programs, such as medicine-pediatrics, and to programs seeking open dialogue and bi-directional learning between residents and faculty. Because it focuses on conversation-based learning to improve patient care, this curriculum required no revisions to remain compatible with recent federal and institutional policy changes.

Categories: Medical Education, Pediatrics, Internal Medicine
Keywords: bias identification, graduate medical education (gme), health equity and disparities, medical education curriculum, med-peds residency

Introduction

Social and structural factors and implicit bias have negative health effects on historically marginalized populations, including shorter life expectancy, increased infant mortality, higher prevalence of mental health disorders, and poor control of chronic diseases [1-4]. As part of the Accreditation Council for Graduate Medical Education (ACGME) Common Program Requirements (2.6.b. and 4.9), it is an expectation that all residency training programs in the United States educate trainees on social determinants of health (SDOH) "with the ultimate goal of addressing these needs and eliminating health disparities" [5]. A challenge graduate medical programs face in developing such curricula is how to create an environment that brings forth evidence on health disparities, acknowledges uncertainties on how best to support patients in the context of the inequities, and promotes dialogue among faculty and trainees on these topics [6]. It is equally challenging to implement curricula acceptable to all trainees in a given program, as individuals come from different backgrounds, have varied life experiences and baseline knowledge of health disparities, as well as place different values on formal health equity curricula.

The existing medical literature describes feasible, reproducible health equity curricula across graduate medical education (GME) [6-13]. Examples include integrated health equity threads or mini-courses, health equity rounds, and representation in educational conferences [8-10]. Some involve fostering academic-community partnerships to facilitate social justice dialogue, interventions, and curricular development [11-

13]. Despite these efforts, didactics alone may not adequately prepare residents to mitigate bias and address gaps in care related to racism [14,15]. As an example, workshops have been noted to only have transient improvement in knowledge and behavior, underscoring the need for longitudinal reinforcement [16]. However, even longitudinal conference series, though evaluated favorably, have fallen short of the expectations of residents desiring concrete, action-oriented content [17]. In addition, although faculty trainings have also been implemented to appropriately prepare faculty to lead or facilitate curricula on health equity, few involve faculty and trainees learning or training together [18].

In 2020, our program and core faculty were challenged with addressing the dual pandemics of COVID-19 and systemic racism. Few available curricula addressing bias in medicine provided a framework to promote an environment of bi-directional dialogue and learning among faculty and trainees. As such, we developed the Engagement & Inclusion (E&I) committee of residents and faculty committed to a renewed approach in recognizing systemic biases and inequities in our community by promoting reflective dialogue through Listening and Learning sessions (L&Ls).

In January 2025, Executive Orders (EO) 14151 and 14173 altered the federal policy environment surrounding diversity, equity, and inclusion (DEI) initiatives [19,20]. Executive Order 14151 directed federal agencies to terminate DEI programs and related activities, while EO 14173 emphasized enforcement of federal anti-discrimination laws and restricted race- and sex-based preferences in federal programs, contracting, and other institutional activities. These actions prompted many academic medical institutions to reassess the terminology, structure, and implementation of existing DEI initiatives. Importantly, the orders do not prohibit education regarding health disparities, SDOH, or equitable patient care. In this context, our E&I Committee continued the L&Ls without modification, given their focus on evidence-based, equitable patient care. Our aim is to describe the development and six-year implementation of a collaborative faculty-trainee curriculum and to evaluate its feasibility and residents' perceptions of its effectiveness in promoting awareness of bias and health equity.

Materials And Methods

Intervention

The E&I committee aimed to enhance understanding of health equity and foster a culture of inclusion in which residents and faculty experience belonging, engagement, and bi-directional learning. The E&I committee's main objective was to implement L&Ls-group meetings that provided a space where faculty and trainees could discuss key topics in health equity, learn from one another, and debrief relevant patient encounters or life experiences to understand the impact of systemic biases in our community and how they affected the ability to care for patients. Ultimately, the L&Ls were designed not only to share experiences but also to learn concrete action items to improve patient care.

The L&Ls were open to all trainees of the combined internal medicine-pediatrics (med-peds) residency program (n=24), med-peds program leadership (n=3), and med-peds clinic faculty members who interacted with residents longitudinally in their continuity clinic (n=6). Participation was encouraged but not required; faculty and guest participant involvement was voluntary and not compensated. The number of attendees per session was tracked. The intervention program is the Duke University Medicine-Pediatrics Residency Program, located in Durham, NC. The study period is from March 2020 to June 2026.

Topics were selected by the E&I committee and facilitated by a designated faculty or resident. The L&Ls occurred during evenings every two to three months and lasted 60-90 minutes. Selected topics are included in Table *1*; relevant preparatory materials were shared in advance of some sessions. Facilitation was most often done by faculty leaders, especially to reduce leading questions and bias in some more sensitive topics. It is important to note that while discussion questions (available by request) were prepared ahead of time for most sessions, natural dialogue sometimes would deviate from the initial agenda. The goal of facilitation was to lead a group of trainees and faculty in open-minded discussion and reflection to improve patient care. The majority of L&Ls were virtual conversations; however, an annual community-based trip and an equity-focused book club were incorporated as well. The community-based trip provided an opportunity to learn how health disparities were shaped by the history of the area and how patient perspectives were impacted by visiting locations directly affected. Since the intervention is curricular design, our institutional IRB declared it as non-human subject research, IRB ID Pro00121362.

Academic Year[a]	Listening and Learning Sessions	Other Activities
2021	Effectively addressing racial inequality	Community trip to a former plantation
	COVID-19 disparities in LatinX populations	
	Guest speaker: Local police officer	
	Discrimination in academic institutions	
	Asian Americans misconceptions and bias	
2022	Vaccine hesitancy (in non-White populations)	-
	Stigmatizing language	
	Increasing diversity in clinical trials	
	Local pioneers and trailblazers in social justice	
	Microaggressions	
2023	Upstander training	Walking tour of the city (with medical historian)
	Anti-ableism	Book Club: “The Best of Enemies: Race and Redemption in the New South” by Osha Gray Davidson
	Women’s health equity: Abortion rights	-
2024	Medical misconceptions	Walking tour of the city (with medical historian)
	Weight bias	Book Club: “Sissy: A Coming of Gender Story” by Jacob Tobia
	Native and Indigenous bias	-
2025	Post-election 2024 discussion[b]	Visit to a local history museum
	“Heartsink” in clinic[c]	Book Club: “Demon Copperhead” by Barbara Kingsolver
2026	Patient Family Panel	Walking tour of the city (with medical historian)
	Immigration Enforcement[d]	Book Club: “Rough Sleepers” by Tracy Kidder
	Discussion with Medical Interpreters	-

TABLE 1: Engagement and Inclusion Committee Activities 2020–2026

a: Academic year corresponds to July–June of year X (e.g., 2021 is July 2020–June 2021)

b: Facilitated generic bipartisan questions reflecting on anticipated changes to healthcare after a major national election

c: Heartsink refers to a variety of complex feelings when preparing for certain patient visits in the clinic

d: Facilitated questions about immigration enforcement effects on the clinic patients and local community

Evaluation

Eight quantitative questions were embedded into the annual program surveys sent to the 24 med-peds residents in the spring each year (Table 2, which includes exact wording of the goals in the surveys), starting in 2021. These program surveys include questions on specific curricula, rotations, and other educational activities, as well as feedback on specific leadership and staff. The full surveys are not included because they

contain program-specific content (i.e., evaluations of rotations, faculty, staff) deemed irrelevant for publication. The survey questions were developed by the study team to assess residents' perceptions of curricular objectives, behavior change, and impact on patient care; to our knowledge, there is no validated study tool we could utilize or model. The annual program surveys are e-mailed to each resident and are anonymous and confidential. While most residents fill out part of the survey, they may omit certain components or sections. Qualitative feedback was gathered through informal debriefings after sessions as well as free text responses on the survey, mostly to guide future topics.

Statistical analysis

Resident survey responses were analyzed descriptively. For each item, we calculated the number and percentage of residents rating the L&Ls very effective, somewhat effective, or not effective, pooled across all six survey years. To describe ratings over time, responses to all eight items were combined within each survey year and summarized as the percentage of ratings that were very effective and the percentage that were somewhat or very effective. "Unable to assess" and blank responses were excluded from denominators. Because surveys were anonymous and residents could respond in more than one year, responses could not be linked across years, and counts reflect ratings rather than unique residents. Given the small number of respondents in each year, inferential statistical testing was not performed. Demographic data were not collected to protect the anonymity of responses on the end-of-year survey. Feasibility was assessed by the number and type of sessions delivered, attendance, and continuity of the program over the study period.

Results

Between May 2020 and June 2026, the E&I committee hosted 21 L&Ls, five community events, and four book clubs (Table *1*). Attendance ranged from 4 to 15 attendees per session. Of 24 eligible residents per year, between 5 (21%) and 13 (54%) responded to the end-of-year program survey for 46 surveys over six years; 39 of these included ratings of at least one L&L item. Because we did not collect demographic data, we are uncertain how many unique residents are represented. Across all items and years, 96% of ratings (286/299) described the L&Ls as somewhat or very effective (Table *2*, Figure *1*). The goals most often rated as very effective were increasing self-awareness of implicit and explicit bias (82%) and increasing awareness of systemic biases (82%). The goal most often rated not effective was creating relationships with community advocacy organizations (11%). The percentage of ratings that were somewhat or very effective remained between 93% and 100% in every survey year (Figure *2*). The percentage rated very effective ranged from 65% to 89% from 2021 to 2025 and was 26% in 2026 (five respondents), when most ratings shifted to somewhat effective. Year-by-year ratings for each item are shown in Supplementary Figure *3*.

Question Theme[a]	Question Text	n[c]	Very Effective, n (%)	Somewhat Effective, n (%)	Not Effective, n (%)	Unable to Assess, n
Bias awareness	The L&Ls[b] increased self-awareness of implicit and explicit bias	38	31 (82%)	6 (16%)	1 (3%)	1
Systemic bias	The L&Ls increased awareness of systemic biases in medicine and community and how that affects our patients and colleagues	38	31 (82%)	7 (18%)	0 (0%)	1
Mistreatment	The L&Ls improve ways to address mistreatment	37	22 (59%)	14 (38%)	1 (3%)	2
Address bias	The L&Ls increased confidence to address biases in the moment	39	28 (72%)	9 (23%)	2 (5%)	0
Community relationships	The L&Ls create relationships with advocacy organizations in our community	37	23 (62%)	10 (27%)	4 (11%)	2
Health equity	The L&Ls help address inequities in healthcare	38	22 (58%)	14 (37%)	2 (5%)	1
Initiative engagement	The L&Ls increased awareness of departmental and institutional-level initiatives for equity and inclusion	38	27 (71%)	10 (26%)	1 (3%)	1
Recruitment interest	The L&Ls improve interest in our program by students from all backgrounds	34	22 (65%)	10 (29%)	2 (6%)	5

TABLE 2: Resident Ratings of Listening and Learning Session Goals, 2021–2026

a: Residents rated how effective the L&Ls were at achieving each goal: very effective, somewhat effective, not effective, or unable to assess. The Question Theme and Text are presented in order and exactly as they appeared in the surveys.

b: L&Ls = Listening and Learning sessions

c: n = number of ratings for each item pooled across six annual surveys, excluding "unable to assess" and blank responses. Residents could respond in more than one survey year, so n reflects ratings rather than unique residents.

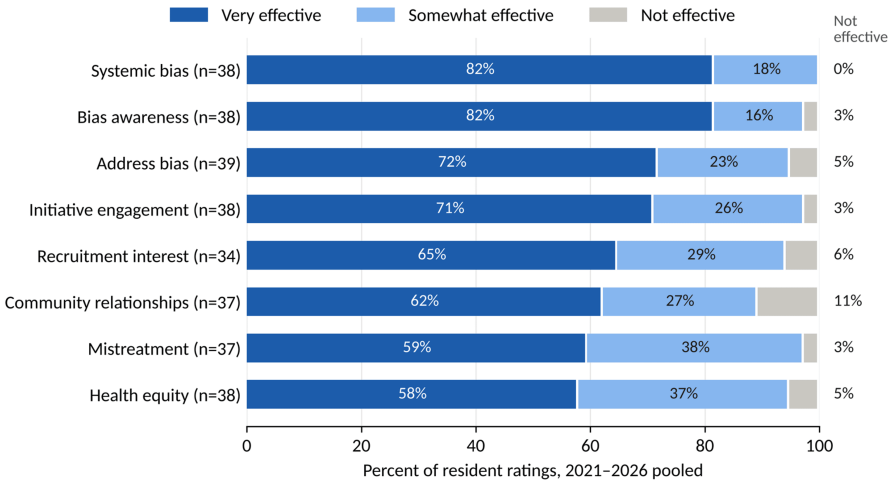


FIGURE 1: Resident Ratings of Each Listening & Learning Session Goals, Pooled 2021–2026

Percentage of resident ratings of very effective, somewhat effective, or not effective for each goal, ordered by the percentage rated as very effective. n = ratings excluding "unable to assess" and blank responses.

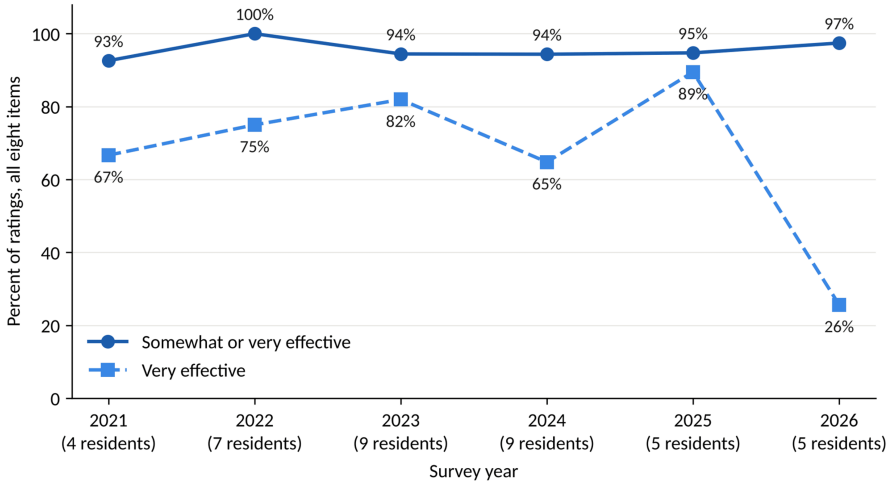


FIGURE 2: Resident Ratings of Listening and Learning Session Goals by Survey Year

Percentage of ratings across all eight items that were somewhat or very effective (solid line) and very effective (dashed line) in each survey year. The number of residents rating at least one item is shown below each year. "Survey year" refers to the spring of the academic year (e.g., 2021 = 2020–2021).

Discussion

Overall, the L&Ls have created a forum of education and dialogue around topics of health equity, bias, and inclusion and have been positively perceived by residents. The goals most often rated as very effective were increasing self-awareness of implicit and explicit bias and increasing awareness of systemic biases in medicine (82% each), suggesting residents perceived the sessions as most helpful in promoting awareness of bias.

Resident ratings were consistently favorable across six years: in every survey year, 93% to 100% of ratings described the L&Ls as somewhat or very effective (Figure *2*). The proportion of “very effective” ratings fell to 26% in 2026, when most ratings shifted from “very effective” to “somewhat effective” rather than to “not effective.” This change should be interpreted cautiously. The 2026 results reflect only five respondents, so a single resident’s ratings substantially alter annual percentages, and because responses were anonymous, we cannot determine whether this shift reflects differences between resident cohorts, changes in session topics or format, or chance variation. Continued monitoring in future years will be needed to determine whether this represents a meaningful trend.

To our knowledge, this is the first GME health equity curriculum evaluated continuously for more than three years. Although longitudinal health equity curricula spanning "months to years" with facilitated dialogue and resident leadership have been suggested as best practice, there have been no published reports of such programs tracked longitudinally [21]. The few studies reporting serial data are shorter and often show behavior scores dropping over time [16] or self-reported knowledge of SDOH dropping over time [22], prompting a call for longitudinal reinforcement by the authors Nwora et al. [16]. The consistently favorable ratings across six survey years support the L&Ls as a feasible model for other programs to consider.

Importantly, we have also demonstrated a health equity curriculum that required no changes in response to the recent EOs. The L&Ls remain compatible with new federal law and institutional policy by focusing on bi-directional, conversation-based learning to improve patient care via enhanced recognition of bias and health disparities.

A unique feature of this intervention is the collaboration between trainees and faculty, both of whom are represented on the E&I committee and invited to participate in major activities such as L&Ls. A major motivation for our specific L&L design was that our residents did not feel they were able to engage meaningfully in institution or system-level discussions and interventions about bias and racism in medicine. The L&Ls were designed to give residents a space to share experiences, debrief complex topics in healthcare, and engage directly with faculty in these conversations. Trainees have also become empowered to facilitate sessions, championing topics meaningful to them. This includes topics of political structures in women’s health, general access to care, and other historically marginalized populations, which often do not have formal educational spaces in training curricula.

We believe this program succeeded in part because it occurred in a med-peds residency program. The relatively small size of the program (24 residents, six clinic faculty, and three program leadership) allowed for more intimate, trusting conversations. While conversation-based learning could work with larger groups, it does decrease the amount of time for each participant to share or ask questions. Another reason why it has been sustainable is because residents may choose all or part of the curriculum based on their interests in specific topics. Trainees at our institution have other means of enhancing their knowledge of health disparities, including traditional lectures and separate training tracks. The option of a conversation-based curriculum may appeal to some residents, and other institutions may consider building similar choices in health equity content.

Advantages of this model are its low cost and ease of implementation. Though this residency training program is relatively small, a larger program could implement this model with little strain on current curricula or budget. It also may appeal to programs hoping to promote health equity education without relying on institutional experts; these proposed sessions accomplished educational goals with one facilitator per session, most of whom having intermediate knowledge and experience in this field, but advanced skills in facilitation as academic physicians. Virtual sessions created accessibility to maximize participation, though other programs might find benefits to hosting these dialogues in-person. The annual community trip allowed residents to learn about the history of the area and community to better understand the populations they serve.

This study has several limitations. The sample size was small: 24 residents were eligible each year, surveys were not incentivized, and annual response rates ranged from 21% to 54%, so respondents may have differed from non-respondents. We also lack any data from faculty participants. Because surveys were anonymous, we could not link responses to L&L attendance or identify residents who responded in multiple years. The survey items were developed by the study team and have not been validated, and ratings reflect residents' perceptions of effectiveness rather than measured changes in knowledge, behavior, or patient outcomes. Concurrent departmental and institutional health equity efforts may also have influenced responses, particularly in early years. In addition, we used a simplified three-point rating scale because we felt any perception of ineffectiveness would be cause for concern; this limited our ability to distinguish degrees of effectiveness, and we plan to adopt a traditional five-point Likert scale in future surveys. It is unclear how this model would perform in a larger residency program; however, we believe its advantages - collaboration among faculty and trainees, low cost, and flexible scheduling - could translate to programs with a larger pool of attendees.

The study highlights an area of improvement for the E&I committee, as building relationships with community advocacy organizations received the highest proportion of "not effective" ratings (11%). Implementing a longitudinal community partnership was not among the program's initial goals; however, we have since made efforts for future potential partnering with community organizations. Other institutions may utilize this opportunity to engage and learn from community-based experts.

Conclusions

In conclusion, implementing shared-space E&I dialogue among faculty and trainees provided a sustainable educational approach that residents consistently rated as effective in promoting awareness of bias and inequities in healthcare. This format was feasible and low cost to implement. Importantly, this is one example of a health equity curriculum that can continue without modifications after federal or institutional policy changes. With fewer institutional opportunities available, this model allows for continued conversations on how health equity can affect patient care. Training programs, specifically med-peds residency programs, could consider adopting similar low-cost, high-reward interventions that engage trainees and faculty in shared learning and dialogue as a replacement or enhancement to current health equity curricula.

Appendices

Supplementary material

Question Theme[a]	2021[b]	2022	2023	2024	2025	2026	All years
Residents rating ≥1 item / surveys returned	*4/5*	*7/9*	*9/13*	*9/9*	*5/5*	*5/5*	*39/46*
Bias awareness	75% (4)	83% (6)	100% (9)	78% (9)	100% (5)	40% (5)	**82% (38)**
Systemic bias	100% (4)	83% (6)	100% (9)	78% (9)	100% (5)	20% (5)	**82% (38)**
Mistreatment	50% (4)	67% (6)	67% (9)	67% (9)	75% (4)	20% (5)	**59% (37)**
Address bias	75% (4)	71% (7)	89% (9)	67% (9)	80% (5)	40% (5)	**72% (39)**
Community relationships	33% (3)	86% (7)	89% (9)	44% (9)	60% (5)	25% (4)	**62% (37)**
Health equity	33% (3)	57% (7)	67% (9)	56% (9)	100% (5)	20% (5)	**58% (38)**
Initiative engagement	67% (3)	71% (7)	78% (9)	78% (9)	100% (5)	20% (5)	**71% (38)**
Recruitment interest	100% (2)	83% (6)	67% (9)	50% (8)	100% (4)	20% (5)	**65% (34)**

FIGURE 3: Percentage of Residents Rating Each L&L Goal Very Effective, by Survey Year

a: Cells show the percentage of residents rating the goal as very effective (number of residents rating the item, excluding "unable to assess" and blank responses). Question text for each theme is listed in Table 2. Shading: darkest ≥90%; medium 70–89%; lightest 50–69%; unshaded <50%.

b: Survey year refers to the spring of the academic year (e.g., 2021 = 2020–2021). Annual percentages are based on small numbers of respondents and should be interpreted with caution; a single response changes a cell by 11–50 percentage points.

c: L&L = Listening and Learning session

Additional Information

Author Contributions

All authors have reviewed the final version to be published and agreed to be accountable for all aspects of the work.

Concept and design: Christopher Prater, Jane Trinh, Colby Feeney, Edward Evans, Samantha Collins, Joseph Goddu

Acquisition, analysis, or interpretation of data: Christopher Prater

Drafting of the manuscript: Christopher Prater, Jane Trinh, Colby Feeney, Edward Evans, Samantha Collins, Joseph Goddu

Critical review of the manuscript for important intellectual content: Christopher Prater, Jane Trinh, Colby Feeney

Supervision: Christopher Prater

Disclosures

Human subjects: Informed consent for treatment and open access publication was obtained or waived by all participants in this study. **Animal subjects:** All authors have confirmed that this study did not involve animal subjects or tissue. **Conflicts of interest:** In compliance with the ICMJE uniform disclosure form, all authors declare the following: **Payment/services info:** All authors have declared that no financial support was received from any organization for the submitted work. **Financial relationships:** All authors have declared that they have no financial relationships at present or within the previous three years with any organizations that might have an interest in the submitted work. **Other relationships:** All authors have declared that there are no other relationships or activities that could appear to have influenced the submitted work.

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