ASIDE Health Sciences

Original Article

# Perceived Roles of People Resource Groups in Cultural Awareness and Community Building: A Qualitative Interview Study in the U.S. Health System

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ARTICLE INFO

Article history:
Received 27 Jan. 2026
Received in revised form 28 Apr. 2026
Accepted 5 May 2026
Published 24 Jun. 2026

Keywords:
People Resource Groups (PRGs)
Cultural Competence
Diversity, Equity, and Inclusion (DEI)
Organizational Culture
Medical Education

ABSTRACT

**Background:** Persistent inequities and the underrepresentation of marginalized groups in healthcare have been described as undermining workforce inclusion and patient experiences. People Resource Groups (PRGs) aim to support peer connection and institutional engagement; however, their roles in healthcare remain insufficiently characterized. This study examined how PRG members perceived their participation as contributing to cultural competence, equity, belonging, and professional identity within a healthcare organization.
**Methods:** Semi–structured interviews were conducted between April and November 2024 with seven members of two PRGs: FIRST Peoples (Indigenous) and Honor in Pride (LGBTQIA+). Interviews explored members' experiences and perceived impacts of PRG participation. Data were analyzed using primarily deductive thematic analysis guided by the Campinha–Bacote model of cultural competence (awareness, knowledge, skill, encounters, and desire), while allowing for inductive insights. Findings reflect participant perspectives rather than measured clinical or organizational outcomes.
**Results:** Four themes emerged. Participants described experiences of cultural invisibility in the workplace. They perceived that PRG participation supported cultural humility and inclusive communication, which they associated with strengthened physician–patient relationships. Participants described PRGs as fostering belonging and cross–cultural solidarity and attributed increased confidence to engage in organizational initiatives to this participation. They emphasized the need for leadership support, protected time, and structural flexibility, noting limitations related to underfunding and inconsistent institutional integration.
**Conclusions:** PRG members perceived that participation supported cultural competence, belonging, and engagement within their organization. These findings represent member perspectives and warrant further study across settings.

## 1. Introduction

Indigenous and LGBTQIA+ communities in the U.S. experience persistent health disparities rooted in historical trauma, structural inequities, and systemic prejudice, underscoring the need for healthcare environments that address structural barriers alongside clinical care [1–4]. Prior scholarship and participant narratives describe how health equity is shaped not only by clinical interventions but also by the cultural, structural, and relational contexts in which care is delivered, with implications for trust, continuity, and perceived quality [5–7]. Healthcare systems have increasingly pursued more inclusive environments through community – building initiatives intended to support both patient experience and workforce wellbeing [8–10].

One organizational strategy increasingly adopted across sectors is the use of People Resource Groups (PRGs), also referred to as employee or affinity resource groups. We intentionally use the term People Resource Group (PRG) rather than the more common Employee Resource Group (ERG) or affinity group to reflect this organization's emphasis on seeing beyond the employee role to center the whole person, recognizing individuals as human beings with lived experiences and identities that extend beyond formal employment, while also highlighting reciprocal resource-sharing, educational contribution, and institutional engagement rather than solely employee affiliation or social identity. In corporate settings, PRGs have been described as supporting employee engagement, mentorship, leadership development, and retention, as well as informing organizational culture and policy [11, 12]. In healthcare, however, the published literature is more limited and primarily consists of descriptive reports on group formation, recruitment initiatives, or mentorship structures rather than empirical examinations of members' experiences or perceived institutional impact. While healthcare PRGs are not absent from the literature, their experiential influence within clinical institutions, particularly regarding workforce belonging, professional identity development, and educational engagement, remains insufficiently characterized [3, 13, 14].

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Published and owned by PubPorta Publishing LLC. Academic oversight and scholarly guidance are provided by the American Society for Inclusion, Diversity, and Equity in Healthcare (ASIDE). ISSN (Print) 3067-8730, ISSN (Online) 3067-8749. 

Citation: Brocchini J, Seema Jain, Dana Sall, Dr. PR. Perceived Roles of People Resource Groups in Cultural Awareness and Community Building: A Qualitative Interview Study in the U.S. Health System. ASIDE Health Sci. 2026;2(3):24-34, doi:10.71079/ASIDE.HS.062426542

This study explored how members of two interprofessional PRGs within a not – for – profit health system in Arizona perceived PRG participation as influencing their professional development, sense of belonging, and engagement in inclusive educational initiatives. In 2022, our institution received an American Board of Internal Medicine grant, "Building Trust through Diversity, Health Care Equity, and Inclusion in Internal Medicine Training," to strengthen care for Indigenous and LGBTQIA+ communities. As part of this effort, two PRGs were launched: FIRST (Fostering Indigenous Representation through Service and Tradition) Peoples and Honor in Pride (HIP), groups for Indigenous and LGBTQIA+ employees and allies, respectively. PRG activities included collaborating with the Internal Medicine residency program to co – develop curricula on Indigenous and LGBTQIA+ health, as well as advocacy and inclusion – focused initiatives within the workplace.

Given the limited empirical literature examining healthcare PRGs from the perspective of participants, we conducted semi – structured interviews with PRG members to explore: (1) how participants perceived PRG participation as shaping their professional development and sense of belonging within the organization; and (2) how participants described PRGs as contributing to inclusive education and culturally responsive approaches to care within their institution.

By centering members' lived experiences, this study addresses a gap in healthcare literature regarding the experiential and educational role of PRGs within clinical systems. The analysis focuses on participants' perspectives related to workforce belonging and educational engagement and does not evaluate clinical outcomes, physician – patient relationships, or organizational performance metrics.

### 1.1. Culturally Responsive Terminology

In alignment with the preferences of the FIRST Peoples PRG, we use the term "Indigenous" to honor the diverse cultures, histories, and languages of peoples across the Western Hemisphere [15]. This editorial choice reflects our commitment to cultural humility and respectful engagement, including our decision to lowercase "white" to de – center whiteness in discourse. Similarly, we use the LGBTQIA+ acronym to affirm a broad and evolving range of identities, including lesbian, gay, bisexual, transgender, queer, intersex, asexual, and aromantic individuals. The "+" signals the spectrum of experiences beyond binary definitions and underscores our intentional use of inclusive, culturally responsive language [15, 16].

## 2. Methods

### 2.1. Study Design and Framework

We employed a qualitative design using a primarily deductive thematic analysis guided by the Campinha – Bacote Model of Cultural Competence [17]. This process – oriented framework provided a structured lens for interpreting PRG member experiences, conceptualizing cultural competence as a lifelong journey across five interrelated constructs: cultural awareness (self – examination of bias), cultural knowledge (understanding cultural practices and beliefs), cultural skill (delivering respectful, appropriate care), cultural encounters (direct interactions with diverse populations), and cultural desire (intrinsic motivation to become culturally competent) [17]. While the analytic framework was deductively derived, the approach allowed for the addition of inductive codes when data did not fit existing constructs, consistent with a flexible, theory – informed qualitative design.

### 2.2. Participants and Sampling Strategy

We recruited participants via email to participate in this study voluntarily. Eligibility was purposefully restricted to PRG members who were actively involved in curricular co – production with the organization's Internal Medicine Residency Program, in addition to other PRG activities. Educational contributions included participation in panel discussions and communication-skills – based sessions.

This criterion reflects an intentional, high – engagement sampling strategy designed to elicit rich, information – dense accounts from participants with direct experience of bridging PRG participation and educational initiatives. We acknowledge that this approach likely privileges perspectives of highly engaged members and may bias findings toward more favorable appraisals of PRG impact; however, this design choice aligns with the study's aim to examine perceived experiential and educational influence rather than to capture the full range of PRG member perspectives.

Participants received branded organizational merchandise (approximate value <$25 USD) for their involvement in educational activities; this incentive was not contingent on participation in research interviews, and no additional compensation was provided for study participation.

Of the seven eligible members of the FIRST Peoples PRG, four participated in semi – structured interviews. Of the six eligible members of the Honor in Pride (HIP) PRG, three participated.

### 2.3. Participant Roles and Backgrounds

To protect confidentiality, only general professional roles and affiliations are reported. Participants represented a multidisciplinary workforce, including nursing, pharmacy, laboratory services, genetic counseling, and diversity leadership. All participant names are pseudonyms.

### 2.4. Data Collection

We developed a semi – structured interview guide informed by a targeted literature review and aligned with the study aims. The semi – structured format allowed participants to narrate their experiences while maintaining consistency across key domains.

Minor real – time refinements were made to the interview guide during early interviews (e.g., rewording prompts for clarity and adding probes to elicit concrete examples of educational engagement or professional development). These adaptations did not alter the core interview questions or analytic domains, which remained consistent across all interviews. A versioned interview guide was maintained to document changes and preserve methodological transparency.

Semi – structured interviews were conducted via Zoom from April to November 2024, with sessions averaging sixty minutes. Interviews explored participant experiences within PRGs, perceived influence on cultural awareness and inclusivity, involvement in resident education, and experiences navigating healthcare systems.

Informed consent was obtained from all participants involved in this study. Participants received detailed information about the study's purpose, procedures, the voluntary nature of participation, and confidentiality protections. Participants were offered the option to keep cameras on or off to prioritize comfort and privacy. All participants agreed to participate prior to the commencement of data collection. Interviews were audio – recorded, auto – transcribed using Zoom, and manually reviewed for accuracy before being uploaded to Dedoose for qualitative data management and coding.

### 2.5. Data Analysis

We conducted a primarily deductive thematic analysis using predefined codes aligned with the five constructs of the Campinha – Bacote Model.

The analytic approach was theory – informed and deductive in structure; however, we explicitly allowed for inductive code generation when participant narratives extended beyond the predefined constructs. Thus, the analysis followed a deductive framework with systematic openness to emergent, data – driven codes. A codebook was developed based on the Campinha-Bacote domains and iteratively refined throughout the analytic process through peer debriefing, member checking, targeted independent review by a second qualitative reviewer, and analytic consensus discussion, to incorporate inductive additions and clarify code boundaries.

### 2.6. Interview Guide: Iterations and Maintenance of Core Questions

During data collection, minor real – time refinements were made to the interview guide to improve clarity and depth. These refinements occurred after the first three interviews. They involved (1) rewording two questions for clarity, (2) adding one optional probe related to leadership support, and (3) reorganizing question order to improve conversational flow. No core questions were removed, and all participants were asked the same foundational questions aligned with the study's aims and theoretical framework.

To preserve comparability across interviews, a stable set of core questions was maintained throughout. Adaptations were limited to probes or clarifications and did not alter the substantive focus of inquiry.

### 2.7. Coding Process and Dependability Strategy

All interview transcripts were initially coded by a primary qualitative analyst using a predominantly deductive coding framework aligned with the Campinha-Bacote Model of Cultural Competence, with openness to inductive code development when participant narratives extended beyond predefined domains.

To strengthen analytic dependability, we implemented a multi-method validation strategy that integrated a second – reader review, peer debriefing, analytical consensus, and member checking. Among these approaches, peer debriefing served as the primary strategy for ensuring dependability, supplemented by a targeted second-reader review and member checking.

### 2.8. Second-Reader Review of Transcripts and Codebook

After the primary qualitative analyst completed initial coding, a second reader, a member of the research team, conducted an independent review of a subset of interview transcripts and the evolving codebook. This review examined code application consistency, thematic alignment, and areas of conceptual overlap among codes (e.g., cultural humility, openness, advocacy, and identity affirmation).

The second reader review functioned as a targeted dependability check rather than a full parallel dual-coding of the entire dataset. Feedback from this review informed the refinement of code definitions, the consolidation of overlapping codes, and the clarification of how codes were organized within the final thematic structure through analytic consensus discussion.

### 2.9. Peer Debriefing and Analytic Consensus

Peer debriefing served as a primary strategy for dependability and was conducted through regularly scheduled analytic meetings with the research team. During these sessions, the primary coder presented evolving codes, thematic structures, and illustrative excerpts for critical discussion. Team members examined code boundaries, challenged interpretive assumptions, questioned potential overextension of findings, and explored alternative explanations to ensure themes remained grounded in participant narratives.

### 2.10. Member Checking (Participant Transcript Review)

Member validation was also incorporated, with participants invited to review and reflect on summary interpretations of their narratives to confirm their resonance with their lived experiences. This process was intended to enhance credibility and ethical representation rather than to achieve consensus on thematic interpretations. Participants who engaged in transcript review did not request substantive changes to content, and no interviews were withdrawn. This form of participant validation focused on accuracy and representation rather than on co-analysis of themes.

### 2.11. Reflexivity and Positionality

To further enhance credibility, the primary analyst engaged in reflexive journaling throughout data collection and analysis. Reflexive documentation included analytic decisions, evolving interpretations, assumptions, and consideration of how insider positionality within the healthcare system might influence interpretation. Independent secondary review by a second coder further strengthened reflexivity by introducing an external analytic perspective and reducing reliance on a single interpretive lens.

### 2.12. Management of Insider Participation

One study participant was also a member of the research team. To mitigate potential bias, this individual was excluded from coding decisions and did not participate in analytic discussions involving their own interview transcript or quotations. Their involvement was limited to broader conceptual discussions unrelated to their personal data.

### 2.13. Analytic Adequacy and Information Power

Given the focused study aim, theory – informed framework, and high – engagement participant sample, the study prioritized depth of information over sample size. Analytic adequacy was assessed by the presence of redundancy within predefined theoretical domains and the absence of substantively new inductive codes. Findings are framed as context – specific and hypothesis – generating.

### 2.14. Methodological Limitations Related to Coding

Although peer debriefing, supported by targeted second – reader review and member checking, strengthens analytic rigor, we acknowledge that systematic parallel dual-coding across the entire dataset and formal inter-rater reliability testing were not conducted. Future qualitative studies would benefit from incorporating full dual-coding from project inception when feasible.

### 2.15. Ethical Review

This study was reviewed by the HonorHealth Institutional Review Board and determined to be exempt from human subjects research oversight due to its focus on professional experiences and minimal risk to participants.

## 3. Results

The findings of this study reveal interconnected dynamics among personal identity, workplace culture, and institutional structures that shape PRG members' experiences and contributions in the healthcare

setting. Four overarching themes emerged. First, through a lack of recognition, misrepresentation, and microaggressions, participants described how cultural invisibility eroded their sense of belonging and undermined equitable care. Second, PRG participation was perceived as a catalyst for strengthening physician – patient relationships by fostering cultural humility, inclusive communication, and trust, particularly through sharing lived experiences with physician trainees. Third, engagement in PRGs nurtured belonging, community – building, and cross – cultural solidarity, empowering members to advocate for institutional inclusion and policy change. Finally, participants highlighted that the sustainability and impact of PRGs depend on visible leadership commitment, structural flexibility, and tangible organizational support to overcome barriers such as scheduling conflicts, lack of recognition, and the emotional labor of equity work. These themes reflect participants' perceptions of how PRGs may function not only as affinity spaces but as potential contributors to cultural change within their organizational context.

Given the small size of PRG rosters and the potential for deductive identification, certain narrative details (e.g., specific clinical roles, departments, or event titles) have been generalized or omitted. Pseudonyms were used, and minor contextual modifications were made where necessary to preserve meaning while protecting participant confidentiality.

### 3.1. Theme I: PRG members describe their experiences of cultural invisibility in the workplace

Most participants described experiences of cultural invisibility in the healthcare workplace, which they reported eroding their sense of belonging and, in their view, could affect the quality of interpersonal and clinical interactions. Cultural invisibility refers to the experience of having one's cultural identity overlooked, minimized, or dismissed within dominant institutional settings [18]. Participants described this invisibility as manifesting through lack of representation, misrecognition, or dismissive comments, contributing to feelings of exclusion and alienation. Several participants further noted that such dynamics limited opportunities for cultural humility and, in their perception, could affect patient communication.

Several participants shared examples of colleagues overlooking or misunderstanding their identities. Aki (Indigenous PRG) described feeling culturally invisible in professional spaces prior to PRG involvement, a sentiment echoed by Taylor (LGBTQIA+ PRG). Taylor recalled overhearing colleagues' dismissive comments about pronoun use early in their employment. They described feeling "shocked" and "devastated," noting that the experience heightened their awareness of how identity is perceived in clinical environments. Taylor explained: "I include Pride in my email signature and share my pronouns in meetings. But in the back of my head, I sometimes wonder whether everyone respects that. I'd say the vast majority of physicians are fantastic… but we still have a long way to go." Similarly, Beni (Indigenous PRG) described instances in which colleagues demonstrated limited understanding of Indigenous cultures, including the use of culturally inappropriate language when referring to patients. Beni reflected, "People just don't know. They just need to be educated." Across interviews, several participants emphasized that healthcare professionals generally enter their fields with the intent to help patients. However, they expressed concern that without adequate cultural awareness and training, well – intentioned clinicians may inadvertently contribute to misunderstanding or marginalization. These reflections represent participants' perceptions of how invisibility may shape workplace climate and communication.

In addition to overt experiences, several participants reflected on the complexity of navigating intersecting identities. Riley (LGBTQIA+ PRG) noted that discrimination often stemmed from the reduction of identity to a single dimension, stating, "I'm more than just this one aspect of my identity." Indigenous PRG members described balancing dual cultural frameworks within professional practice. Shay (Indigenous PRG) discussed reconciling participation in traditional cultural practices with Western medical norms, describing this as both challenging and enriching.

While most participants reported experiences of invisibility or marginalization, one participant described predominantly supportive interactions with colleagues and emphasized variability across teams and departments. This counterpoint suggests that experiences of cultural invisibility were not uniform, even within the same institutional context.

Collectively, these narratives illustrate how participants experienced cultural invisibility as both an individual and structural phenomenon affecting professional identity, workplace climate, and, in their view, clinical communication. Participants emphasized the importance of institutional commitment to inclusive practices and culturally grounded education to address these gaps.

### 3.2. Theme II: PRG participation was perceived to strengthen physician – patient relationships by promoting cultural humility and inclusive communication

Most members described PRG participation as reinforcing the importance of cultural humility in physician – patient interactions. They emphasized that sharing their lived experiences within healthcare settings can inspire humility, trust, and empathy, which they believed could strengthen communication with patients from diverse backgrounds. These reflections represent participants' perceptions of how PRG engagement may influence clinical relationships rather than direct measurement of patient outcomes.

Several participants emphasized that humility is foundational to effective care. Riley (LGBTQIA+ PRG) described a need for openness in physician – patient relationships, particularly for individuals from marginalized communities who may carry prior negative healthcare experiences. Riley explained that even a single dismissive interaction can shape a patient's long – term willingness to seek care. Similarly, Dakota (Indigenous PRG) reflected that "initial visits are where people get their lasting impressions," underlining the perceived importance of culturally attentive first encounters.

Across both PRGs, participants consistently described humility as involving acknowledgment of one's knowledge gaps and willingness to learn. Beni (Indigenous PRG) noted that healthcare professionals who are vulnerable and who openly recognize limits in their cultural understanding create more meaningful interactions with patients. Participants characterized such acknowledgment not as weakness but as a core component of culturally responsive care.

Several LGBTQIA+ PRG participants similarly emphasized that cultural competency requires adaptability rather than perfection. Casey (LGBTQIA+ PRG) stated: "Physicians need to accept that they'll make mistakes and be open to learning from them… It's not about being perfect but about approaching situations with openness and willingness to adapt." Participants described this mindset as essential for building trust with patients whose identities may not align with dominant cultural norms, aligning with broader discussions of humility as foundational to continuous professional growth in healthcare.

Most participants also reflected on their involvement in co – produced educational sessions for resident physicians. They reported that residents appeared receptive and engaged when hearing directly

from PRG members. These observations are based on participant perception, as residents were not interviewed in this study. Several participants described perceiving increased curiosity and thoughtful questioning from residents during sessions. Beni (Indigenous PRG) described perceiving a "hunger" among some learners to better understand Indigenous patient experiences.

Dakota (Indigenous PRG) described how communication norms within Indigenous communities, such as avoiding direct expressions of pain, may be misunderstood by providers unfamiliar with these practices. They described a clinical encounter involving an elderly Navajo – speaking patient in which limited interpreter access and cultural understanding led to a difficult visit. Despite their shared heritage and efforts to assist, the communication barriers were not fully resolved. Dakota (Indigenous PRG) interpreted this experience as illustrating the limits of individual cultural awareness in the absence of adequate structural language support. Several participants emphasized that while individual humility is necessary, it is insufficient in the absence of structural support. Limited interpreter access, time constraints, and unclear clinical role expectations during educational simulations were described as barriers that could undermine even well – intentioned efforts at culturally responsive care. For example, participants involved in standardized patient sessions noted that residents sometimes appeared uncertain about the clinical context (e.g., inpatient versus outpatient setting), and in one instance, inaccurate information about HIV pre – exposure prophylaxis (PrEP) was shared. These experiences reinforced participants' view that cultural humility must be paired with accurate clinical knowledge and institutional preparation to meaningfully improve care.

Aki (Indigenous PRG) reflected that participation in PRG activities and resident sessions could encourage clinicians to consider alternative communication approaches: "I think just having PRG groups and having that representation and encouragement will help us do better for our patients, whether it's just learning how to communicate better or learning how to communicate differently to patients." Shay (Indigenous PRG) similarly emphasized that physicians who listen attentively and demonstrate genuine interest in patients' cultural backgrounds are more likely, in their view, to build trust. Riley (LGBTQIA+ PRG) stated, "When patients feel safe, they're more likely to open up." While participants described these anticipated downstream effects, the present study did not assess patient – level outcomes.

Participants also described using PRG forums to highlight how seemingly small clinical interactions may carry lasting significance for marginalized patients. Taylor (LGBTQIA+ PRG) noted, "It was a great opportunity to show residents how even small interactions, like dismissive comments, can have a lasting impact." Riley (LGBTQIA+ PRG) reflected on conversations with residents: "Yes, we may have a label associated with one of the PRG groups, but all of us are unique and multifaceted individuals. I feel like that really goes a long way." From Beni's (Indigenous PRG) perspective, some residents appeared open and willing to learn more about Indigenous patient experiences, though participants acknowledged variability in engagement. Dakota (Indigenous PRG) noted that sustained exposure and practice might be necessary for learning to "sink in," suggesting that single sessions alone may be insufficient for lasting change.

When asked how PRG participation influenced their own perceptions, Aki (Indigenous PRG) described feeling that they were "contributing something valuable" and becoming more integrated within the organizational community. Importantly, Aki (Indigenous PRG) also offered a nuanced counterpoint regarding the limits of PRG impact on their immediate work environment. While Aki (Indigenous PRG) described PRG participation as meaningful for validating identity and contributing to resident learning, they noted that their day-to-day clinical work setting remained largely unchanged. As Aki (Indigenous PRG) explained, participation in PRG activities did not directly alter routine workflows or workplace dynamics, underscoring that perceived educational and relational benefits did not necessarily translate into observable changes in the immediate work environment. This perspective highlights that PRG influence may be experienced more strongly in educational, relational, or personal domains than in structural workplace conditions. Observing resident interest during sessions was described as "rewarding." Participants suggested that recognizing the potential educational influence of their contributions enhanced their motivation to remain engaged in PRG activities.

Although most participants were optimistic about the influence of PRG – informed education, one participant offered a contrasting perspective, questioning whether brief educational exposures alone were sufficient to meaningfully alter entrenched communication patterns, suggesting that sustained reinforcement would likely be necessary. Participants also acknowledged that the broader impact of PRG – informed education may be shaped by variable engagement and participation within the PRGs themselves. Some described limited attendance at events or inconsistent involvement among members, suggesting that the reach of educational efforts may depend on sustained organizational support and protected time for participation.

Together, participants perceived PRG involvement as creating opportunities to model humility, share culturally grounded perspectives, and encourage more inclusive communication practices. At the same time, they recognized that the translation of these efforts into sustained clinical change likely requires structural reinforcement, accurate clinical preparation, and consistent organizational support. Although direct clinical or educational outcomes were not measured, participants described PRG engagement as contributing to a culture that aspires to openness, reflective practice, and patient – centered care, while acknowledging the limits of brief or inconsistently supported interventions.

### 3.3. Theme III: PRG participation was perceived to build belonging and cross – cultural solidarity, fostering member engagement in institutional inclusion efforts

Most participants described PRG participation as creating networks of emotional and professional support that deepened their sense of belonging within the organization. Many participants, particularly those from historically underrepresented backgrounds, characterized PRGs as spaces where aspects of their identity felt recognized and affirmed.

Aki (Indigenous PRG) reflected on initial hesitancy to join the Hispanic PRG due to uncertainty about "fully qualifying or belonging." With encouragement from a manager, Aki (Indigenous PRG) chose to participate and described eventually finding meaningful connection: "I understood the culture and the hardships people face. It's not about being a perfect fit; it's about bringing that awareness to healthcare and making a difference." Aki (Indigenous PRG) later described feeling "super excited" when the Indigenous PRG was formed, observing that it felt distinct yet aligned with broader efforts to increase representation in healthcare settings. Rather than describing this shift as transformative at an institutional level, Aki (Indigenous PRG) framed it as personally affirming and motivating. They further emphasized that the sense of belonging they developed through PRG involvement was not automatic, but required personal effort, vulnerability, and active participation. They

described belonging as something that had to be "pushed for," noting that meaningful connection emerged only when individuals showed up consistently, advocated for themselves, and were willing to engage despite uncertainty or discomfort. This account highlights that while PRGs may create supportive structures, the experience of belonging is co-constructed through both institutional opportunity and individual agency.

Similarly, Shay (Indigenous PRG) described being encouraged by a colleague to become involved in PRG activities. Initially uncertain about the purpose of PRGs, Shay described conducting independent research and becoming inspired by observing community outreach efforts. When learning that a Native – focused PRG was forming, Shay described feeling "compelled to get involved," linking participation to a desire to support their community. These narratives reflect participants' perceptions of PRGs as entry points into both identity affirmation and broader institutional engagement.

Several participants emphasized the role of informal social gatherings in cultivating belonging. Taylor (LGBTQIA+ PRG) described hosting recurring social events intended to foster connection: "The number one way to get people more involved is to build connections… We started hosting monthly gatherings where we simply hang out. This year, after building more connections, we had over 50 participants!" Taylor interpreted this to be a sign that members were finding value in these interactions. Participants noted that rotating meeting times and offering varied formats (e.g., coffee meetups, family – friendly events) were perceived as responsive to member needs, suggesting that low – barrier, relationship – centered activities contributed to participants' sense of inclusion and engagement.

For many participants, representation and recognition were central motivators for continued involvement. Shay (Indigenous PRG) remarked, "They want to hear our voices… They really wanted my input." Dakota (Indigenous PRG) described involvement in PRG – related education as feeling part of "something bigger than myself." Taylor (LGBTQIA+ PRG) similarly stated that contributing to resident education "made me feel like my voice mattered." Aki (Indigenous PRG) reflected, "I felt like I was being heard, or at least seen… I felt really proud of myself for putting myself out there." Participants consistently linked these experiences to enhanced personal engagement within the organization. Importantly, these reflections describe perceived shifts in individual sense of belonging rather than measured changes in institutional climate. Consistent with this distinction, Aki (Indigenous PRG) also noted that participation in PRG activities did not markedly change their immediate day-to-day work environment. While involvement reinforced their belief in the importance of PRG advocacy and strengthened their motivation to participate, Aki (Indigenous PRG) described routine workplace expectations and workflows as largely unchanged. This counterpoint underscores that PRG benefits were often experienced at the level of personal meaning, validation, and engagement, rather than through observable structural or environmental change.

For some participants, this strengthened sense of belonging was associated with increased willingness to engage in advocacy efforts. Taylor (LGBTQIA+ PRG) described feeling purposeful in working toward more inclusive care environments. Members of the LGBTQIA+ PRG discussed advocating for inclusive restroom signage and respectful pronoun usage on intake forms. These examples were described as participant – initiated efforts aimed at promoting inclusivity. The present study did not evaluate the implementation or outcomes of these advocacy efforts but captures how participants understood PRGs as supportive spaces for raising such concerns.

Participants also described cross – cultural solidarity across PRGs. Although Indigenous and LGBTQIA+ PRGs differed in focus, members emphasized perceived shared goals related to visibility, psychological safety, and equity. Riley (LGBTQIA+ PRG) stated: "I'm more than happy to show up in solidarity with the Black, American Indian, Veterans, or any other PRGs because we do have a lot of the same struggles." Beni (Indigenous PRG) noted, "It's reciprocal... I advocate for what's right because I feel a sense of belonging." Participants framed solidarity not as uniformity across identities, but as mutual recognition of overlapping experiences of marginalization.

Several participants described cultural humility and self – reflection as foundational to sustaining cross – group engagement. Riley and Taylor (LGBTQIA+ PRG) reflected on learning from other PRGs and recognizing both differences and shared challenges. Participants described this process as ongoing rather than complete, emphasizing learning and relationship – building over definitive institutional change. This aligns with the idea that solidarity is not just about advocacy but also about self – examination and understanding one's position within broader systems of power [19].

Not all participants described uniformly strong cross – group engagement, representing a deviant perspective within the sample. One participant noted that while solidarity across PRGs was encouraged, collaboration between groups remained sporadic and often dependent on individual relationships rather than formal structures. Another reflected that some employees may remain hesitant to join PRGs due to concerns about visibility or perceived stigma. These perspectives suggest that while belonging was widely described, participation may still be shaped by personal and contextual factors.

Collectively, participants perceived PRGs as spaces that foster belonging, relational connection, and cross – cultural engagement. While institutional outcomes were not directly assessed, participants consistently described PRG involvement as strengthening their sense of voice, visibility, and motivation to participate in inclusion – related efforts within the organization, while also recognizing, through counterpoints such as Aki's (Indigenous PRG), that these benefits were neither uniform nor automatic and did not necessarily translate into immediate changes in workplace structure or climate.

### 3.4. Theme IV: PRGs participation was perceived to require sustained leadership support, protected time, and structural flexibility to address participation barriers

Participants described multiple barriers that they perceived as limiting sustained engagement in PRG activities. These included scheduling constraints, variability in leadership support, and the emotional labor associated with advocacy and organizational change efforts. Rather than presenting these challenges as universal, participants described them as contextual and variable across roles and departments. For example, Riley (LGBTQIA+ PRG) emphasized the challenge of scheduling, especially for those working night shifts and those without flexibility in their workday: "The biggest challenge I experience in participating in LGBTQIA+ is really timing and scheduling because I work the night shift." Several participants described perceiving that PRG participation was sometimes expected to occur outside regular work hours or during lunch breaks. These expectations were described as discouraging for some employees. Participants framed protected time during work hours as an important facilitator of equitable participation, particularly for hourly staff or those in patient – facing roles.

Shay (Indigenous PRG) described a different type of participation barrier related to navigating personal cultural boundaries. Raised off

reservation and within both Christian and Indigenous traditions, Shay (Indigenous PRG) expressed initial uncertainty about participating in certain traditional ceremonies. Shay (Indigenous PRG) described addressing this by communicating boundaries openly with group leadership, which allowed continued engagement without compromising personal beliefs. Participants described such flexibility as important for sustaining inclusive spaces within PRGs themselves.

Leadership support was also described as influential in shaping participation experiences. Several participants emphasized the perceived importance of visible executive endorsement and structural backing. Beni (Indigenous PRG) stated, "It has to come from the top," reflecting a belief that leadership engagement signals institutional legitimacy. Beni further noted a desire for greater executive visibility to encourage broader participation. Some participants expressed concern that without sustained institutional commitment, PRGs could risk becoming under – resourced or symbolic rather than structurally supported.

At the same time, leadership experiences were not uniformly described as limited. A small number of participants reported having supervisors who actively encouraged PRG engagement during work hours and expressed support for their involvement. These accounts suggest that participation conditions may vary considerably across departments and reporting structures.

Other participants described encountering barriers, including canceled meetings or limited administrative follow – through. Taylor (LGBTQIA+ PRG) reflected: "At first, it went nowhere, meetings were canceled, emails ignored… Sometimes, you just need to do it and ask for permission later." Rather than framing this solely as resistance, participants described it as part of navigating complex organizational systems. Dakota (Indigenous PRG) perceived that increased institutional backing over time contributed to expanded group activity, though participants did not describe formal evaluation of these efforts. Sustaining engagement was also described as challenging. Riley (LGBTQIA+ PRG) and Beni (Indigenous PRG) both discussed difficulties maintaining consistent participation despite initial enthusiasm, citing demanding clinical workloads and differences in scheduling flexibility between salaried and hourly employees. These constraints were described as structural rather than individual shortcomings.

Participants additionally highlighted the emotional labor involved in advocating for inclusion – related changes. Taylor (LGBTQIA+ PRG) noted: "Some members have been told they shouldn't send emails or attend meetings during work hours. That's frustrating because the PRG work directly benefits [the organization]." While participants perceived PRG efforts as beneficial, they also described feeling that the labor required to sustain momentum was sometimes underrecognized. These accounts reflect participants' experiences of navigating both visible and less visible dimensions of organizational change work.

Together, participants perceived that sustained PRG engagement required more than informal acknowledgment. They emphasized the importance of protected time, leadership visibility, and structural flexibility to facilitate equitable participation. Although the present study did not evaluate institutional policy or leadership perspectives, participants consistently described structural support as central to the long – term viability of PRG initiatives.

## 4. Discussion

The findings of this study highlight PRG members' perceptions of how participation contributed to experiences of affirmation, belonging, and professional engagement within their healthcare organization. Participants described PRGs not merely as peer – support spaces, but as forums through which they could share lived experiences, reflect on identity, and engage with institutional processes. These descriptions should be understood as participant – reported perceptions rather than evidence of demonstrated organizational change, and they reflect participant narratives rather than independently verified institutional effects.

Importantly, our findings are limited to participants' reported experiences and perceptions. While participants described PRGs as influencing workplace culture and professional engagement, we did not directly measure clinician behavior change, curriculum effectiveness, patient outcomes, or institutional performance metrics. Therefore, any discussion of potential organizational or patient – level impact should be interpreted as hypothesis – generating rather than as established outcomes.

Our findings suggest that participants described PRGs as potentially contributing to institutional conversations about equity and inclusion, framing these contributions as aspirational rather than as established organizational functions.

### 4.1. Strengthening PRG Infrastructure Through Healthcare Leadership

Participants emphasized the importance of equity – focused leadership in supporting PRG sustainability and engagement, aligning with existing literature on leadership's role in fostering cultural awareness and inclusion [20–24]. Importantly, participants suggested that leadership support would ideally include adequate funding, dedicated staffing, and protected time for PRG members to fulfill their roles effectively. They emphasized that without this infrastructure, PRG efforts were perceived as being at risk of becoming symbolic, episodic, and vulnerable to turnover or shifting organizational priorities.

To provide effective and culturally inclusive leadership in healthcare, prior literature suggests it is important that there are structured opportunities for self – reflection and skill – building in culturally inclusive communication to enable leaders to recognize their own identity, biases, and assumptions, address systemic inequities, and learn more about the diverse backgrounds and lived experiences of their team [21, 25, 26]. For healthcare leaders, introspection that is centered around cultural awareness and understanding was perceived as potentially influencing how they approach their leadership position [25]. However, because this is not an innate trait for most, intentional self – reflection should not be assumed as a natural part of leadership development, and efficiency and clinical outcomes often take precedence in the realm of healthcare [25].

For this reason, prior literature suggests that leadership development programs benefit from explicitly teaching skills in critical self – examination, including how to question assumptions, recognize implicit bias, and understand how positional power shapes others' experiences [20–23, 25]. One way healthcare organizations can nurture this development is by expanding Cultural Knowledge through engagement with PRGs, as described by participants and supported by prior literature, as Cultural Knowledge is essential for fostering equity – focused leadership in a diverse organization [17, 20–23]. Leaders who are well versed in the challenges faced by marginalized communities can better support PRGs and ensure that institutional policies align with their needs [25].

Participants described sustained, visible leadership support as important for the perceived success and legitimacy of PRGs within their organization [27]. As highlighted by participants in both

the LGBTQIA+ and Indigenous PRGs, managerial and executive support was described as contributing to participants' sense of belonging and willingness to engage [27–29]. Further, equipping leaders to facilitate cross – PRG collaboration was described by participants as a way to support perceptions of intergroup solidarity and reduce silos, rather than as a demonstrated driver of broader organizational impact [30, 31]. Moreover, when PRGs are meaningfully resourced with staffing support, protected time, and access to decision – making spaces, their contributions to DEI goals were perceived by participants as more consistent rather than intervallic [32].

Leadership development programs and performance evaluations could consider assessing Cultural Skill competencies, equipping leaders to anticipate and dismantle structural barriers [20–23]. We frame this as a recommendation informed by participant narratives and existing literature, rather than as a tested intervention within this study.

Participants also described aspirational views of PRGs serving as more formally recognized contributors to institutional equity efforts within healthcare settings. These views reflected participant hopes and priorities rather than empirically observed organizational outcomes. Positioning PRGs in this way reinforces the importance of integrating their insights into organizational strategy. However, in this study, such positioning was described aspirationally by participants; we did not evaluate whether or how these integrations translated into measurable institutional change. Participants suggested that sustainability may involve more deliberate, phased approaches to growth, including clearer alignment with organizational mission statements, performance metrics, and operational plans [32, 33]. Such integration was perceived by participants as one way institutions might signal commitment and provide greater visibility for PRG efforts [32, 33].

In prior scholarship, PRGs have been conceptualized as potential contributors to institutional change when meaningfully supported and integrated into organizational structures [20–23, 32, 33]. PRGs have been described in the literature as theoretically positioned to influence organizational culture when sufficiently resourced and integrated [34, 35]. We reference this literature to contextualize participant narratives rather than to suggest that such outcomes were observed in the present study. PRGs can serve as consultative bodies that bring forward critical perspectives on hiring practices, retention strategies, and community engagement, while also addressing systemic inequities that impact marginalized groups [34]. Their contributions can extend beyond representation, with the potential of offering actionable solutions that enhance institutional resilience and accountability which may contribute to improved perceptions of engagement, team dynamics, and accountability [34–36].

When PRGs are conceptualized as strategic assets and guided by culturally responsive leadership, participants perceived that PRGs could inform equity – oriented conversations and priorities within their organizational context [34]. We did not measure improved patient outcomes, clinician performance, or system – level metrics, and thus such impacts remain areas for future empirical study.

This study was informed by Campinha – Bacote's model of cultural competence, which conceptualizes competence as an ongoing process involving cultural awareness, knowledge, skill, encounters, and desire [17]. Throughout our analysis, participants frequently described processes aligned with cultural humility, particularly critical self – reflection, recognition of power imbalances, and lifelong learning [25]. We conceptualize cultural humility not as a replacement for competence, but as a relational and reflective orientation that operationalizes key elements of Campinha – Bacote's framework within PRG contexts [37]. In this study, PRGs appeared to facilitate cultural encounters and awareness (competence domains) through narrative exchange and reflective dialogue (humility practices) [17, 21, 22, 38]. We therefore view competence and humility as complementary constructs, with humility functioning as a mechanism through which competence is continually developed [17, 21, 22, 38].

### 4.2. Centering PRG Narratives in Clinical Education to Advance Cultural Competence and Humility

Importantly, while PRG members served as educators and facilitators of resident physician learning, their involvement in these roles was also described by participants as contributing to their own development in cultural competence [21, 22]. The act of teaching, mentoring, and engaging in outreach was perceived as supporting resident education and as reinforcing PRG members' self-awareness, cultural knowledge, and commitment to inclusive care [38, 39]. This reciprocal process highlights the perceived educational value of culturally grounded leadership and peer-based learning [38–41].

Early exposure to PRGs during medical training has been described in prior literature as immersing resident learners in authentic, culturally grounded narratives that may challenge biases and support the development of more inclusive care practices [38, 42]. Narrative-based training rooted in lived experience has similarly been associated in prior studies with empathy development, person-centered care, and increased comfort navigating cultural complexity in clinical settings [38]. PRG-led educational sessions are therefore conceptualized in the literature as providing cultural encounters that reinforce the importance of cultural humility and self-awareness in healthcare delivery [17, 21, 22, 38]. For example, a co – produced Indigenous Health curriculum delivered in partnership with Indigenous PRG members significantly improved resident physicians' self – reported knowledge about Indigenous communities and enhanced perceived communication skills [43]. We cite these findings to contextualize participant narratives rather than as evidence of educational impact within the present study, as they reflect perceived educational outcomes rather than objectively measured clinical effects [43].

To support the potential continuity of such educational efforts, healthcare institutions may consider sustained support for PRGs by involving them in medical curriculum design, faculty development, and broader equity strategies [34, 44]. These recommendations are offered as practice considerations informed by participant narratives and existing scholarship, rather than as interventions evaluated or tested within this study.

### 4.3. Facilitating Intersectional Solidarity and Cross – PRG Collaboration

PRG members in our study often navigated dual or intersecting identities that shaped both their lived experiences and professional roles. Intersectionality, the overlapping of race, ethnicity, gender, sexuality, and cultural heritage, creates layered dynamics of marginalization and privilege that influence how individuals are perceived, how they engage with systems of power, and how they advocate for themselves and their communities [19, 30, 31]. For healthcare professionals, cultivating intersectional awareness is essential for fostering stronger relationships, improving team dynamics, and delivering equitable care [19, 31]. Structured reflection practices, such as identity mapping and narrative sharing, can deepen this awareness by validating complex lived realities and encouraging critical examination of how one's own identity and social position affect the interpretation of others' experiences [25]. Within PRG

and peer support settings, listening through an intersectional lens, acknowledging power imbalances, validating lived experience, and fostering mutual understanding can transform surface level engagement into meaningful connection and collective growth [19, 29, 31].

The significance of solidarity across PRGs in our study was apparent in participant narratives. Many described how engagement across identity groups seemed to broaden their understanding and empathy [30, 31]. However, it is important to note that while cross – PRG collaboration was widely viewed positively, dissenting perspectives were limited in our sample. This may reflect self – selection bias, as participants who chose to be interviewed may have been more engaged or more satisfied with PRG involvement. Future research should intentionally sample individuals with neutral or critical perspectives to more fully capture variation in experiences.

Healthcare organizations may consider developing structured strategies to facilitate intergroup alliances, such as cross – community events and collaborative education programs [30, 31]. These suggestions are grounded in participant experiences and supported by prior literature and are offered as practice implications rather than as evidence-based interventions evaluated within this study.

### 4.4. Addressing Social Desirability and Insider Dynamics

An important limitation of this study relates to the potential influence of social desirability bias and insider dynamics. Participants were interviewed within their employing healthcare system, and some were engaged in DEI – adjacent work. These contextual factors may have influenced how participants described their experiences, potentially emphasizing positive aspects of PRGs or aligning responses with perceived institutional values.

To mitigate response pressure, participants were informed that interviews were confidential, participation was voluntary, and findings would be reported in aggregate without attribution to identifiable roles. The interviewer was not in a direct supervisory relationship with participants, and raw transcripts were not shared with institutional leadership. Nevertheless, we acknowledge that power dynamics and organizational loyalty may have shaped responses. Future research conducted by external evaluators or across multiple institutions may help further reduce insider influence.

## 5. Limitations

This study has several limitations. The focus on only two PRGs may not capture the experiences of other marginalized populations. Participants were self – selected, which may have overrepresented positive experiences. Conducted within a single healthcare system, findings may not generalize in other contexts.

Additionally, we did not measure objective outcomes such as clinician behavior change, patient satisfaction, retention rates, or institutional performance metrics. Our findings therefore reflect perceived experiences rather than demonstrable system – level effects.

As noted above, social desirability bias and insider dynamics may have influenced participant responses despite mitigation efforts.

Future research should incorporate broader samples across multiple institutions, intentionally include dissenting or disengaged perspectives, and integrate measurable organizational and patient – level outcomes to evaluate PRG effectiveness more rigorously.

## 6. Conclusion

PRGs were perceived by participants to play an important role within healthcare organizations by addressing cultural invisibility, promoting a sense of belonging, and creating supportive spaces for marginalized healthcare workers.

Because participants perceived their educational involvement as meaningful, PRG members described reinforced cultural awareness, validation of their lived experiences, and a strengthened sense of belonging and commitment to inclusive practice. These reflections describe participants' internal and relational experiences and should not be interpreted as evidence of changes in resident clinical practice or patient care. Participation in PRG-informed educational activities was experienced by participants as mutually reinforcing, in that contributing to resident learning was perceived to deepen PRG members' engagement, empowerment, and sense of belonging within the organization.

The study found that PRGs were described by participants as most sustainable and meaningful when recognized and supported within organizational processes. PRG members reported that visible leadership involvement, such as attending PRG events or publicly endorsing initiatives, was perceived as validating their work and as contributing positively to their sense of belonging. Participants also highlighted that structural support, including flexibility to participate during work hours and formal recognition of contributions, was perceived as reducing emotional labor associated with engagement and encouraging sustained involvement.

Importantly, our findings reflect the lived experiences and perceptions of PRG members within a single healthcare system. We did not measure organizational accountability, institutional performance outcomes, or patient – experience indicators. Therefore, while participants described PRGs as influencing workplace culture and educational practices, the extent to which these perceptions translate into measurable systemic change remains an empirical question for future study.

This research contributes to the growing body of knowledge on healthcare equity, workforce inclusion, professional development, cultural competence, cross – cultural solidarity, and organizational leadership by centering the narratives of PRG members. Our findings suggest that PRGs are perceived by participants as supporting belonging and educational contribution within the contexts studied.

A concrete next step for this line of inquiry would be a mixed – methods evaluation that pairs qualitative inquiry with quantitative measures, such as validated belonging and retention metrics among healthcare workers and patient – experience indicators to empirically assess whether and how PRG engagement is associated with measurable organizational and clinical outcomes.

## Conflicts of Interest

The authors declare no competing interests that could have influenced the objectivity or outcome of this research.

## Funding Source

This work was supported by the ABIM Foundation through the Building Trust Through Diversity, Health Care Equity, Inclusion, and Diagnostic Excellence in Internal Medicine Training grant.

## Acknowledgments

We would like to acknowledge contributions of the PRG members, Honor in Pride (LGBTQIA+) and FIRST Peoples (Indigenous). We also extend our gratitude to the ABIM grant group members for their guidance and collaboration: Fiker Bekele, Chris Black, Carol Mayer, Debrah Schneider, and Dr. Catherine Wagner. We would like to give special recognition to Evener Scott for his exceptional insight, and contributions informed by his lived experiences, which greatly strengthened our work.

## Institutional Review Board (IRB)

This study was reviewed by the HonorHealth Institutional Review Board and determined to be exempt from human subject research oversight, based on its focus on professional experiences and minimal risk to participants.

## Large Language Model

A large language model (OpenAI ChatGPT, GPT-5.3-mini) was used for language editing and stylistic refinement of the manuscript. The use of this tool was restricted to improving clarity and grammar and did not involve generation of scientific content or modification of study results. The authors take full responsibility for the integrity of the final manuscript.

## Author Contributions

JB contributed to conceptualization, methodology, investigation, formal analysis, writing original draft preparation, writing review and editing, and project administration. SJ contributed to conceptualization, methodology, and writing review and editing. DS contributed to conceptualization, writing review and editing, and supervision. PR contributed to conceptualization, writing review and editing, and supervision.

## Data Availability

The data supporting the findings of this study are not publicly available due to the sensitive and confidential nature of the participant narratives. Access to the data is restricted to protect the privacy of the participants. However, de–identified excerpts from the data may be made available upon reasonable request to the corresponding author, subject to ethical approval and institutional guidelines.

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