Diversity, Equity, Inclusion, and Justice

Call for Collaboration: The Role of Accreditation in the Transformation, Accountability, and Sustainability of Education in Social Determinants of Health

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The complex roots of bias, discrimination, and health inequity are entangled within our social tapestry. The causes and devastating consequences of racialized medicine have aggravated the suffering of disenfranchised groups. This reality poses painful challenges for health care professionals. In this article, we (1) highlight factors impeding meaningful equity,[1] diversity,[2] and inclusion[2] (EDI) education in graduate medical education (GME); (2) identify resources and guidelines in structuring EDI education; and (3) suggest how accrediting bodies, sponsoring institutions (SIs), training programs, and specialty organizations can be credible models demonstrating holistic integration of EDI. We believe that interdisciplinary collaboration across these entities will deepen the GME community's endeavors toward health equity—empowering trainees, administrators, and faculty to become change agents.

Publication of the *Report of the SI2025 Task Force*[3] by the Accreditation Council for Graduate Medical Education (ACGME) sharpened our perspectives on EDI education. SI2025 describes pervasive neoliberalism as "a way to do business" within the health care system. Neoliberalism posits that profitability is the primary aim of large companies, including those in health care. The report, with phrases like "strong business interest" and "market trends," predicts (1) corporate priorities threatening the medical profession's mission of public service to address community needs; (2) persistent, multifactorial health care disparities; and (3) corporate health systems' failure to serve rural and urban populations. Considering that a racially diverse population will outnumber Whites by midcentury,[4] these predictions illuminate a reality in which much of the population remains disenfranchised by the health care system. These signals demand heightened action by the GME community.

Research identifies systematized transformation, accountability, and sustainability as key elements in promoting meaningful EDI.[5] One way that SIs and programs are guided toward accountability and sustainability is through the ACGME and specialty-specific requirements. ACGME Common Program Requirements (CPRs) reference EDI in many categories (provided as online supplementary data). Furthermore, the Clinical Learning Environment Review (CLER) visit requires that trainees are involved in addressing health care disparities at the clinical site of training.[6]

These CPR and CLER components may have motivated SIs and programs to integrate EDI into the educational program, leveraging accreditation as an essential vehicle for institutional change.[7] However, many requirements will benefit from additional scaffolding. Substantial and sustainable EDI education will require standards, theoretical frameworks, pedagogical practices, and evaluation within the constructs of the competency-based medical education model. GME leaders must spearhead interdisciplinary collaboration to respond to shared needs. Below, we outline a series of 5 observed challenges and suggestions for mitigation.

Challenge 1: Misperception That EDI Is a Stand-Alone Domain

Suggestion: Expand EDI Requirements Across Accreditation Domains

CPR incorporation of EDI within multiple categories as discussed reinforces that EDI work does not stand alone. The ACGME can further expand references to EDI within the domains of trainee and faculty

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Editor's Note: The online version of this article contains equity, diversity, and inclusion (EDI) related standards in ACGME Common Program Requirements and examples of EDI hidden curriculum within graduate medical education operations, administrations, and sponsored projects.

TABLE 1
Examples of Potential Common Equity, Diversity, and Inclusion Milestones

Patient Care and Procedural Skills [CPR IV.B.1.b)] 1: Underrepresented Communities				
Level 1	Level 2	Level 3	Level 4	Level 5
Demonstrates lack of knowledge of the unique health challenges the underrepresented community faces	Demonstrates general knowledge of the unique health challenges the underrepresented community faces	Analyzes and synthesizes the unique health challenges the underrepresented community faces	Applies in-depth knowledge of the unique health challenges of the underrepresented community to patient care	Teaches colleagues about applying in-depth knowledge of underrepresented community's unique health challenges to patient care
Comments:				
Medical Knowledge 1: History of Racialized Medicine [CPR: IV.B.1.c)]				
Level 1	Level 2	Level 3	Level 4	Level 5
Demonstrates lack of knowledge of the history of racialized medicine	Uses vague terms to describe the history of racialized medicine	Demonstrates general knowledge of the history of racialized medicine	Identifies complex social factors that have influenced racialized medicine	Teaches colleagues about racialized medicine
Comments:				
Systems-Based Practice 1: Resources [CPR IV.B.1.f)]				
Level 1	Level 2	Level 3	Level 4	Level 5
Demonstrates no awareness of resources to provide optimal health care for patients with diverse cultural and linguistic backgrounds	Demonstrates limited awareness of resources to provide optimal health care for patients with diverse cultural and linguistic backgrounds	Demonstrates in-depth knowledge of local and national resources to provide optimal health care for patients with diverse cultural and linguistic backgrounds	Calls effectively on local and national resources to provide optimal health care for patients with diverse cultural and linguistic backgrounds	Serves as an expert on local and national resources; participates in resource development to provide optimal health care for patients with diverse cultural and linguistic backgrounds
Comments:				

TABLE 2
Resources for Critical Pedagogy

Resources	Information on Resources
Manca N, Gormley G, Johnston J, Hart N. Honoring medicine's social contract: a scoping review of critical consciousness in medical education. *Acad Med*. 2020;95(6):958–967. doi:10.1097/ACM.0000000000003059.	▪ Identifies 4 ways critical consciousness has been conceptualized in medical education. ▪ Includes concrete examples of practical applications of critical pedagogy in undergraduate and graduate medical curricula.
Ross BM. Critical pedagogy as a means to achieve social accountability in medical education. *Intl J Critical Pedagogy*. 2015;6(2):169–186.	▪ Explains how to use critical pedagogy as framework in altering medical curricula to further social accountability. ▪ Will benefit those who want to incorporate EDI into medical curriculum (included examples are for general medical education).
Cavanagh A, Vanstone M, Ritz S. Problems of problem-based learning: towards transformative critical pedagogy in medical education. *Perspect Med Educ*. 2019;8(1):38–42. doi:10.1007/s40037-018-0489-7.	▪ Suggests that medical educators use Freire's problem-posing model (as opposed to "banking model") so that health professionals can address the social sources of illness that shape their patients' lives.
Matthews C. Critical pedagogy in health education. *Health Educ J*. 2014;73(5):600–609. https://doi.org/10.1177/0017896913510511.	▪ Advocates for the 3-phase model of critical pedagogy—listening and naming, dialogue and reflection, and promotion of transformative social action—to ensure that learners are critically engaged in health information rather than simply passive recipients of it.
Academic Medicine Addressing Race and Racism in Medical Education collection	▪ https://journals.lww.com/academicmedicine/pages/collectiondetails.aspx?TopicalCollectionId=72.

assessments as well as other relevant areas to ensure that EDI content permeates all core competencies. However, this expansion should not obviate the need for a distinct EDI category within the CPRs. The expanded references should join a distinct, separate EDI category within the CPRs to enhance integration of EDI content through training.

Challenge 2: Misperception That EDI Training Is Optional or Can Be Added Sporadically

Suggestion: Outline a Common EDI Curriculum for Specialty Adaptation

Most current GME EDI training remains sporadic or optional[8]—often a "special" topic delivered in fragmented ways (eg, guest speakers, orientation session, short-term, international immersion trip). Experts have called for delivery of a universal curriculum addressing core EDI skills, knowledge, and behaviors in all specialties.[8,9] This shared EDI curriculum should be visibly rooted in GME core competencies (particularly patient care) and should not assume effective training during medical school. The curriculum should include the history of racialized medicine and social and political factors systematically exacerbating health inequities. Each specialty should then supplement this with unique information and/or skills relative to their own patient populations and social determinants within communities served.

Challenge 3: A Lack of Constructs Against Which EDI Curriculum and Evaluations Can Be Mapped

Suggestion: Craft Cross-Specialty Common EDI Milestones

The GME community has already collaborated across specialties (Milestones 2.0), with interdisciplinary groups "harmonizing" subcompetencies and milestones for 4 core competencies: professionalism, practice-based learning and improvement, interpersonal and communication skills, and systems-based practice. The themes of these subcompetencies apply across all specialties.

EDI is also relevant across specialties. Most specialty Milestones include 1 or 2 EDI descriptor(s), offering only basic language (eg, "cultural diversity" or "socioeconomic status"). Such limitation risks oversimplification of EDI concepts and hindrance of nuanced understanding of health inequities. TABLE 1 provides potential common EDI Milestones for GME.

Challenge 4: Few Faculty Members Are Experts on Pedagogical Practices Promoting EDI

Suggestion: Highlight Pedagogical Practices to Foster Effective Implementation of EDI Education

GME education leaders must compile and distribute resources on critical and anti-racist pedagogy to improve instructional quality—this is a key target

for centralized faculty development. Critical pedagogy and anti-racist pedagogy, rooted in critical theory, are pedagogical approaches or paradigms that encourage questioning of social structures, power, and oppression.[10,11] Faculty skilled in teaching practices founded on critical pedagogy and anti-racist pedagogy will foster the development of critical consciousness in trainees, particularly if examples of critical pedagogy are offered with respect to the core competencies. Select resources referencing critical pedagogy are outlined in TABLE 2.

Challenge 5: EDI Education Is Only Credible if Accompanied by Equitable and Inclusive GME Processes and Operations

Suggestion: Enculturate EDI as Core Values Within Daily Operations, Administration, and Sponsored Projects

The GME community must nurture hidden curriculum that promotes EDI in order to reinforce direct EDI education as previously suggested. Modeling EDI within daily organizational operations and administration (provided as online supplementary data) reifies and bolsters accountable, sustainable, and inclusive EDI learning experiences.[5]

As the above outlined structures are made available, SIs and programs will have concrete resources for creating, implementing, evaluating, and reflecting on key content and outcomes. These challenges cannot be fully addressed in a brief period. Yet interdisciplinary collaboration is highly feasible, considering the work the AAMC (eg, Core Entrustable Professional Activities for Entering Residency[12]) and the ACGME (eg, Milestones 2.0) have already engaged. The GME community must continue its work of consensus building and develop an initial timeline for elevating awareness, collecting resources, and thoughtfully planning implementation. We offer these perspectives as a roadmap toward 2025, by which time we hope all health care professionals will be "educated to address the needs of patients from a variety of backgrounds"[3] and "prepared to address ongoing disparities in health care."[3] We believe that a GME community that is willing to examine itself and forge meaningful collaborations will become a driving force in dismantling health inequity.

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