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Inclusion in the clinical learning environment: Building the conditions for diverse human flourishing

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ABSTRACT

Aim: While diversity, equity, and inclusion are much proclaimed aspirational goals in education programs, the clinical learning environment (CLE) frequently falls short of meaningful incorporation of these concepts in processes, policies, and local culture. In this paper, we explore how inclusion, diversity, and equity can and should be defined and operationalized within medical education.

Methods: Three cases, organized around Hafferty's curricular framework (formal, informal, and hidden), we illustrate lapses and potential best practices in inclusion in the CLE.

Results: The essential "best-practice" of programs inclusive of diverse individuals is the design of policies, processes, and behavioral norms co-creatively with all community members. Potential pitfalls to greater inclusion include nostalgic reference to "the past", a neutrality that is operationalized without the rudder of explicit values and not recognizing that ethical obligations between teachers, learners, and programs are at the heart of the discussion of how inclusive learning and work environments are built.

Conclusion: Inclusive CLE's provide space for co-creation, understand the need to ensure the voices of the vulnerable (i.e. learners) are heard and valued and through this promote the flourishing of diverse human capital, in keeping with a model that views diversity as a key attribute or organizational excellence.

Introduction

Diversity and inclusion encompass acceptance of and respect for the attributes of individuals along socially meaningful dimensions of difference. In different societies, meaningful dimensions may vary, but typically include ones such as race, ethnicity, gender, sexual orientation, socio-economic status, age, religious beliefs or other attributes. Inclusion, diversity, and equity are abundantly proclaimed aspirations in most medical education programs and are rooted in an ethos of fairness and respect in learner-teacher, learner-learner, and learner-colleague relationships. Yet, the clinical learning environment (CLE) in many medical education programs often falls short of meaningful incorporation of the concepts of diversity, equity, and inclusion into processes, policy and program culture (Liebschutz et al. 2006, Beagan 2003, and AAMC 2014). Instead, these concepts find difficulty progressing beyond vague platitudes on program websites and the like, with little usefulness in the real world of trainees' lived experiences within their programs.

In medical education, there have been frequent and high-level calls to increase diversity (Association of Faculties of Medicine of Canada 2010 and Josiah Macy Jr. Foundation 2008). These calls have met with variable success. Medical school classes have become majority women in North America, and are ethnically more diverse than previously. However, within this apparent increasing diversity, there are important pockets of underrepresentation of persons from historically marginalized groups (Young et al. 2012 and AAMC 2014). In addition, women are underrepresented in leadership positions in teaching institutions (Carr et al. 2015, Rochon et al. 2016).

The CLE is defined as the cultural norms and institutional practices that learners experience through the course of their learning, whenever and wherever they gather to learn (Maudsley 2001). With respect to diversity and inclusion, problems with the CLE comprise issues that are both structural and relational. Structural issues include systemic barriers that might be experienced by persons from specific groups to participation within programs, while relational impediments might include mistreatment experienced by diverse persons based on the group to which they belong. In a study of minority residents in the United States, 3 major CLE themes were described: frequent episodes of microaggressions and bias, minority residents tasked as race/ethnicity ambassadors, and challenges negotiating professional and personal identity, while seen as "other." (Osseo-Asare et al. 2018)

Shore et al. (2011) defined inclusion as a series of institutional practices and cultural norms which promote a high sense of belongingness of individuals within organizations or institutions, while simultaneously recognizing and valuing individuals' uniqueness. Belongingness is fostered through minimization of hierarchical decision-making and attention to the safety of the CLE, while recognition of individuals' uniqueness might include a willingness to alter practice to accommodate diverse persons.

Diversity, at its core, is best characterized not as a "problem" to be dealt with, but rather, as a fundamental property of populations (Razack 2018). Populations are defined by what they share (e.g. trainees in a program).

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Practice points

- Inclusive practices include: recognizing uniqueness and promoting belongingness.
- Diversity is a fundamental property of populations and not a "problem" to be fixed.
- Equity addresses ongoing injustices experienced by marginalized persons.
- Inclusive spaces are co-creative.
- Beware of nostalgia, neutrality and conflated outcomes in inclusion discussions.

The "diversity" of a population is simply the characteristics not shared by all members – in the example of trainees above, how they may differ in their gender, race, and sexual orientation, etc. Context defines the domains that matter, which results in actions on the part of programs. Actions might include committing to track data or to develop and implement policies that address the concerns of members of specific groups. From an outcomes perspective, diversity is becoming recognized as an attribute of excellent organizations within medical education (Nivet 2011 and Nivet 2015), with this further supported by showing that diversity and inclusion in the physician workforce increase access for underserved patients (Marrast et al. 2014). Beyond being important to their experience in the CLE, data suggests inclusion is important to educational attainment for non-majority learners in postgraduate medical education programs (Woolf et al. 2016).

A related concept to diversity, and one which impacts heavily on inclusion issues in the CLE is the construct of "equity". Equity is about recognizing historical and current marginalization experienced by members of certain groups within society, and understanding institutions as places where the injustices have occurred.

In analyzing issues within the CLE, a useful framework is to consider training in postgraduate medicine as a curriculum, with formal, informal and hidden components (Hafferty 1998). The formal curriculum consists of "what we say we teach" – required rotations, educational sessions and the like. The informal curriculum consists of the behavioral norms in the CLE that govern the interactions between teachers, learners, and other agents within a milieu during the course of learning. The hidden curriculum consists of institutional policies and practices which serve to reinforce certain actions and constrain others (Hafferty 1998, Martimianakis et al. 2015 and Muntinga et al. 2016).

In this paper we will take the concepts of inclusion, equity and diversity from meaningful definition to concrete action within residency programs, exploring how each term has been conceptualized and problematized within medical education, through several representative cases.

Case analysis

Case 1: Didactic teaching

Within a urology training program, didactic teaching has been held since its inception on Wednesdays between 5 and 8:30 pm at night. Two residents, Jill and Jacques, have consistently had poor attendance at this activity, missing greater than 50% of the sessions. Jill has 2-year-old twins at home. Jill states that the period between 5 and 7:30 pm is incredibly active for the kids. She misses it frequently for her on-call duties and needs to prioritize family life when not on call. Jacques has a 7-year-old and a 9-year-old and is recently divorced. The divorce is acrimonious with very strict shared custody apportionment. Evenings (5–7:30 pm) are important family times. Jacques has the children every second Wednesday, has no stable child care for that time, and wants to spend time with the children.

In this case example, the hidden curriculum is the salient aspect of learning that might threaten the inclusivity of the CLE. The institutional practice of having academic teaching sessions in the evening constrains the participation of residents who might be parents with significant caregiving responsibilities. This can be analyzed as a form of systematic exclusion, because residency training is often undertaken by persons of childbearing age, and a significant portion of them might be parents. An equity issue might also be raised with this case – presumably, the practice evolved the way it has because in the past, most residents would not have had primary caregiver responsibility.

The implications for inclusion policies certainly involve the ultimate output of policy–will the time of teaching be changed or not?—but really have to do with the process by which decisions are made. Inclusive programs display the courage to co-create with their learners the conditions (policies and procedures) under which all will operate within the bounds of training, and commit to using broad sources of data to make decisions. Co-creation does not imply an abdication of decision-making responsibility solely to learners, but rather committing to policy development with minimization of hierarchies and respecting the voices of all who might be affected by the policies.

Case 2: Rounding on indigenous patients with an indigenous trainee

In the pediatric critical care unit, the night resident is Hannah, who is a member of an Indigenous group in the country where training is taking place. By her outside appearance, she is not visibly identifiable as Indigenous and a member of a minority group. She is transferring care to the day team of trainees with supervisor Dr. Zahid. There are 3 patients from various Indigenous communities, all infants with respiratory infections and very similar stories. Some team members point out that the unit occupancy versus population share for Indigenous patients is very skewed, with one-quarter of the beds occupied by Indigenous patients, versus a 1% population share. Team members ponder potential causes, wondering aloud if there are issues with hygiene and child care in these northern communities that promote respiratory illnesses. The language used contains many instances of casual stereotyping and factual inaccuracies. Hannah discloses her Indigenous status. The team's way of discussing these patients changes with the disclosure and some team members are visibly embarrassed at their previous "othering" language. Dr. Zahid seems unsure how to proceed.

In this case example, the salient aspect of the CLE to analyze is the informal curriculum—the behavioral norms

and "cultural" practices of the actors within it, with attention to its empowered members. The medical team's speculation about child care practices of Indigenous parents constitutes "othering," a process that identifies individuals and groups that are considered different from the "mainstream" and that can be used to create or reinforce positions of domination (Johnson et al. 2014 and Said 1993). The Indigenous resident's experiences can be classified as a microaggression, defined as small verbalizations or other behaviors experienced by the recipient as biased in some way on the basis of his or her group belonging (racist, sexist, homophobic etc.) (Sue et al. 2007). The responses of the powerful (i.e. the supervisors) and the collective (fellow learners) are keys to determining the effect of the experience as a threat. Significant distress can also arise within learners who witness microaggressions but who, for reasons of disempowerment, fail to act at the moment (Dover 2016). Anti-racism training often focuses on giving witnesses the tools to speak up at the moment for this reason (Wing Sue et al. 2009).

Dr. Zahid's lack of clarity as to how to proceed in Case 2 demonstrates the importance of faculty development in influencing behavioral norms within the CLE towards greater inclusion, giving teachers the tools to label issues as they arise ("microaggression", "othering") and skill-building to sensitively debrief them for transformative learning. Underlying any faculty development aimed at inclusion is the notion of building critical consciousness capacity. Critical consciousness, a term coined by Brazilian educator Paulo Freire, focuses on achieving an in-depth understanding of the world, allowing for the perception and exposure of social and political contradictions. Critical consciousness also includes taking action against the oppressive elements in one's milieu that are illuminated by that understanding (Kumagai and Lypson 2009). In critically conscious faculty development aimed at enhancing understanding of biases (Harris et al. 2016) and increasing inclusion in the CLE, the perceptions that need to be developed are an appreciation of structural racism, oppression, and marginalization. Teachers equipped with these tools are then able to examine the language used in teaching. Is it free of othering terminology?

Case 3: Queer family building

Medical student concerns are next on the agenda at the curriculum committee. Louis-Charles, the student representative on the committee, raises the following issue brought to him by a student undertaking an infertility elective. This student was assigned to an in vitro fertilization clinic and recently encountered a Gay couple and their surrogate who were consulting for IVF through surrogacy. Indeed, the student was surprised that the clinic had a fulltime nurse assigned to "LGBT family building". The student asked whether there should be a session in the curriculum on queer family building. Several senior members of the committee dismiss the idea. One faculty member states, "It is not our responsibility to teach about how two men build a family."

In this case, it is the formal curriculum that comes into salience with respect to the CLE. Most analyses of the CLE concentrate on informal behaviors and hidden practices rather than the formal curriculum. We argue for an enlarged definition of what constitutes the CLE, as the formal curriculum can be understood as an object within the CLE, just as capable of manifesting inclusion and exclusion as other parts of it (Ly and Crowshoe 2015). The issue, in this case, is the notion of representativeness—how are the medical concerns of diverse groups portrayed in what is learned? Damon Tweedy (2015), an African American psychiatrist in the United States, has written a poignant memoir entitled, "Black Man in a White Coat", which describes his experience as a student in medical school, and his learning about how his own people's health problems and behaviors were being represented within the formal curriculum, and the experience of threat, stereotyping and othering (and inaccuracies) that such portrayals produced within him and the other black students in his classes.

Discussion

Building inclusive spaces for dialogue

How can spaces that are welcoming of diversity and mindful of equity be purposefully built within programs for greater inclusion in the CLE? The answer lies in having a multipronged approach that is committed to the notion of co-creation—that is, of building a CLE that the rules of which, whether they be informal and formal, both learners and teachers co-construct, with each group contributing their experience and expertise to the process. If case one highlights more of a "top-down" approach, focusing on policy and process, case two suggests a need for "bottom-up" strategies as well — with educational approaches for both teachers and learners that encourage critical consciousness and transformation. Case 3 brings to the fore that the formal curriculum is not an innocent bystander in the CLE, but can also be a powerful agent in processes of inclusion and alienation. Curricular development and governance also must be co-creative and indeed should ideally involve the patient voice as well.

What form should co-creation take? Learners and teachers must be engaged in all forums where decisions are made, with learners' expertise recognized in the discussions, to avoid tokenism. Curricular governance, policy development, and solution-finding committees must commit to hearing the voices of diverse stakeholders. Rigorous policies for dealing with lapses in the inclusion or regulating the terms of inclusion often exist in institutions and within programs. However, their application and enforcement can lag behind the stated values. Individuals in leadership positions must commit to enacting the will of stakeholders as expressed through policy. Finally, true transformation can only occur through dialog. Effective dialog requires a commitment to addressing critically and explicitly any concerns raised, in ways that privilege the voices of the vulnerable (i.e. learners), recognizing that one of the reasons people do not raise concerns is because of the fear of reprisal as disempowered members of groups.

Avoiding the pitfalls of nostalgia, neutrality, and conflated outcomes

Nostalgia is a pitfall frequently encountered in inclusion discussions that go awry. When behavioral norms are questioned that previously have not been questioned, there

may be a tendency to look back to a golden past when one did not need to be so "politically correct". For instance, if a faculty member shows exasperation at having his comment that a trainee is a "fine gal" be questioned, stating that in the past this would have been seen as a compliment, how does one respond? On the one hand, it is genuinely possible that behavioral norms are evolving. On the other hand, the narratives of the past that generally get remembered nostalgically are those of the empowered. Did female residents from the imagined past, where it was acceptable to say "fine gals," consider that terminology appropriate at the time or were they just too disempowered to speak up? Appreciating nostalgic pasts through the lens of narratives of the powerful runs the risk of dishonoring those marginalized by those histories, and creates unhelpful barriers to progress in the present.

A second pitfall encountered in inclusion discussions related to the CLE is that of "neutrality" or "impartiality". We refer here particularly to how leadership might set the stage for discussions around conflicts in the CLE. Terms used might include "hearing both sides" or similar phrasing. For instance, in the case with the learner above, the Indigenous learner perspective (perceiving the microaggression) might be contrasted with the ignorance (lack of familiarity with the issues and not mean-spiritedness) on the part of the other learners. The CLE essentially made invisible the possibility that one of the learners could be Indigenous, and none of the others within it was equipped to question the narrative of othering of Indigenous patients that took place, causing the space to function as a colonizing one for the Indigenous learner. A debrief that fails to recognize this issue and instead focuses on "hearing both sides" would run the risk of being itself unsafe for the Indigenous learner. Instead of neutrality or impartiality, a better approach in these types of difficult discussions is to explicitly recognize the values (inclusion, mutual respect, diminution of hierarchies) guiding the discussion at the outset.

A third pitfall encountered in inclusion discussions is one of the conflated outcomes. The justification goes something like this: improve the CLE and better and more open communication ensues; improving communication leads to better health outcomes for patients. To frame the discussion this way is not untrue, but only tells one half of the story and not the half that started the discussion in the first place. Discussions of the CLE and how it should be are about the ethics of medical education—teachers' and programs' obligations towards their students, and how best to define them. Indeed, we must ask ourselves how power and hierarchy are operating such that it is easier to talk about improving patient outcomes in issues related to the CLE, rather than discussing the ethical obligations of teachers in medical education.

Moving forward towards more inclusive learning environments

A courageous commitment to co-creation in all processes is the key to building inclusive CLE's. This implies stakeholder partnerships and integration in the design and management of the CLE, within a framework of diminished hierarchies. An ethos of co-creation between programs, teachers, and learners can feel like moving from a well-manicured garden to an untended and overgrown wood, with unknowns lurking at every corner. It means relinquishing some control over the outcomes of discussions and recognizing that specific expertise exists within all stakeholders, learners, and teachers alike. In spaces where these discussions take place, we must be explicit to embed the principles of critical consciousness, mutual respect, and recognition of the need to hear all stakeholder voices, which might require strategies that privilege the voices of the vulnerable. If true co-creation can be accomplished, we will be able to move beyond the platitudinous with respect to equity, diversity, and inclusion within medical education, and to engage thoughtfully in transformational policy and culture change for the flourishing of the diverse human capital that comprises our learner population.

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