Using Accreditation to Transform Diversity, Equity, and Inclusion Efforts Into Diversity, Equity, and Inclusion Systems

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Abstract

The Liaison Committee on Medical Education accreditation process is an important component of professional regulation and is used by medical schools to strengthen their medical education programs. Accreditation-related consultations with schools often include a review of relevant documents, stakeholder interviews, and mock site visits. A review by the author of this commentary of these consultations at 17 schools showed variability in how information regarding diversity, equity, and inclusion (DEI) was incorporated and discussed in accreditation-related materials and interviews.

At all schools, DEI information emerged in materials related to the accreditation standards that specifically inquire into DEI. However, at some schools, DEI emerged more broadly across a variety of standards. These differences suggest that considering the totality of the Liaison Committee on Medical Education standards and elements may be a useful tool for enabling schools to analyze and describe their DEI efforts, consider additional ways to engage in continuous quality improvement related to DEI, and achieve institutional DEI goals.

In addition, a small number of the reviewed schools appeared to have had particular success in meeting institutional DEI goals. An appreciative inquiry-informed review suggested that these exemplar schools had both area-specific and cross-functional systems focused on achieving DEI goals. In addition, senior leadership demonstrated a commitment to DEI, DEI champions were empowered, and leaders displayed legislative-style and systems leadership skills. Schools that nurture these characteristics may be better positioned to advance DEI. Scholarly evaluation of these observations is necessary.

The social contract between society and the medical profession allows the profession substantial autonomy in setting education, assessment, and practice standards, with the expectation that these standards will be high and that outcomes will be measured.[1,2] One important component of this system of professional self-regulation in the United States is the accreditation of undergraduate medical education programs by the Liaison Committee on Medical Education (LCME) or the Committee on Osteopathic College Accreditation.[3–5] Standards established by these accreditors and the processes used to ensure that medical education programs are in substantial compliance with these standards serve important quality assurance and continuous quality improvement (CQI) functions. Changes in accreditation standards are driven by shifts in societal needs and expectations, in pedagogic and assessment practices, in knowledge and technology, and in learners' needs.

The intersection of the COVID-19 pandemic and heightened awareness of systemic racism has spotlighted longstanding health inequities and health care disparities, drawing renewed attention to the lack of diversity in the medical profession.[6–8] This lack of diversity extends to medical schools and raises important concerns about equity, inadequate educational experiences for students in homogeneous cohorts taught by nondiverse faculty, and poor individual and population health outcomes associated with health care disparities.[9–11] It also raises concerns that the institutions of medicine, including medical schools, may be missing out on the strategic and business-related benefits of diversity, including greater innovation and improved financial outcomes.[12–15]

Observers have noted the substantial influence of accreditation standards on medical education in general.[16–18] Specifically, investigators have explored the impact of accreditation standards on medical school diversity; while the number of underrepresented students in medical schools has increased since the implementation of accreditation elements intended to improve diversity, the proportional representation of these students in medical schools compared with that in the U.S. population has not substantially increased.[9,19] Laraque-Arena has stimulated thought about how the accreditation process and standards can further diversity in medicine.[20]

My professional activities include work with institutions of higher education that are committed to using the accreditation process as a lever for CQI. Over a 30-month period of time, during work with 17 LCME-accredited medical education programs that included the review of accreditation-related documents, interviews with stakeholders, mid-cycle gap analyses, and mock site visits, our teams found that all schools made diligent efforts to advance diversity, equity, and inclusion (DEI). However, the ways in which these efforts were documented and discussed differed. In addition, our teams identified a few schools (called exemplars in this commentary, although this term is not intended to imply that these schools have achieved the success to which they aspire) that were making notable progress toward their DEI goals.

I (the person common to all teams) reflected on these differences in documentation among the 17 reviewed schools. Also, using an appreciative inquiry-informed approach, I considered

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what characteristics appeared to distinguish the exemplars among them. Easy answers—that these schools had more resources, common organizational types, or similar local environments—were rejected because exemplar institutions included wealthy and resource-limited programs, public and private schools, and those situated in different geographic and demographic circumstances. My reflections led to 3 observations that I share in this commentary. First, I suggest that schools can maximize the value of their accreditation-related activities to achieve specific DEI goals by considering their work across the totality of the LCME standards. Next, I propose that focusing on systems rather than siloed efforts can maximize impact. Finally, I explore how attention to leadership, particularly legislative leadership skills and systems leadership science, may have particular importance to this work. Scholarly evaluation of these observations is necessary and welcomed.

Accreditation Elements Not Specifically Addressing DEI Are Often Relevant to Those Efforts

Twelve standards, incorporating 93 elements, constitute the current LCME Standards for the Accreditation of Undergraduate Medical Education Programs.[21] As part of the accreditation process, medical schools provide information about their approach to meeting these elements and standards in documents that include the LCME Self-Study Summary, the LCME Data Collection Instrument, and the Data Collection Instrument's multiple appendices. Additional materials that are used by both the school and the LCME include the Association of American Medical Colleges Graduation Questionnaire and the Independent Student Analysis, a comprehensive survey conducted by the school's students. After reviewing these documents, a visiting team representing the LCME spends several days interviewing a broad group of stakeholders and evaluating the school. The team's findings and the documents are considered by the entire LCME (excluding any member with a possible conflict), which makes accreditation determinations. The documents and interviews provide accreditors with a detailed window into all aspects of a medical education program; they can also serve as valuable internal CQI tools for the school.

Every medical school is different, and one would expect differences in DEI content in each institution's materials and interviews. But the degree of difference can be surprising. In our reviews and interviews, all schools answered specific inquiries about DEI associated with elements 3.3, 3.4, and 7.6, the elements that most specifically inquire into diversity categories, programs and outcomes, antidiscrimination policies, cultural competence, and health care disparities. But for some schools, DEI efforts and information emerged across elements that are less specific to DEI. For example, information about DEI may appear within the context of a school's mission, strategic plan, and CQI activities (element 1.1). Student perspectives about the environment related to DEI can be gleaned from Graduation Questionnaire responses, the Independent Student Analysis, and interviews related to administrative responsiveness (2.4), the learning environment (3.5), and student mistreatment (3.6). Intersections between DEI and educational content are sometimes elaborated upon in descriptions of the curriculum (e.g., 6.0, 7.6, 7.7, 7.9) and the admissions process (10.2, 10.3).

Differences in how DEI emerges in accreditation materials and discussions can reflect true programmatic differences among schools. However, in some cases, the differences appeared to reflect compartmentalization of information and lack of communication across the different functional areas (e.g., curriculum, student affairs, business/finance, faculty affairs) of a medical education program. For example, many schools did not include DEI-related faculty development sessions in their formal list of faculty development opportunities requested in element 4.5 even though these sessions had occurred.

These observations suggest that schools may benefit from considering their DEI work across the totality of the LCME standards and from using the standards to consider possible ways to expand their DEI efforts. Appendix 1 presents some examples of DEI-related questions linked to the LCME standards. Questions such as these may expand awareness of DEI intersections with other areas of the medical education program, suggest new ways to advance DEI, and highlight ways in which schools could more effectively present existing DEI activities.

Exemplar Schools Are Notable for the Presence of Systems

All 17 reviewed schools had taken steps to improve DEI. However, it appeared to me that it was the presence of systems advancing DEI goals that distinguished exemplars from other schools. These systems were found both within and across distinct functions of the school. Two examples may be helpful.

First, although all schools reported efforts to recruit a diverse student body, exemplar schools also exhibited an intense focus on student retention. Multiple student support services were directed toward academics (e.g., academic counseling, tutors, test preparation programs), individualized personal support (e.g., personal counseling, mentoring), and community building (e.g., social gatherings, small group sessions). Prematriculation programs were offered to admitted students who were identified (or identified themselves) as facing challenges, and support continued throughout the course of undergraduate medical education in developmentally appropriate and coordinated ways. In addition to this longitudinal support, there was integration across the various types of student support services, structured to respect privacy while treating student support holistically.

This systematic approach to student support makes sense. Recruiting students whose background may put them at a disadvantage and then failing to provide them with support is counterproductive. Academic challenges often create emotional stress for students, and their needs for support extend beyond tutoring and academic counseling. By the same token, personal issues related to a sense of isolation, economic challenges, and family concerns sometimes manifest themselves as academic problems.[22,23] Accreditation explicitly examines the horizontal and vertical integration of the curriculum; student support should be addressed in a similar fashion. Exemplar schools exhibited not only such integration across multiple services within their student affairs office but also coordination between the student affairs, admissions, curriculum, and diversity offices. This coordination was clear from the level of congruence across various portions of the Data Collection Instrument and during interviews.

Second, the exemplar schools directed substantial and organized attention to faculty recruitment. In addition to

advertising in publications aimed at a diverse audience and issuing statements of the institution's commitment to diversity, efforts included placing diversity advocates on search committees, stating institutional expectations that finalist lists would be diverse, and formally educating search committees about unconscious bias. Pathway programs from residency to junior faculty and financial resources supporting diverse hires were sometimes present, as were programs directed to faculty retention.

Although faculty recruitment, student admissions, curriculum, and student support are typically housed in separate offices, they are clearly linked. The presence of a diverse community with successful students, staff, and faculty conveys an important message about an institution's climate. Faculty members have important roles as teachers, role models, leaders, mentors, and advocates for students, and their diverse collective experiences, approaches, and ideas can influence and enhance the curriculum, community engagement, and advising. Hence, faculty recruitment, either external (e.g., hiring from beyond the institution) or internal (e.g., residency pathway programs), can be an important part of a system aimed at increasing DEI.[24]

These examples demonstrate a level of coordination and implementation of DEI priorities within and across functions of the school, a characteristic that is thought to be important to DEI outcomes.[25]

Leadership Makes a Difference

Reflection on the exemplar schools also highlighted the engagement of leadership with DEI efforts at all levels of the organization. The importance of explicit commitment to DEI from university presidents, medical school deans, and institutional governance boards cannot be overstated. Strategic plans that incorporate DEI, institutional DEI goals with monitored outcomes, and the articulation of diversity as a strategic business imperative are examples of how this leadership commitment may manifest in accreditation-related documents.

The topic of leadership emerges during interviews when students, faculty, and staff describe which events leaders attend and how they talk and behave. At the exemplar schools, DEI was present in strategic documents, and the school community perceived that exhortations by top leadership about DEI were consistent with their behaviors. Furthermore, some schools had created a senior executive leadership position focused on DEI. Clarity of role, an appropriate match of authority with responsibility, and adequate resources appear to be important to the success of the person in this role.

Although overall direction from institutional leadership is important, it is insufficient for achieving DEI goals. Success requires coordinated effort across multiple offices, functions, and teams. At exemplar schools, mock site visit meetings focused on DEI topics often included attendees not only from the DEI office but also from other functional areas. Conversely, DEI expertise was included in sessions focused on issues such as faculty, admissions, curriculum, and student support. Those present clearly had established relationships and articulated a shared commitment to, and responsibility for, achieving DEI goals. The senior DEI champion was acknowledged as central to these efforts, and that leader acknowledged others' crucial contributions. Leaders from a variety of professional backgrounds had forged a shared identity through their work toward achieving DEI.

As I reflected on these meetings, I found 2 characteristics that were common among exemplar schools. First, I recognized examples of what leadership expert Jim Collins defines as legislative leadership.[26] Legislative leadership skills are particularly important in situations where organizational goals are too complex for any single leader to mandate solutions using executive authority. Instead, individuals demonstrating legislative leadership leverage skills in politics, relationship building, and consensus development to engage other leaders and stakeholders to collaboratively adopt, shape, and achieve shared goals.

Second, I recognized that, either intentionally or not, the representatives with whom we met at the exemplar schools spoke the language of and used a framework consistent with systems leadership.[27] Systems leadership is more commonly evoked in conversations about projects that span multiple complex organizations, but it is also applicable to multistakeholder intraorganizational projects. Area leaders at exemplar schools described an understanding of each other's work, collaborative action, and shared commitment. They described results achieved through coalition building and informed by insights into the complexities of their own medical school, university, and community systems.

These characteristics have implications for institutional placement of the senior DEI professional and for leadership training within medical schools. Placing this professional in the dean's office helps ensure adequate resources and reinforces systems of shared responsibility across key education, student support, and faculty development areas. Furthermore, successful decanal leadership, from the assistant deans to the dean of the school, is highly dependent on outstanding legislative leadership skills.

Intentional leadership training for area leaders, committee chairs, and other faculty and staff is important for achieving DEI goals. Skills such as communication, strategic planning, consensus building, negotiation, and the ability to develop and use metrics should be fostered. The Association of American Medical Colleges Healthcare Executive Diversity and Inclusion Certificate is one example of such a program.[28] In addition, the science of systems leadership may help explain the success of some DEI programs and provide a framework for schools wishing to take their DEI activities to a new level of success.

Conclusions

Leaders at one new medical school described how they built DEI into the fabric of their school from its first days.[29] Most schools are working hard to make alterations to their existing fabric to incorporate their DEI goals. Observations of the ways in which DEI topics arise in materials and discussions related to accreditation across multiple medical schools and reflections about the characteristics of a few exemplar schools that appear to have had particular success in achieving DEI goals lead me to the following conclusions.

First, accreditation serves an important professionalism function in medicine. Although few LCME accreditation standards explicitly address DEI, it is an important component of the educational program, the hidden curriculum, and the lived experience of students and faculty.

Schools that examine their DEI efforts across the totality of the LCME standards may see opportunities for strengthening their programs, highlighting their successes, or both. Second, exemplar schools exhibited systems directed toward DEI goals rather than siloed efforts. Recruitment processes are linked to retention efforts; student support services enable community building and academic success; and a diverse faculty contributes in multiple ways. Engaging all constituents, from students to faculty to staff, reinforces inclusivity, offers multiple avenues of support, and contributes to a culture in which DEI is understood as a strategic advantage and critical to the institution's success. Third, leadership is crucial for the success of DEI efforts. Commitment from the highest levels of the organization, empowered DEI leadership, and engaged leaders throughout the organization are important. The skills of legislative leadership and the framework of systems leadership may be of particular value to those working to achieve DEI goals.

I hope that these observations and reflections facilitate our collective success at medical schools in achieving the DEI goals that are important to the education of our students and the care of our patients. Scholarly evaluation of these observations and conclusions is necessary and welcomed.

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Appendix 1

DEI-Related Questions Linked to the LCME Accreditation Process and Standards

No. of LCME standard(s)	Area(s) of focus of LCME standard(s)	Potential questions[a]
1, 2	Mission, Planning, Organization, and Integrity Leadership and Administration	• Are DEI activities linked to the mission and vision of the institution? • Does DEI appear in the strategic plan for the school? For the parent organization? For affiliated health systems? • Are there associated specific and measurable goals for DEI? • Can senior leadership articulate their individual roles in advancing DEI? • Is the leader of DEI efforts included in regular senior leadership team meetings? • Can senior leadership identify the DEI categories on which the school focuses? • Does the senior leadership team discuss, at least annually, DEI metrics related to recruitment/retention of students, faculty, and senior administrative staff? • Does the senior leadership team discuss, at least annually, metrics related to the learning environment at the school, clinical sites, and regional campuses, including student reports of mistreatment? • When there is positive movement toward a DEI goal, is credit shared among the offices/leaders responsible for the success? • How do students/faculty/community members describe the institution's approach to DEI?
3, 5	Academic and Learning Environments Educational Resources and Infrastructure	• What, if any, elements of the recruitment and retention programs are linked? • What linkages exist across student academic, personal, and community support activities? • Within the limitations of the institution's resources, are DEI efforts receiving an appropriate level of support? How is this support defined and demonstrated? • What resources (e.g., financial, space, scholarship, philanthropic, attention from the top) are directed toward DEI?
4	Faculty Preparation, Productivity, Participation, and Policies	• How do department chairs, faculty affairs leadership, and staff contribute to the recruitment and retention of faculty from the school's diversity categories? • How do department chairs, faculty affairs leadership, and staff contribute to an environment that values and leverages DEI for the benefit of the institution? • What faculty development opportunities are presented on topics related to DEI? • Is there a respectful and mutually productive relationship between the faculty affairs leadership and the diversity office? • Do the appointment, promotion, and tenure rules of the institution recognize scholarly work and service activities related to DEI?
6–9	Competencies, Curricular Objectives, and Curricular Design Curricular Content Curricular Management, Evaluation, and Enhancement Teaching, Supervision, Assessment, and Student and Patient Safety	• What materials in the curriculum (e.g., cases, simulations, texts) reflect the full diversity of society and particularly of the communities served by the school? • Does the ethics curriculum acknowledge that some research practices involving marginalized communities are now recognized as unethical and have contributed to distrust of the medical profession and research? • How does the curriculum address cross-cultural competence, societal problems that contribute to health disparities, and interprofessional education? • During their education, do students encounter faculty members, standardized patients, staff members, patients, and student colleagues from diverse groups? • Are teaching and learning conducted in an atmosphere that invites respectful discourse and welcomes a diversity of perspectives? Does this diversity of perspectives include the opportunity for students to hear progressive and conservative perspectives, with the understanding that evidence must drive our work as physicians?
10–12	Medical Student Selection, Assignment, and Progress Medical Student Academic Support, Career Advising, and Educational Records Medical Student Health Services, Personal Counseling, and Financial Aid Services	• Is the school's admissions process holistic? Does it include ways of identifying students who can succeed in medical school and whose life circumstances (e.g., economic resources, limited access to advanced coursework, need for employment during college) may have influenced traditional metrics of capability (grade point average, Medical College Admission Test score)? • Does the school's academic advising program include opportunities for the early identification of, and services for, students at risk of academic challenges? • Do the school's counseling offerings include opportunities for students to receive services that are culturally sensitive? • What is the average student debt? What scholarships and other financial support are available for students with limited economic means? What emergency financial support is available for students at economic risk? Does emergency financial aid involve a loan or gift? • Are there opportunities for students to access and participate in support structures (student groups, professional associations, etc.) that give them the opportunity to spend time in a community in which they are a member of the majority group? • Are there ways of assisting students, faculty, and staff in identifying culturally diverse services in the local community?

Abbreviations: DEI, diversity, equity, and inclusion; LCME, Liaison Committee on Medical Education.

[a]These questions are suggested to help medical education professionals consider their DEI work across the LCME accreditation standards.[21] These questions do not outline specific accreditation requirements. Instead, they and others like them may assist medical education professionals in (1) considering the topic of DEI across a variety of medical education program areas where the standards may be less explicit in their mention of DEI, (2) evaluating the breadth of a school's diversity-related efforts, and (3) maximizing continuous quality improvement of DEI efforts. Furthermore, they may suggest ways in which schools can create systems within and across student services, education programming, assessment, faculty affairs, and other areas.