**EDITORIAL**

# Person-Centered Care Starts with Community-Centered Medical Education: Medical Education Must Answer the Call for Diversity

*James D. Katz, MD; Emily Rose, BS; Katlin Poladian, MD; Karina D. Torralba, MD*

Civil unrest is a call for realignment of values in all aspects of society, including medical education. Systematic difference in the treatment of groups of individuals concerning educational curricula has previously been highlighted in South Africa during student-led campaigns to decolonialize and diversify medical curricula[1]. Institutional resistance that results in a failure to account for the politics of identity or for pluralistic thinking,[1] implies that the academic 'fence of unambiguous knowledge' not only creates an ivory tower but it may simultaneously insulate itself from community input and access. Confronting the tension between communal meaning (which sanctions a culturally relevant curriculum) and privileged meaning (which derives from a monolithic mindset) demands that educators recognize that the scientific method is only one 'way of knowing.' In this manuscript we ask: Who possesses authoritative medical meaning-making? And, Who confers authoritativeness to academia?

Our thesis is that it is possible and preferable to move away from the didactic orthodoxy of education to incorporate a collaborative community learning model.[2] Through enhanced community access, medical education may best emphasize fairness (health equity) while disabusing helping relationships of oppression that is typified by non-transparency in medical power, (prejudicial dominance).[3,4]

Calls for curricular reform exist in medical and lay literature.[5,6] They decry an academic product that lacks in justice, courage, and truthfulness.[5] Moreover, canonical didactic learning has been challenged (quite literally 'upended') with the advent of 'flipped classroom methodology.'[6] Taken together, it is evident that traditional education does not necessarily provide a guarantee of attainment of entrustable levels of independent knowledge, skills and attitude.[7] The key word here is 'entrustable' wherein educators are constrained by the public demand for proof of quality. The reflexive response to this constraint has been to embrace hegemony. Put simply, medical educators are tasked with assessing higher order reasoning skills. To achieve this, medical faculty rely upon surrogate measures of proficiency, namely, testing raw knowledge along with a determination to what extent of supervision a given trainee requires at a given developmental stage. Unfortunately, there exists neither a shared

**James D. Katz, MD**
Office of Clinical Director, National Institute of Arthritis and Musculoskeletal and Skin Diseases (NIAMS), National Institutes of Health (NIH), Bethesda, Maryland, USA
Email: james.katz@nih.gov

**Emily Rose, BS**
Office of Clinical Director, National Institute of Arthritis and Musculoskeletal and Skin Diseases (NIAMS), National Institutes of Health (NIH), Bethesda, Maryland, USA

**Katlin Poladian, MD**
Wake Forest School of Medicine, Wake Forest Baptist Medical Center, Medical Center Boulevard, Winston-Salem, North Carolina, USA

**Karina D. Torralba, MD**
Chief and Fellowship Program Director, Division of Rheumatology, Department of Medicine,
Loma Linda University Health, Department of Medicine, Loma Linda, California, USA
Email: KTorralba@llu.edu

**Received**: November 23, 2020.
**Accepted:** June 15, 2021.
**Conflict of interest:** none.

nomenclature nor a shared mental model among educators to translate competency frameworks to real world medical practice.[8] Despite calls to assess more complex and abstract attributes, knowledge acquisition, but not input by the community at large, remains the measuring stick of proficiency and entrustability.[9],[10],[11]

Entrustable Professional Activities (EPAs) encompass statements of value (e.g., professionalism) but without providing quantifiable measures. For one example: How is empathy quantified?[12] For another, there is lack of consensus among faculty as to the level of entrustment needed to certify a given EPA.[13] But perhaps more importantly, it is rarely asked how such EPAs are aligned with the priorities of the communities within which they serve?[14] A post-modern approach to medical education demands such questioning of hegemonic thinking.[15]

Medical education is the process of transitioning learners from competency mastery to person-centered care. Entrustment is an endorsement of the ability to provide safe care as per community standards. But endorsing EPAs is a process hampered by inadequate outcome measures of quality.[16] Moreover, it fails to account for the importance of mentoring and of role-specific education.[17] Similarly, it fails to engage the community in assessing trainees' sensitivity to cultural and socioeconomic agendas.[18] And because it is a values-based activity, without community involvement, granting the right to unsupervised practice fails to live up to the EPA's promise of safe care per local standards. This is another way of saying that EPA assignment without community input is vulnerable to social advantage (class-based inequality).

The unique juxtaposition of science and of the commitment to meaningful engagement at the level of the individual demands 'socially-accountable medical education'.[19] For one thing, longitudinal care is a mainstay of engagement by the community in outcome needs.[20] For another, clinical care often represents needs-based (as opposed to rote learning inspired) understanding of the patient.[21] To this end, properly designed learning strategies involving the community can inform practice-based learning and provide the foundation for whole systems improvement. This has been accomplished, for example, by administratively involving Indigenous communities in medical education.[22] Another novel strategy emphasizes assessing diagnostic medical skills. Here, advanced statistical methods are able to capture the strength of alignment of thinking between trainees and faculty, and in this manner illuminate critical thinking skills.[23] The process of identifying a discrepancy in medical meaning-making that exists between learner and faculty serves two goals. First, it functions as a measure of learning since it serves to discriminate between two groups. Second, it is a mechanism to capture systemic errors that need to be addressed for purposes of quality improvement. At the level of the trainee, this reflects systems-based learning because it requires seeing interrelationships, recognizing dynamic complexity, and ultimately a refinement of medical meaning-making. At the level of the institution, it reflects Practice-based Learning and Improvement because it functions as a performance audit of the system. But at the level of the community, alignment of thinking between trainee and (in this case) the local population, brings 'citizen power' to medical education by providing attention to issues of marginalization and difference.[24] A third strategy concerns implementing reflection into curricular learning activities that specifically examines human rights abuses, and then in turn using this strategy as a mechanism for exposing class-based inequality.[25]

An implication of this proposal is that a new format is needed for educational conferences. Novel modes of collaboration could involve community testimonials paired with expert commentaries.[26] In this manner, altruism, compassion, and integrity all may be captured as meaningful learning objectives. These otherwise ill-defined characteristics lend themselves to operationalization in this new format because the behaviors, per se, are compatible with a 'compassion training' effect.[27]

Community and population health are higher-level educational outcomes that specifically aim to correct injustices in our social and medical systems. To achieve this, training programs need to emphasize an awareness not only of hard science but also of "contemporary and historical social injustices."[28] For example, community-based review processes currently employed in the research arena should equally lend themselves to implementation within the arena of medical curricular development.[29]

Embedded in this learning-community structure is a value of cultural diversity and an acknowledgement that trainees must consider the interface of science and policy, as well as to be able to communicate clearly and succinctly to diverse audiences in a variety of formats.[30] Consider, for example, that citizen engagement in learning lends itself particularly well to education efforts simply by virtue of embracing two-way (as opposed to top-down, or hegemonic) communication.[31]

In summary, social unrest is a reminder that medical education also has a role in dismantling racial and ethnic division. This perspective piece serves to re-envision and reorient the traditional curricular worldview. Interdisciplinary problem-solving experiences with multicultural input serve to encourage trainees to think critically and creatively, communicate with others, and to be intellectually flexible.[32] Implementing a learning community model for medical education requires a new vision for how the medical education system functions both as a community (academia) and within a community (the public). And at all times it behooves us to ask: Will the new curriculum allow for implementing quality indicators of care and will it overcome the issue of racial and ethnic disparities? [33] Concurrently with this agenda, we must be mindful that any enacted curricular adjustment captures the authentic needs of the community that medical education serves.[34]


## Funding/Acknowledgement

This effort was supported by the Intramural Research Program of the National Institute of Arthritis and Musculoskeletal and Skin Diseases of the National Institutes of Health. This effort was made possible in part through the NIH Medical Research Scholars Program, a public-private partnership supported jointly by the NIH and contributions to the Foundation for the NIH from the Doris Duke Charitable Foundation, Genentech, the American Association for Dental Research, the Colgate-Palmolive Company, and other private donors. The manuscript herein is not an official statement of the NIH or NIAMS. The authors appreciate the thoughtful comments of Drs. Laura Lewandowski and Robert Lembo, who pre-reviewed the manuscript.


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