Our House Won't Rebuild Itself: Peace, Love, and Hope as Tools to Transform Graduate Medical Education

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Abstract

Graduate medical education (GME), the period of specialty and subspecialty training following attainment of a medical degree, is the final step in a continuum of medical education culminating in independent physician practice. This manuscript uses the metaphor "our house" to describe all aspects of the GME environment in which health care professionals and trainees learn and work. Our house's inhabitants have unequivocally stated that our house is in a state of disrepair. While physicians-in-training inevitably face challenges on their journey to independent practice, those from historically marginalized backgrounds face these challenges compounded by the disproportionate impact of identity-based harms. The authors use critical and liberatory theories to explore dominant power dynamics in GME, classifying identity-based harms as silence, pain, and despair. To strive for true transformation, the authors advocate for a new set of house rules, a different way of coexisting based on the principles of liberatory design. The authors call on readers to rebuild the house of GME by drawing parallels between the foundational human values of peace, love, and hope and the educational principles of psychological safety, identity safety, and belonging. To transform GME, our community must make space in our house for all individuals to join and, indeed, to rebuild together.

> You will be in positions that matter. Positions in which you can decide the nature and quality of other people's lives. Your errors may be irrevocable. So when you enter those places of trust, or power, dream a little before you think.
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> —Toni Morrison, *The Sources of Self-Regard*[1]

Graduate medical education (GME), the period of specialty (residency) and subspecialty (fellowship) training following attainment of a medical degree, is the final step in a continuum of medical education culminating in independent physician practice. This period offers deep clinical immersion and situated engagement in interdependent professional development and service. GME aims to facilitate the development of a competent, independently practicing physician workforce to deliver high-quality, equitable health care to meet society's needs. Physicians-in-training face both opportunities and challenges on this journey to independent practice.

Residency is an exercise in uncertainty. Match results dictate the necessity of geographic relocation, which may disrupt personal and professional relationships. Medical training often involves a steep learning curve, changing clinical environments, long work hours, and high emotional intensity. Many of these characteristics serve important learning functions in medical education. Nevertheless, these sociocontextual factors can collectively result in cognitive and affective overload for many learners. As training progresses, residents must choose whether to subspecialize and, if so, in which specialty. Subspecialization, which often requires another match process, further disrupts learners' senses of control and stability in both their personal and professional lives.

Residents and fellows from historically marginalized backgrounds face these challenges of training compounded by the disproportionate impact of identity-based harms, such as bias and discrimination within GME.[2] Bias and discrimination must be addressed and prevented by multifaceted, sustained efforts. This special issue of *Academic Medicine* documents the lessons learned from educational interventions intended to overcome bias and discrimination by fostering civility, safety, and belonging in our learning environments.

This paper uses the metaphor "our house" to describe all aspects of the academic medical environment in which health care professionals and trainees learn and work. Many of our house's inhabitants, particularly trainees, have declared our house to be in a state of disrepair. The cracks in our house's foundation are the result of construction with faulty materials: pain inflicted by bias and discrimination, silence inhibiting meaningful change, and despair resulting in the loss of members in our community. These cracks have persisted as the inhabitants of our house have long adhered to a set of rules that unduly disadvantage individuals of some identity groups more than others. Even those in majority identity groups and positions of power face identity-based harms in our house. All house members who share the collective goal of promoting health equity must share a collective commitment to repair our house.

We, the authors, initially entered this work armed with words to tear our house down, believing that the destruction of our house and starting anew were the only ways to liberate medicine from the structural inequities within current GME training systems. We began our discussions anchored in critical theory, centering the interventions to foster

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civility, psychological safety, and belonging. We strived toward critical consciousness, wherein we understand and challenge dominant power dynamics through dialogue and action.[3] As our dialogues progressed, we found ourselves confronted with the dilemma of writing to demolish our house while we still exist within it, anticipating the impact of such personal and collective chaos. Our dialogue and reading led us to liberation psychology, a theoretical extension of critical theory. Ignacio Martín Baró, a foundational liberatory theorist, articulated that liberation does not require us to destroy our house and abandon everything of the past, but it does require us to examine the cracks in our house's foundation to critically examine all of our ways of being.[4] In the ensuing article, the use of "we" includes all those individuals and structures which contribute to the learning environment: educators, training institutions, administrators, patients, and learners themselves.

Critically Examining How Our House Was Built

We built our house with pain

> If one really wishes to know how justice is administered in a country, one does not question the policemen, the lawyers, the judges, or the protected members of the middle class. One goes to the unprotected —those, precisely, who need the law's protection most!—and listens to their testimony.
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> —James Baldwin, *No Name in the Street*[5]

Pain results from oppression of individuals within the community. Identity-based inequities are pervasive and persistent forms of oppression that disproportionately inflict pain on members of some identity groups. This oppression may be roughly categorized as inequities of experience and inequities of assessment. Inequities of experience and inequities of assessment are fundamentally intertwined and amplified by learners' vulnerable positioning within the educational system. For example, stereotype threat describes the impaired performance that occurs when an individual fears fulfilling negative stereotypes about their identity group.[6] Commonplace identity-based experiences, such as microaggressions and standing out, can trigger stereotype threat, overwhelming a learner's cognitive load. A recent study of gender-based stereotype threat in residents demonstrated that when feedback is perceived as gendered, it can trigger stereotype threat and potentially impair future performance.[6]

Inequities of experience include, but are not limited to, discrimination, mistreatment, harassment, and abuse. Discrimination occurs when one person treats another less favorably than others because of some aspect of their identity. Discrimination is commonplace within GME. A cross-sectional study of over 7,400 surgery residents revealed that 65% of women respondents reported incidents of gender discrimination during training.[7] Additionally 16% of residents endorse having experienced racial discrimination from supervisors, peers, and patients.[7] Physicians with disabilities may face barriers related to inhospitable work environments as well as barriers discouraging disclosure of disabilities and utilization of appropriate disability accommodations.[8] Physicians who are international medical graduates may encounter discrimination related to their nationality, may experience stress related to the possibility that poor performance could impact their immigration status, and must adapt to contextually new expectations for professionalism and patient-provider communication.[9] Transgender and nonbinary individuals may face transphobia and misgendering, which are psychologically and cognitively harmful.[10]

Furthermore, assessment is highly susceptible to bias and inequities.[11] This is consequential for learning, advancement, and certification of competency in GME. Numerous multi-institutional studies have revealed bias in assessment in GME due to race/ethnicity.[12,13] Anderson et al's recent discourse analysis of pediatric residency assessment policy and procedure documents found that identity-based inequities are "woven into the fabric" of assessment.[14] The language in assessment policy documents used to describe learners with differences signals the bias within the system: learners with disabilities, such as mental illness or learning differences, are classified in these documents as "problematic" residents.[14] This language forces a false dichotomy between "problematic" residents such as those with disabilities and "successful" residents.

We built our house with silence

> My silences had not protected me. Your silence will not protect you. But for every real word spoken, for every attempt I had ever made to speak those truths for which I am still seeking, I had made contact with other women while we examined the words to fit a world in which we all believed, bridging our differences.
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> —Audre Lorde, *The Cancer Journals*[15]

Silence results when conflict meets unmitigated power hierarchies. For those experiencing harm, there unquestionably are times when silence is the only safe option. Too often, however, we as educators and colleagues of the harmed remain silent in the face of injustice or oppression to protect our own positions of privilege. A lack of diversity of community members or of those in leadership positions perpetuates silence in our house. When diversity is not protected, dominant discourses persist unchallenged. Professionalism has long been viewed as an essential competence of medical practice. Increasingly, education literature has highlighted the nuances and limitations of the professionalism construct.[16] In particular, professionalism can be wielded as an undesirable conforming force targeting those outside of the group norms and can result in the silencing and erasure of differences that may benefit patient care.

Structural barriers prevent many trainees from speaking about their experiences of bias and discrimination. Academic institutions, which often serve as arbiters in claims of bias or discrimination, may be unfair judges with competing priorities.[17] Trainees who report allegations of institutional discrimination to larger governing bodies such as the Accreditation Council for Graduate Medical Education may risk loss of program accreditation, thereby jeopardizing future career prospects. Formal legal action against institutions, which could drive structural change, can be prohibitively expensive, time consuming, or retraumatizing for trainees. Finally, professionalism, as described above, can be wielded to silence whistleblowers.

Program directors hold a complex role at the intersection of learners and

department or institutional leadership. As such, they may experience tension between the competing interests of learner well-being and institutional demands and expectations. Program directors may experience conflict in their dual roles as summative evaluator and advocate. While program directors are found to be generally attuned to feelings of burnout and suicidality among the learners in their programs, they may overestimate well-being and underestimate mistreatment compared to resident perceptions of the clinical training environment.[18] While learners are often dependent on program directors for support following reporting of mistreatment or harmful training structures, program directors themselves face burnout and discrimination.[19] The notion that program directors must be willing and able to effectively advocate for learners in complex health care systems is both critical and unacknowledged in recent guidelines around the roles of program directors.[20]

We built our house with despair

> I ask no favors for my sex. I surrender not our claim to equality. All I ask of our brethren is that they will take their feet from off our necks.
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> —Sarah Grimké, *The Public Years of Sarah and Angelina Grimke*[21]

Perpetuating pain and silence results in many downstream impacts within the GME community; despair results when these experiences are compounded by a lack of belief in a hoped-for future. Attrition is perhaps one of the most significant outcomes. Sadly, absent flexible pathways to practice that support sufficient leave from or extension of training, many residents leave their programs.[22] And although leaving a training program may be the best and healthiest decision for a given trainee, we must examine the training factors that may have adversely informed each learner's ultimate decision. A majority of the attrition literature comes from the surgical specialties, with evidence of higher rates of attrition for women and surgeons from underrepresented backgounds.[23] We, as authors, know that attrition is not limited to the surgical specialties. Trainee attrition increases when clinical duties are prioritized over education, when trainees have negative interactions with authority figures, when they lack identity-concordant role models, have poor mental health, and lack available leave time.[24]

Much has been written also of the epidemic of depression and suicidality in health care and medical education. Residents experience rates of major depression 3 times that of age-matched counterparts. Tragically, too many physicians end their lives.[25] Despair grows when health system leaders, administrators, educators, and even trainees themselves prioritize delivery of care over the deliverers of care. This resulting belief that things will not get better drives this preventable loss of trainees and others from our community.

Such evidence of pain, silence, and despair suggests that it is unnecessary for our community to tear GME down; the system is already crumbling. GME must confront factors that oppose progress, including outdated funding structures; active resistance against diversity, equity, and inclusion; lack of commitment to meaningful change; and leadership stagnation. To accomplish true transformation, we must employ a new set of house rules, a different way of living together based on the practice of liberatory design[26] (see List 1). With these mindsets, we can begin this work by taking up old tools—peace, love, and hope—to craft a house that can become a safe home for us all. These tools bridge identity differences in a time where there is fear and opposition to difference.

Rebuilding Our House With Primitive Tools

We must rebuild our house with peace

> I agree that it is more tension now. But peace is not merely an absence of this tension, but the presence of justice. And even if we didn't have this tension, we still wouldn't have positive peace.
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> —Martin Luther King Jr, *When Peace Becomes Obnoxious*[27]

Peace is possible where connection supports psychological safety, inviting individual and collective voices to the resistance. Silence is often mistaken for peace. Silence in the face of injustice signals assent and can oppose our goals of progress toward true peace and justice. The pursuit of peace in GME requires educators to confront hierarchical structures that are counterproductive to true and genuine peace. These hierarchical structures, long considered essential to medical training, are imbalanced across identity groups, creating a complex dynamic for GME trainees. To upend bias and discrimination, we must closely examine relationships at the core of our work and learning environments.

Hierarchies are organizational groupings that allow a community to coordinate skills and resources in pursuit of a common goal, but these exist in tension within medical education. As trainees build medical knowledge in the apprenticeship model, hierarchy serves an important purpose for patient safety and allows for efficient decision-making in critical or time-sensitive situations. However, hierarchy can also perpetuate oppression and impair relational learning in medical education. Exchanging control of the hierarchy for connection between all team members may be an antidote to the pain of oppression.

One way to operationalize this change is through a concerted effort to develop psychological safety in our learning environments. Psychological safety is defined as the belief that team members can speak up without fear of interpersonal consequences, such as being shamed, blamed, or ignored. The presence of psychological safety promotes speaking up in teams across a wide range of work and learning environments.[28] In the presence of psychological safety, team members feel comfortable disclosing errors and can speak up or question another team member. A psychologically safe learning environment prioritizes reciprocity and honesty and allows for recognition and sharing of each individual's experience and wisdom regardless of level of training.[29] Coconstruction of a psychologically safe learning environment allows trainee and supervisor to collaboratively generate learning goals, to collectively interrogate "the way we have always done things," and to mutually determine how bidirectional feedback can be best delivered.

Resistance, acts of agency that disrupt in some way, can help to foster

psychological safety. Resistance often represents an act of current discomfort in response to a perceived injustice in hopes of the future benefit of peace. Resistance in medical trainees can be enacted through a variety of ways, such as questioning attending physicians, petitions, walkouts, protests, research, and social media campaigns.[30] Historically, movements of resistance from marginalized groups, including pivotal social justice movements, have challenged and transformed hierarchies of power. Competing resistance from those in power often occurs as a reaction to resistance from groups with relatively less power. Reforming GME to become a more welcoming space for those who have been traditionally excluded from medical training includes embracing resistance in a constructive manner.

To rebuild with peace and combat bias and discrimination, medical educators should support structures that prioritize speaking over silence (Table 1). Attending to psychological safety, removing barriers to disclosure of bias, and ensuring accountability provide opportunities for trainees to exercise their agency and contribute to the process of change. These processes require faculty, leadership, and trainees to genuinely commit to prioritizing respectful behavior, policies, and practices.[31] For example, an initial increase in the number of reported incidents of bias is a sign of an effective intervention to promote trainee bias reporting. When effective reporting tools are supported by transparent, principle-driven processes to address allegations of bias and discrimination, we foster peace. Supporting trainee resistance is one of many ways to foster peace: educators and systems must be skilled in peace-making as well. Where there is resistance, there will be relational strain, yet simultaneously opportunities for repair and restoration. All educational leaders should have ongoing training in practices such as conflict resolution and restorative justice and should own the impact of concerns related to power and privilege.[32] Acts of resistance signal that there is life still in the house and that those inside are willing to embrace discomfort for something different.

We must rebuild our house with love

> To truly love we must learn to mix various ingredients—care, affection, recognition, respect, commitment, and trust, as well as open and honest communication.
> —bell hooks, *All About Love: New Visions*[33]

Love is possible in an identity-safe community that encourages inhabitants to leverage their identity capital to enable more meaningful relationships. Love is a foundational human emotion and, simultaneously, a deeply taboo concept in medical education. Love is desperately needed in GME. Many educators would consider it unprofessional to express love for one's patients or for one's residents or fellows. In English, love has many definitions. In this article, when we describe love, we look beyond *eros*, also known as romantic or sexual love, to instead elaborate on 3 other forms of love: *philia* (deep friendship), *agape* (selfless, unconditional love), and *philautia* (love for oneself).

Table 1
Strategies for Building With Peace in the Transformation of GME

	Strategies
Educator development	• Provide faculty development in specific observable skills and behaviors that foster psychological safety in trainees (e.g., emphasizing learning as a core goal, setting clear expectations for trainees, inviting trainees at all levels to offer input or speak up and ask questions). Faculty should acknowledge their own knowledge gaps and/or struggles. • Ensure faculty well-being, which impacts the learning environment created for trainees. • For faculty who are "repeat offenders" for mistreatment unresponsive to remediation, consider removal from teaching settings. • Create psychologically safe environments for faculty to disclose and discuss their own uncertainty and personal challenges in medicine. • Provide opportunities for skill-building in speaking up.
GME and program leadership	• Provide easily accessible mechanisms for trainee reporting of harmful/abusive behavior that provide accountability and protect reporter security. If desired, the trainee should be informed of actions taken in response to their report. • Program directors should actively support trainees' efforts to advocate for changes that improve patient safety, trainee safety, and wellness. • Trainees must feel comfortable sharing challenges with program leadership. This involves trainees feeling heard without leader assumptions, leaders asking permission before escalation, and, if agreed upon, leaders using their power to make changes or delegate to others. • Cultivate collaborative relationships with groups organized in resistance (e.g., house staff unions). • Offer training and resources for restorative practices for community building and harm.
In the learning environment	• Be curious and respect boundaries: use open-ended questions/ice breakers rather than those which compare past accomplishments. • Challenge the notion of strict interpersonal boundaries between levels of "hierarchy." Take a genuine interest in trainees' lives and well-being (e.g., invite a team out to dinner at rotation's end, engage on social media, share important life milestones, etc.). • Some trainees want or need separation between their personal and professional lives or may not engage in social events due to competing personal or financial priorities. Supervisors should clarify that external events are unrelated to assessment and consider asking preemptively about external factors which might influence team participation outside of work (e.g., avoiding events with alcohol, child bedtime, etc.). • Model language that demonstrates intellectual humility (e.g., after summarizing a team plan, ask about omissions or share a time when things did not go according to plan).

Philia exists when we value others for the intrinsic worth of their authentic self. When individuals are unable to be their authentic selves due to lack of safety, they are unable to form deep friendships, inhibiting their ability to love and feel love. Literature describing the construct of identity safety may highlight the promising role of deep, authentic friendship. Identity safety refers to a state where an individual can exist as their authentic self.[34] Identity safety in medicine arises when individual, interpersonal, and structural needs are met. Individually, when team members feel agency to leverage their identities on their own terms to improve patient care or help others, they empower their authentic self. Learning how and when to thoughtfully disclose personal information in the spirit of healing may improve the care we provide to patients by creating shared humanity in our house. Interpersonally, identity safety is fostered when a learner feels seen by others as a unique individual with valuable identities and also as a unique person who exists beyond their identity group(s). Finally, a person fulfills their structural need of identity safety when their authentic self is welcomed into community. Early evidence suggests that identity-safe practices may help to prevent and combat the pain of identity threats. By promoting identity safety, educators may allow learners and themselves to show up more often as their authentic selves, thereby creating an opportunity for love to arise via deep friendship.

Selfless *agape* love and self-loving *philautia* are often juxtaposed as competing concepts for medical trainees. For example, Stergiopoulos et al[35] described the internally competing narratives of the good doctor and the good patient for medical trainees with disabilities. Good doctors work long and hard, often sacrificing their personal bodily and social needs in service of their patients. Good patients listen to their bodies and prioritize themselves and their health. Without self-love and self-care, health professionals are unable to healthily sustain the selfless *agape* in their work. Educational policies and collective action and bargaining can be powerful but incomplete tools to create formal barriers to balance the demands of physicianhood.[36] *Agape* and *philautia* must exist simultaneously and in balance to support the spaces necessary to sustain the work of a medical career.

Medical educators, including administrators, program directors, attending physicians, and senior residents, play a pivotal role in fostering a culture of love in the clinical learning environment (Table 2). Educators should lay a foundation of safety by emphasizing 3 overarching leadership tasks. These are to set expectations of love, invite loving participation, and respond productively with love. Setting expectations of love includes defining underlying team goals, such as emphasizing simultaneous self-care and patient care, prioritizing collaborative learning, and nurturing a team culture of acknowledging and addressing identity threats.[37] Inviting participation refers to valuing and eliciting the diverse critical knowledge that team members bring to patient care. Within such a construct that elevates learners' experiences, opinions, and emotions, existing curricula may be productively disrupted and enhanced. Vulnerability modeled by educators in the form of intellectual candor can increase the exchange of diverse ideas.[38] For example, intellectual candor would be demonstrated if a team leader, as part of their commitment to creating a safe learning environment for all learners, were to acknowledge that, despite their

Table 2
Strategies for Building With Love in the Transformation of GME

	Strategies
Educator development	• Practice team introductions to establish norms, efficiently orient new team members, and create a culture that welcomes diversity of opinion and experience. • Offer faculty the opportunity to interact with identity-concordant mentors and peers outside their department for debriefing and community building, as desired. • Train faculty in skills for mentoring across differences, including the opportunity to role-play and receive feedback on mentoring others facing common identity-based challenges (e.g., sexual harassment, racial bias). • Call on and sponsor community members who hold unique identities for educational and leadership opportunities, especially those that are traditionally reserved for individuals in higher leadership positions (e.g., presentations, teaching, mentoring, writing, etc.).
GME and program leadership	• Specifically engage learners or leaders with dissenting, nonmajority opinions as the program or institution considers changes. Consider alternatives to in-person forums to facilitate dissent. • Create assessment structures that prioritize equity by regularly monitoring assessment outcomes and reporting findings to trainees. Equitable assessment systems must include educators, learners, and patients in determining assessment metrics. • Strive for continuity in work and learning assignments to maximize opportunities for high-quality relationship building both with patients and preceptors. • Advocate for changes in systems of care delivery that facilitate the best care of self and others (e.g., patients, colleagues). • Advocate for increased staffing, with a goal of allowing programs and learners maximal curricular flexibility.
In the learning environment	• Elicit preferences from trainees regarding how the attending physician should respond in the moment if that trainee is faced with harassment or microaggressions from patients or others. • Promote inclusion and flexibility by adapting to trainees' various needs for accommodation. • With struggling learners, consider how the learning environment may be impeding their success. • Support trainees who wish to speak up against mistreatment or injustice in our system. This can and should be done thoughtfully, even when there is interpersonal risk.

Abbreviation: GME, graduate medical education.

position on the team, they may not be the most skilled at responding to identity threats. Using one's position of power for, and inviting participation in, advocacy is love.

We must rebuild our house with hope

> For there is always light if only we're brave enough to see it, if only we're brave enough to be it.
> —Amanda Gorman, *The Hill We Climb*[39]

Hope is possible where belonging exists and enables a vision for a future GME more fully aligned with our values and goals. Importantly, hope can simultaneously mourn the pain, silence, and despair of the past while looking forward. Everyone in our house must grieve the individual and collective pain, silence, and despair that they have experienced in learning and in labor. GME leaders must also grieve their historic and current complicity within systems that have perpetuated harm to learners and the often-glacial pace of change, even when catalyzed in moments of moral conviction and deep effort. We must expect that, at first, we may fail more often than we succeed. Racism, as one example, has been described as "complex, contradictory, and fast changing; it follows that anti-racism must be equally dynamic. What works in one place at one time may not work at another place or another time."[40] After finding fellowship in our grief, we must remind one another that our house will not rebuild itself and join our hands and hearts for the good work that lies ahead.

True belonging within a community provides hope that the community can evolve just as the members in the community can evolve. Within new conceptualizations of belonging, learners perceive that it is less important that they "fit" within a learning community as members of the community demonstrate attunement to each individual's needs. True belonging brings an imagination for how the learning environment might in turn adapt to each member. Within educational psychology, a robust body of literature ties a sense of belonging to improved academic performance, academic engagement, and psychological well-being,[41] and, in GME, to lower burnout and attrition.[42] That said, representing belonging as a panacea to pain, silence, and despair is oversimplistic. Feelings of similarity, often mistaken for belonging, may comfort some individuals in the community, but falsely conflating similarity with belonging alienates other individuals who perceive themselves to be different, engendering feelings of isolation and loneliness.

To truly foster belonging, all members within GME must recognize and own personal responsibility for intentionally creating opportunities for others to belong—spaces and practices by which hope may be rekindled. Within GME, early evidence suggests that these opportunities for learners must address the desires to be known, be celebrated in difference, succeed, and see oneself within a possible future (Table 3).

As we pursue the slow yet critical work of dismantling inequitable systems and structures, educators must steward the imagination of GME learners from the inside out and from the outside in. The former requires that we explicitly and uniformly normalize the challenges of GME, reinforcing that adversity is common, improves with time, and is not to be conflated with nonbelonging. These facts are true regardless of learner identity, but the message is more powerful where learners' identities have been marginalized within the learning environment. Offering credible examples of struggles encountered by "successful" learners within the environment can be particularly powerful. Furthermore, educators must commit to "wise criticism," a discipline of learner-centered feedback that centers high expectations critically paired with expressions of our belief in their ability to meet these expectations. This practice has been shown to improve academic performance, academic persistence, and the perception of having been evaluated without bias; it also has enhanced learner trust in their

Table 3
Strategies for Building With Hope in the Transformation of GME

	Strategies
Educator development	• Support faculty in teaching via a coproduction model, recognizing the expertise and goals of trainees, and tailoring teaching to those goals and broader needs. • Teach faculty to give "wise feedback," which explains that faculty hold high expectations and believe in trainees' capabilities to meet them. Give specific feedback in support of those goals. • Promote systems of holistic review within processes for recruitment.
GME and program leadership	• Elicit frequent perspectives from trainees regarding their personal and professional goals and help to tailor their training to provide the specific experiences and mentorship needed to reach those goals. Avoid projecting professional expectations and aspirations onto trainees. • Design and implement meaningful longitudinal mentorship programs. • Celebrate and highlight differences within the program or institution as an asset. • Be explicit within the community regarding goals and vision for transformation of GME. • Cultivate and fund strong programs in remediation and learner support. • Evaluate built and digital environments with an eye toward cues to belonging.
In the learning environment	• Center the perspectives and experiences of learners on a team rather than those of faculty. For instance, it is better to acknowledge changing training environments with regard to workload and work hours to optimize learning in a noncomparative fashion (i.e., avoid "back in my day…"). • Enhance individual learners' and teams' ownership in the learning environment by regularly seeking feedback on group dynamics and adjusting as needed.

Abbreviation: GME, graduate medical education.

List 1
Mindsets of Liberatory Design[a,26]

1. Build relational trust
2. Practice self-awareness
3. Recognize oppression
4. Embrace complexity
5. Focus on human values
6. Seek liberatory collaboration
7. Work with fear and discomfort
8. Attend to healing
9. Work to transform power
10. Exercise creative courage
11. Take action to learn
12. Share, don't sell

[a]Liberatory design is the process of fostering awareness of design practices that perpetuate inequities and collectively freeing the design process by interrogating the relationship between designers and those impacted by the design.

educational supervisors.[41] This messaging may be particularly important for trainees at risk of identity threats such as stereotype threat.

From the outside in, within an unpredictable and distributed learning environment, educators must be attentive for practices that "systematize" or cues that imply a lack of belonging. Belonging begins with early engagement before college and gains momentum with reevaluation of current admissions criteria and scrutiny of biased systems of assessment. Environmental cues, such as a lack of diversity in photos lining the walls of hospitals or clinics, can indicate to learners that they do not belong. To have hope of belonging, trainees need identity-concordant colleagues and leaders that stand as evidence that they can exist and succeed within that setting.[43] It is equally important for identity-discordant mentors and colleagues to be attuned to and curious about the experiences of others. Representation without belonging returns to pain, silence, and despair.

Anticipating imperfections in the house we will build together

The work of rebuilding our house will be difficult. No individual or group can complete this work singlehandedly. Although individuals within the house have historically lived as siloed within an environment of perceived scarcity, rebuilding the house with peace, love, and hope will require our collective power. Transformation requires personal reflection and a yearning for justice. We must hold the dialectic that we are painfully far from a house that does not perpetuate harm and that we have made substantial progress from where we once were.

Although we believe that peace, love, and hope will fortify the house of GME, no materials are without imperfections. Individual rooms within our house may require further adaptations that depart from a one-size-fits-all training experience in keeping with the needs and circumstances of a specific resident or fellow, thus prioritizing equity over equality of experience. As educators, we are duty-bound to evaluate each educational intervention to determine whether it accomplishes our hoped-for outcomes or threatens our foundations by introducing unintended harms. As we strive toward true representation with psychological safety, identity safety, and belonging, future generations of learners may rightly ask new questions of educators and institutions for which we may not yet have answers. Our house is influenced by the broader sociopolitical climate ("neighborhood") of medicine and informed by local, regional, national, and international events as they relate to education, health care, policing, legislation, and environment, among others. Although we tend to our own house, we also must recognize that those sociopolitical events impacting our neighbors also impact everyone within our house and act accordingly.

Finally, at the center of our transformation are our patients, who deserve our highest craftsmanship. They are wise with life, and they too seek peace, love, and hope. As we build for and with them toward a more humane medicine, this struggle is also our own. May we begin by opening the doors wide to and welcoming individuals of all identities, allowing us to create the blueprints for liberation together and confidently take up the tools we have held all along.

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References

1 Morrison T. The Source of Self-Regard: Selected Essays, Speeches, and Meditations. 1st ed. New York: Alfred A. Knopf; 2019.
2 Humphrey HJ, Levinson D, Nivet MA, Schoenbaum SC. Addressing harmful bias and eliminating discrimination in health professions learning environments: an urgent challenge. Acad Med. 2020;95(12): S1–S4.
3 Freire P. Pedagogy of the Oppressed. New York: Continuum; 2007.
4 Martín-Baró I. Writings for a Liberation Psychology. Cambridge, MA: Harvard University Press; 1994.
5 Baldwin J. No Name in the Street. New York, NY: Dial Press; 1972.
6 Frank AK, Lin JJ, Warren SB, et al. Stereotype threat and gender bias in internal medicine residency: it is still hard to be in charge. J Gen Intern Med. 2024;39(4):636–642.
7 Hu Y-Y, Ellis RJ, Hewitt DB, et al. Discrimination, abuse, harassment, and burnout in surgical residency training. N Engl J Med. 2019;381(18):1741–1752.
8 Pereira-Lima K, Meeks LM, Ross KET, et al. Barriers to disclosure of disability and request for accommodations among first-year resident physicians in the US. JAMA Netw Open. 2023;6(5):3–11.
9 Al-Haddad M, Jamieson S, Germeni E. International medical graduates' experiences before and after migration: a meta-ethnography of qualitative studies. Med Educ. 2022;56(5):504–515.
10 Dimant OE, Cook TE, Greene RE, Radix AE. Experiences of transgender and gender nonbinary medical students and physicians. Transgender Heal. 2019;4(1):209–216.
11 Lucey CR, Hauer KE, Boatright D, Fernandez A. Medical education's wicked problem: achieving equity in assessment for medical learners. Acad Med. 2020;95(12 suppl): S98–S108.
12 Lett E, Tran NK, Nweke N, et al. Intersectional disparities in emergency

medicine residents' performance assessments by race, ethnicity, and sex. JAMA Netw Open. 2023;6(9):E2330847. doi:10.1001/jamanetworkopen.2023.30847, e2330847
13 Osseo-Asare A, Balasuriya L, Huot SJ, et al. Minority resident physicians' views on the role of race/ethnicity in their training experiences in the workplace. JAMA Netw Open. 2018;1(5):e182723. doi:10.1001/jamanetworkopen.2018.2723.
14 Anderson HL, Abdulla L, Balmer DF, Govaerts M, Busari JO. Inequity is woven into the fabric: a discourse analysis of assessment in pediatric residency training. Adv Heal Sci Educ Theory Pract. 2024;29(1):199–216.
15 Lorde A. The Cancer Journals. San Francisco: Aunt Lute Books; 1997.
16 Maristany D, Hauer KE, Leep Hunderfund AN, et al. The problem and power of professionalism: a critical analysis of medical students' and residents' perspectives and experiences of professionalism. Acad Med. 2023;98(11):S32–S41.
17 Smith CP, Freyd JJ. Institutional betrayal. Am Psychol. 2014;69(6):575–584.
18 Penwell-Waines L, Kulshreshtha A, Brennan J, et al. Comparing resident and program director perspectives on wellness curricula: a CERA study. PRiMER. 2023;7:1–11. doi:10.22454/primer.2023.300982.
19 De Golia SG, Houston LJ, Madaan V, et al. The burden of leadership: a survey of burnout experiences among psychiatry program directors. Acad Psychiatry. 2023;47(2):174–180.
20 Caniano DA, Bernstein CA, Carter W, Mitchell SR, Nasca TJ. Transactional competence, reliability, and trustworthiness: essential attributes of the successful program director. J Grad Med Educ. 2023;15(1):134–139.
21 Grimké S, Grimké A. The Public Years of Sarah and Angelina Grimke. New York, NY: Columbia University Press; 1989.
22 Khoushhal Z, Hussain MA, Greco E, et al. Prevalence and causes of attrition among surgical residents a systematic review and meta-analysis. JAMA Surg. 2017;152(3):265–272.
23 Haruno LS, Chen X, Metzger M, et al. Racial and sex disparities in resident attrition among surgical subspecialties. JAMA Surg. 2023;158(4):368–376.
24 Liang R, Dornan T, Nestel D. Why do women leave surgical training? A qualitative and feminist study. Lancet. 2019;393(10171):541–549.
25 Yaghmour NA, Brigham TP, Richter T, et al. Causes of death of residents in ACGME-accredited programs 2000 through 2014: implications for the learning environment. Acad Med. 2017;92(7):976–983.
26 Hasso Plattner Institute of Design at Stanford University. Liberatory design. Accessed April 15, 2024. https://dschool.stanford.edu/resources/liberatory-design-cards
27 King Jr. ML. When peace becomes obnoxious. Stanford: The Martin Luther King Jr Research and Education Insitute. Published March 18, 1956. Accessed May 20, 2024. https://kinginstitute.stanford.edu/king-papers/documents/when-peace-becomes-obnoxious
28 Edmondson AC. The Fearless Organization. 1st ed. Hoboken, NJ: John Wiley & Sons; 2019.
29 McClintock AH, Fainstad TL, Jauregui J. Creating psychological safety in the learning environment: straightforward answers to a longstanding challenge. Acad Med. 2021;96(11):S208–S209.
30 Wyatt TR, Jain V, Ma TL. 'When I stood up for something it's because I felt a … moral violation': trainees' acts of resistance against social harm and injustice. Med Educ. 2024;58(4):457–463.
31 Leape LL, Shore MF, Dienstag JL, et al. Perspective: a culture of respect, part 2: creating a culture of respect. Acad Med. 2012;87(7):853–858.
32 Wolfe AD, Hoang KB, Denniston SF. Teaching conflict resolution in medicine: lessons from business, diplomacy, and theatre. MedEdPORTAL. 2018;14:10672. doi:10.15766/mep_2374-8265.10672.
33 Hooks B. All About Love: New Visions. New York: William Morrow; 2000.
34 Bullock JL, Dyster TG, Teunissen PW, et al. 'Yourself in all your forms': a grounded theory exploration of identity safety in medical students. Med Educ. 2024;58(3):327–337.
35 Stergiopoulos E, Fernando O, Martimianakis MA. "Being on both sides": Canadian medical students' experiences with disability, the hidden curriculum, and professional identity construction. Acad Med. 2018;93(10):1550–1559.
36 Woodrow SI, Segouin C, Armbruster J, Hamstra SJ, Hodges B. Duty hours reforms in the United States, France, and Canada: is it time to refocus our attention on education? Acad Med. 2006;81(12):1045–1051.
37 O'Brien MT, Bullock JL, Minhas PK, et al. From eggshells to action: a qualitative study of faculty experience responding to microaggressions targeting medical students. Acad Med. 2023;98(11):S79–S89.
38 Molloy E, Bearman M. Embracing the tension between vulnerability and credibility: 'intellectual candour' in health professions education. Med Educ. 2019;53(1):32–41.
39 Gorman A. The hill we climb. Published January 20, 2021. Accessed August 9, 2024. https://www.youtube.com/watch?v=LZ055ilIiN4
40 Gillborn D. Critical race theory and education: racism and anti-racism in educational theory and praxis. Dent Discourse. 2006;27(1):11–32.
41 Yeager DS, Purdie-Vaughns V, Garcia J, et al. Breaking the cycle of mistrust: wise interventions to provide critical feedback across the racial divide. J Exp Psychol Gen. 2014;143(2):804–824.
42 Salles A, Wright RC, Milam L, et al. Social belonging as a predictor of surgical resident well-being and attrition. J Surg Educ. 2019;76(2):370–377.
43 Yemane L, Kas-Osoka O, Burns A, et al. Upholding our PROMISE: underrepresented in medicine pediatric residents' perspectives on interventions to promote belonging. Acad Med. 2023;98(12):1434–1442.