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THE TRANSFORMATIVE POWER OF INCLUSION, DIVERSITY, EQUITY, ACCESSIBILITY, AND SOCIAL JUSTICE IN INTERPROFESSIONAL EDUCATION AND COLLABORATIVE PRACTICE

DISCUSSION PAPER

January 2024

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Canadian Interprofessional Health Collaborative
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A Publication by the Global Network for Interprofessional Education and Collaborative Practice Research (InterprofessionalResearch.Global), in collaboration with the Canadian Interprofessional Health Collaborative (CIHC) and members of the American Interprofessional Health Collaborative (AIHC)

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American Interprofessional Health Collaborative

Prepared by:

- **Kelly Lackie, BScN MN PhD CCSNE**, Associate Director, Simulation-based Education and Interprofessional Education and Assistant Professor, Dalhousie University School of Nursing.
- **Hossein Khalili, BScN, MScN, PhD, FNAP**, President, InterprofessionalResearch.Global (IPR.Global); Senior Associate Dean of Academic Administration, School of Health Sciences, Winston-Salem State University; Adjunct Research Professor, Western University; Member, Canadian Interprofessional Health Collaborative (CIHC) Board of Directors.
- **John Gilbert, CM, PhD, LLD, FCAHS**, University of British Columbia.
- **Susan Bookey-Bassett, RN, PhD**, Assistant Professor, Daphne Cockwell School of Nursing, Toronto Metropolitan University, Co-Lead Better Work Better Care Coalition @BWBCare, Director, Research and Education, Nursing Leadership Network of Ontario, Vice-President, Registered Nurses Foundation of Ontario.
- **Suzanne Cutler, BPharm, PhD, IP, FHEA, PGCert, Dip Pres Sci**, School of Pharmacy and Biomolecular Sciences, Liverpool John Moores University, Liverpool, UK.
- **Kala Dixon, PhD, MS**, Assistant Professor and Director of Interprofessional and Continuing Education, Department of Family and Community Medicine|Heersink School of Medicine, UAB| The University of Alabama at Birmingham.
- **Moni Fricke, BMR(PT), PhD**, Department of Physical Therapy, College of Rehabilitation Sciences, Office of Interprofessional Collaboration, Rady Faculty of Health Sciences, University of Manitoba, Winnipeg, Canada.
- **Christopher Green, PhD SFHEA**, Professor and Director of Education, School of Health and Social Care, University of Essex, UK.
- **Robin Ann Harvan, EdD, (H)FNAP, FIAMSE, FACE**, Professor of Health Sciences and Co-Leader of the Center for Interprofessional Practice and Education, Massachusetts College of Pharmacy and Health Sciences, Boston, MA.
- **Jennifer Jessen, EdD, RN, CNOR**, Assistant Professor, Executive Director of the Center for Interprofessional Practice, Education, and Research (CIPER), Creighton University.
- **Sylvia Langlois**, Associate Director, Academics Centre for Advancing Collaborative Healthcare and Education, University Health Network and University of Toronto, Associate Professor, Department of Occupational Science and Occupational Therapy, Temerty Faculty of Medicine, University of Toronto.
- **Laura MacDonald, RDH, PhD**, Associate Professor, Dr. Gerald Niznick College of Dentistry & School of Dental Hygiene, and College Lead, Office of Interprofessional Collaboration, Rady Faculty Health Sciences, University of Manitoba, Winnipeg, Canada.
- **Barbara Maxwell, PhD, DPT, MSc, Cert THE, FNAP**, Associate Dean & Director, Indiana University Interprofessional Practice and Education Center, Professor of Physical Medicine & Rehabilitation, IU School of Medicine, Adjunct Professor Physical Therapy, School of Health & Human Sciences.
- **Charlotte McCartan, PhD(c), MN, BScN (RN)**, University of Alberta.
- **Ghaidaa Najjar, PharmD, PhD**, Adjunct clinical faculty & Instructor at Eugene Applebaum College of Pharmacy and Health Sciences, Wayne State University. Adjunct faculty at University of Michigan. Michigan, USA.
- **Vikki Park PhD., PG Dip., PG Cert., BSc (Hons), RN, RNT, SFHEA**, Assistant Professor of Interprofessional Education & Collaborative Practice, IPE Faculty Lead, Northumbria University, United Kingdom; CAIPE National Board Member & Research Priority Group Co-Lead; IPR.Global Communications Co-Lead and Steering Committee Member; IP.Global Communications Working Group Member.
- **Aline Saad, Pharm.D**, Director of Faculty Development, Coordinator of Interprofessional Education, Associate Professor (Clinical) of Pharmacy Practice, Eugene Applebaum College of Pharmacy and Health Sciences, Wayne State University, Detroit, Michigan.
- **Kaisa Syvaoja, OTD, OTR/L**, Assistant Professor, Department of Occupational Therapy, The College of St. Scholastica, Duluth, Minnesota, United States.
- **Carl R Schneider, PhD, PGCert(Higher Ed), BN, BPharm (Hon), FFIP, FHEA**, Associate Professor, Sydney Pharmacy School, Faculty of Medicine and Health, The University of Sydney.

Edited by:

- **Kelly Lackie, BScN MN PhD CCSNE,** Associate Director, Simulation-based Education and Interprofessional Education and Assistant Professor, Dalhousie University School of Nursing.
- **Hossein Khalili, BScN, MScN, PhD, FNAP,** President, InterprofessionalResearch.Global (IPR.Global); Senior Associate Dean of Academic Administration, School of Health Sciences, Winston-Salem State University; Adjunct Research Professor, Western University; Member, Canadian Interprofessional Health Collaborative (CIHC) Board of Directors.
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- **Ghaidaa Najjar, PharmD, PhD**. Adjunct clinical faculty & Instructor at Eugene Applebaum College of Pharmacy and Health Sciences, Wayne State University. Adjunct faculty at University of Michigan. Michigan, USA.

Designer:

- **Camila Souza, BScN, PhD Student**, School of Nursing, University of São Paulo, Brazil.

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*Co-First Authors

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Preface

In the vast expanse of healthcare education and practice, where disciplines converge and practitioners collaborate, we find ourselves at a critical juncture. The compass guiding our journey displays the inscription: *Inclusion, Diversity, Equity, Accessibility, and Social Justice*. These five cardinal points illuminate our path, urging us to explore uncharted territories, challenge long-held assumptions, and redefine the contours of compassionate person-centered care.

This Discussion Paper is not a mere academic exercise; it is a call to action. As we assemble at this intersection of knowledge and practice, we recognize that *inclusion, diversity, equity, accessibility, and social justice* are not abstract concepts—they are the warp and woof of our personal and professional fabric. They shape our interactions, influence our decisions, and ripple through the lives of those we serve.

Our Shared Journey

As we embark on this intellectual journey, let us engage with courage, curiosity, and compassion. Let us question assumptions, listen intently, and honor the dignity of every learner. Let us recognize that *inclusion, diversity, equity, accessibility, and social justice* are not mere signposts—they are the constellations guiding us toward a more just, inclusive, and resilient healthcare ecosystem.

May this discussion paper ignite conversations, spark collaborations, and inspire transformative action. Within these pages, we hold the compass that charts our course—a course where every learner finds their place, every practitioner advocates for equity, and every patient receives care that transcends boundaries.

Kelly Lackie BScN MN PhD RN CCSNE
Associate Director, Interprofessional Education and Simulation-based Education and Assistant Professor, Dalhousie University School of Nursing
InterprofessionalResearch.Global (IPR.Global) Steering Committee member & Co-Chair
IPR.Global Knowledge Network Committee
Cross-Appointment, Department of Emergency Medicine, Dalhousie University
Affiliate Scientist, Nova Scotia Health
Dalhousie University Centre for Transformative Nursing and Health Research
Co-Editor, Journal of Research in Interprofessional Practice & Education

Hossein Khalili, BScN, MScN, PhD, FNAP
President, InterprofessionalResearch.Global (IPR.Global)
Senior Associate Dean of Academic Administration,
School of Health Sciences, Winston-Salem State University
Adjunct Research Professor, Western University
Program Committee Member, American Interprofessional Health Collaborative (AIHC)
Co-Editor In-Chief, Journal of Best Practices in Health Professions Diversity
Associate Editor, Journal of Interprofessional Care

Executive Summary

Executive Summary

In the ever-evolving landscape of healthcare and education, the principles of *Inclusion, Diversity, Equity, Accessibility, and Social Justice* have emerged as guiding beacons for Interprofessional Education and Collaborative Practice (IPECP). We recognize that these foundational elements are not mere buzzwords, they are the pillars upon which our collective impact rests. In this Discussion Paper, we unravel the significance of inclusion, diversity, equity, accessibility, and social justice in shaping a more compassionate, equitable, and effective healthcare ecosystem.

The Essence of Inclusion, Diversity, Equity, Accessibility, and Social Justice

Inclusion: Beyond Tokenism

Inclusion transcends mere representation, headcounts, and quotas. It is the deliberate act of creating psychologically safe spaces where every voice is heard, every perspective valued, and every identity celebrated regardless of ethnicity, gender, ability, or background. In IPECP, inclusion means acknowledging the richness of cultural narratives that students and practitioners bring to the table, weaving cultural sensitivity and humility into our pedagogy. It means eliminating barriers—whether physical, cognitive, or attitudinal—that hinder participation. When we embrace inclusion, we cultivate a sense of belonging that empowers individuals to thrive. Inclusion is the art of making room at the table, not as an afterthought, but as an essential ingredient in the alchemic mix of collaboration.

Diversity: The Prism of Possibilities

Diversity extends beyond demographics. It encompasses and celebrates the myriad ways that humans differ from one another; in the ways they perceive the world, solve problems, and empathize with others. Interprofessional teams are richer when they embrace this mosaic. In an interprofessional context, diversity introduces a fresh lens through which we view person-centered care. Diversity of thought challenges

assumptions, sparks creativity, and fosters innovation to ensure that our solutions are robust, culturally sensitive, and holistic. Acknowledgment and integration of diversity challenges our echo chambers, open our mindset, and invite innovation. It is the symphony where different instruments harmonize, creating melodies that resonate across, between, and among professions.

Equity: Leveling the Playing Field

Equity is not equality. Equity is not a passive state; it is an intentional pursuit. It acknowledges that people have different starting points and require tailored support to thrive and achieve their fullest potential. In IPECP, equity manifests in fair admission processes, accessible learning materials, tailored assessments, and accommodations for diverse needs. It means addressing biases that perpetuate disparities. Equitable education ensures that no student is left behind, regardless of their background, abilities, or socioeconomic status. As practitioners, it means advocating for equitable policies, eliminating discriminatory practices, and championing justice.

Accessibility: Breaking Down Barriers

Accessibility is the bridge between intention and impact. In IPE, it involves designing curricula, physical spaces, and digital resources that accommodate diverse abilities. Accessibility in education involves the use of captioned videos, screen readers, tactile models, and adaptive technologies. When we prioritize accessibility, we empower all individuals to participate actively, contribute meaningfully, and thrive academically.

Accessibility in healthcare considers availability, affordability, and acceptability for people with various health-related and/or situational disabilities and/or socio-economic restrictions. It involves inclusive practice in support of universal access to health and social care services, and designing physical spaces where there are no barriers that prevent interaction with and across health and social care services. When we prioritize accessibility, we ensure that healthcare education and practice are not privileges.

Social Justice: Advocacy in Action

Social justice is the heartbeat of inclusion, diversity, equity, and accessibility. It compels us to examine power structures, challenge inequities, and advocate for change. In IPECP, social justice means addressing health disparities, amplifying marginalized voices, promoting health literacy, and challenging the status quo. It means recognizing that health outcomes are shaped by social determinants such as race, income, and education. As collaborative practitioners, we engage in community-based initiatives, advocate for policy reforms, and strive for a world where health is a right, not a privilege.

The Impact of Inclusion, Diversity, Equity, Accessibility, and Social Justice in Education and Practice

Inclusion, diversity, equity, accessibility, and social justice manifest in tangible ways:

1. Curriculum Design: inclusion, diversity, equity, accessibility, and social justice are infused into curricula with case studies that reflect diverse patient populations. They encourage cross-professional learning experiences that challenge biases and promote cultural sensitivity and humility.

2. Clinical Encounters: inclusion, diversity, equity, accessibility, and social justice guide practitioners in tailoring interventions to individual needs. They prompt us to examine and change the use of language that is exclusionary and which furthers marginalization, barriers, accessibility, and social context when formulating care plans.

3. Research and Advocacy: inclusion, diversity, equity, accessibility, and social justice inspire research that investigates health inequities, explores innovative models of care, and advocates for policy changes. They drive us to address inequities head-on.

As we navigate the complex currents of IPECP, let us weave inclusion, diversity, equity, accessibility, and social justice into our professional fabric. Let us be architects of change, advocates for justice, and stewards of compassionate care. By embracing inclusion, diversity, equity, accessibility, and social justice, we transform ourselves and the world, creating a place where health is universal, discrimination is absent, and all voices are valued.

Let us march forward, hand in hand, towards a more inclusive, diverse, and just future.

Introduction

Introduction

Recent global crises, such as the COVID-19 pandemic, international conflicts, and global migration, have demonstrated to the world that diseases and healthcare services are not experienced equitably by all people, including communities that have been historically marginalized (Chen & Krieger, 2021; Machado & Goldenberg, 2021; Turner, et al., 2021). The tacit associations, attitudes, stereotypes, prejudices, and implicit biases that impact individuals' and societies' views of characteristics such as race, ethnicity, age, gender, sexual orientation, and weight, perpetuate health disparities (Edgoose, et al., 2019; Marcelin et al., 2019). Consequently, the provision of lower quality care (FitzGerald & Hurst, 2017), reduced empathy, and unequal treatment for specific populations (Maina et al., 2018) ensues.

Narratives that draw heavily on colonial, White, western, and male perspectives dominate health and social care providers. This results in the potential for implicit biases about historically marginalized patients, families, and communities to further perpetuate health inequities, resulting in poorer quality of care (Marcelin et al., 2019). Likewise, biases *about* health and social care providers who are from historically marginalized communities by health service users (i.e., patients, families, communities) can also negatively impact patient-provider and interprofessional interactions. Health and social care providers from historically marginalized communities are affected by bullying, harassment, and discrimination in the workplace, including in hiring and promotion practices (FitzGerald & Hurst, 2017; Marcelin et al., 2019; Sutcliffe, 2023; World Health Organization [WHO], 2021). To reduce biases and increase representation in the health and social care professions, various efforts have aimed to diversify the student population of health professions (e.g., by enrolling more students of Indigenous or African descent). However, these efforts have not always resulted in higher acceptance or

graduation rates for health and social care providers from underrepresented, underserved, and marginalized communities (Awuonda et al., 2021; Condon et al., 2013; Fite et al., 2021; Greenway et al., 2021; López et al., 2021; Morgan et al., 2021; Richard-Davis 2021; Taylor et al., 2019; Upshur et al., 2018; Yelorda et al., 2021). This implies that recruiting students from these communities is not enough; they also need equitable and inclusive education to complete their studies successfully (Edmondson & Bransby, 2023). After graduation, they deserve equitable and inclusive employment opportunities to retain and succeed in the health system (WHO, 2019). According to the World Health Organization (WHO), health workforce diversity is the extent to which the health and social care workforce reflects the diversity of the population it serves in terms of gender, ethnicity, culture, language, religion, sexual orientation, disability, and other characteristics (WHO, 2019). Health workforce diversity is important for ensuring equitable access to quality health services, promoting cultural competence and responsiveness, and fostering social inclusion and cohesion (WHO, 2022a).

Creating interprofessional collaborative learning environments that are centered on inclusion, diversity, equity, accessibility, and social justice may promote representation, recruitment, retention, and successful graduation of historically marginalized health and social care providers. These collaborative practice-ready providers will then be better prepared to care for patients and families from these same underrepresented and marginalized communities, enhancing health outcomes for populations historically underserved in health and social care (Ackerman-Barger et al., 2020).

There is a need to clarify commitment to inclusion, diversity, equity, accessibility, and social justice and develop interventions that bring about change by shifting the focus from normative educational structures and practices that perpetuate inequity to those which embed the

above noted principles into interprofessional education and collaborative practice (IPECP). In these contexts, new ideas can be embraced that influence and support psychologically safe organizational cultures in which the health and wellbeing of all peoples are equitably addressed. In this discussion paper, we invite the reader to explore the critical need to incorporate an inclusive, diverse, equitable, accessible, and socially just lens to IPECP. This paper begins with a discussion of language, idioms, definitions, and core concepts before presenting the key drivers of inclusion, diversity, equity, accessibility, and social justice. We then examine foundational theories, followed by a presentation of novel strategies to incorporate these concepts into IPECP. Impacts and outcomes are examined, and recommendations are offered to support health and social care education and practice organizations.

Guiding Concepts and Definitions

Guiding Concepts and Definitions

It is important at the outset to present the rationale for why we chose *not* to use an acronym in the discussion of inclusion, diversity, equity, accessibility, and social justice in this paper. Certainly, the use of acronyms for these constructs is ubiquitous (Wolbring & Nguyen, 2023). For example, EDIA, representing equity, diversity, inclusion, and (sometimes) accessibility, is predominant in Canada and some European countries; while DEI - diversity, equity, and inclusion (and sometimes disability) - is the more commonly used nomenclature in the United States, Africa, and Asia. Critics of the use of these acronyms (Navas, 2019; Stoner, 2021) argue that the collapse of the constructs into an abbreviated form risks diluting the importance of each word and its associated core messages. Navas (2019) contends that when one begins the acronym with D for diversity, for instance, there is an assumption that "whiteness" is the criterion by which everything else is compared. But diversity should not be measured by "how many" based on race, gender, sexual orientation, citizenship, etc., but rather by how many people feel included and respected. Navas (2019) asserts that,

> Diversity, equity, and inclusion are three distinct principles that are all gravely misunderstood by many people. Grouping them together in fun acronyms to sprinkle around like "I'm not racist" candy, is harmful to the actual work of diversity, equity, and inclusion (para. 16).

Stoner (2021) likewise postulates that when these words are merged into a single acronym, critical distinctions and meaning are lost. Equity, diversity, accessibility, inclusion, and social justice are complex and nuanced principles that when combined into mere letters hypothecates that work on one will automatically encompass the others; this is a flawed assumption. Equity, inclusion, diversity, accessibility, and social justice are distinct and interdependent, and are not synonymous; however, when operationalized collaboratively, sustainable change is possible (Brown McNair et al., 2020).

From a global perspective, Wilson et al. (2022) studied diversity data (ethnicity, race, nationality, Indigeneity), gender/sex, and disability in relation to workforce and research in 24 higher education settings in Africa, Asia, Europe, Latin America, North America, and Oceania. They found that the meanings of inclusion, diversity, equity, and accessibility differed between countries, making global discussions and comparisons difficult. We acknowledge that there are differences in understanding of these terms that are based on history, culture, colonization, and multiple perspectives, which is why we have chosen not to simplify them into an acronym. Throughout this discussion paper, the terms - inclusion, diversity, equity, accessibility, and social justice - will be presented in no particular order to acknowledge that no term is more important than the other. As you read, we encourage reflection, openness, and appreciation for the possibilities that may unfold as we consider the application of these constructs and their associated principles into IPECP.
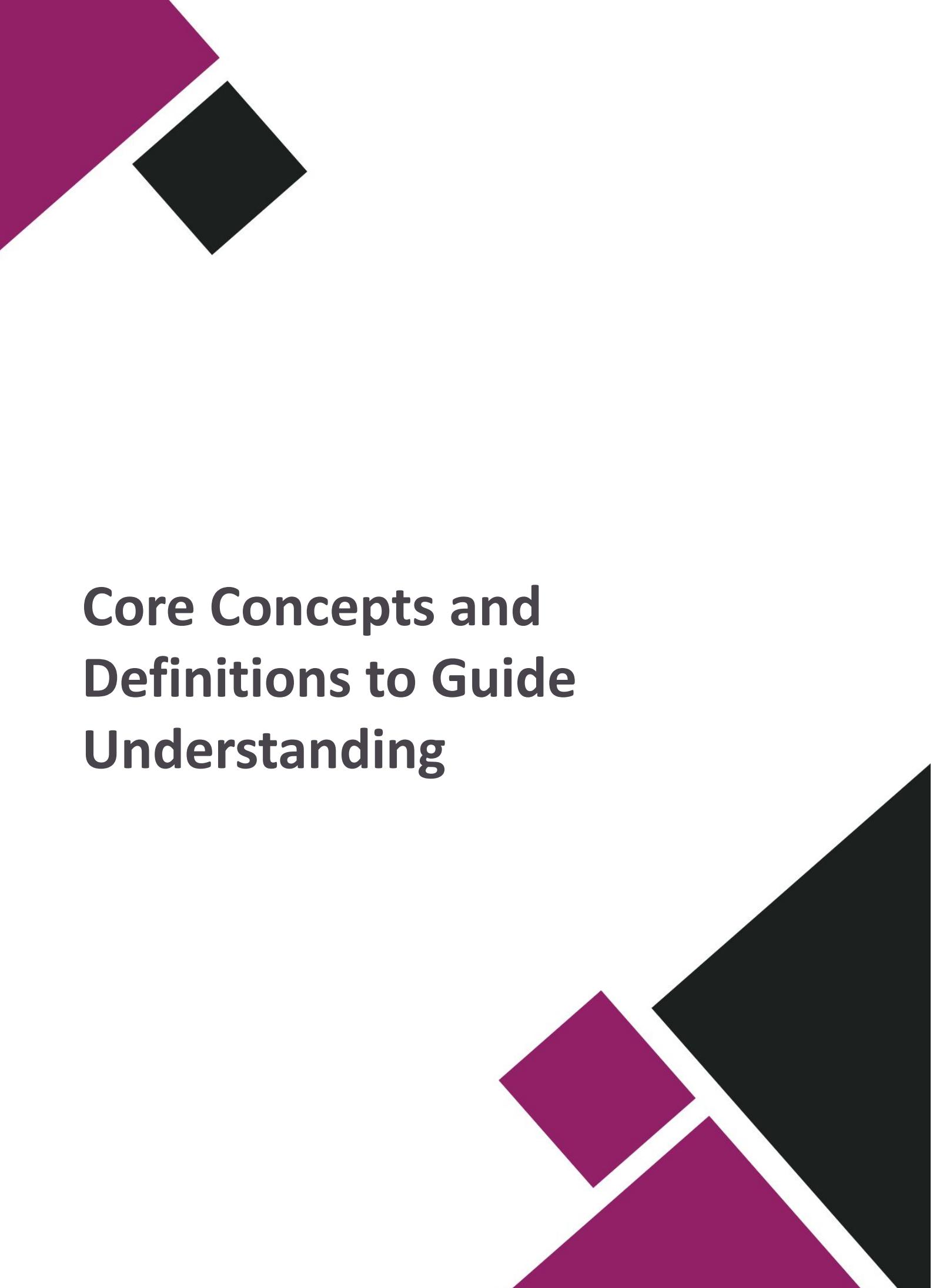
Core Concepts and Definitions to Guide Understanding

Core Concepts and Definitions to Guide Understanding

Further to our comprehension of the importance of inclusion, diversity, equity, accessibility, and social justice in IPECP is the understanding of core concepts and definitions, which are provided in the following section and expanded upon throughout the paper.

Inclusion

Inclusion in education is defined as creating environments and opportunities in which individuals or communities, including those from historically marginalized groups, are (and *feel*) welcomed, respected, represented, supported, and valued in order to fully participate (Mullin et al., 2021). For the purposes of this discussion paper, inclusion also refers to social inclusion, as defined by the United Nations Department of Economic and Social Affairs (2016) as,

> [T]he process of improving the terms of participation in society for people who are disadvantaged on the basis of age, sex, disability, race, ethnicity, origin, religion, or economic or other status, through enhanced opportunities, access to resources, voice and respect for rights (p. 17).

The concept of inclusion has been critiqued as denoting inclusion by the grace or charity of those who have historically been in a position of power and privilege to invite and include the "other" (Miller, 2020). There is a benefit in considering and reflecting on who holds the power to include others and from whence that power has emerged.

Diversity

Diversity is described as a "complex and nuanced construct" (Fuentes et al., 2021, p. 3) representing varied social categories of identity, such as race, ethnicity, gender,

(dis)ability/ableness, sexual orientation, national origin, citizenship, tribe, caste, socio-economic status, thinking, and communication styles. Considering that there are many different provider groups and professional roles within health systems, diversity can also be viewed as holding both professional and interprofessional identities, described as having a dual identity (Khalili et al., 2013). Professional worldviews among health and social care providers differ and are particularly noticeable within professional socialization that is informed principally by profession-specific education and has enhanced development of uni-professional identities that create barriers to interprofessional collaborative practice IPCP (Khalili et al., 2013; Park, 2022). To overcome such barriers, it is essential that health and social care students and providers learn about, recognize, and value all diversity that exists within and among these groups. Importantly, interprofessional education (IPE) when facilitated well may help to disrupt stereotypes, particularly when students are immersed in collaborative practice (CP) settings during their pre-licensure education (Ateah et al., 2011).

Equity

Equity seeks to ensure fair outcomes based on needs by acknowledging that people have unequal starting points; it is not synonymous with equality (Centre for the Study of Social Policy, 2019). Equality, where everyone is treated the same, ignores historical and structural discriminatory practices that benefit some in society while disadvantaging others.

Equity in education is described as equal access, contributions, and participation in programs that have taken strides to close opportunity gaps so as to support student success and program completion (Fuentes et al., 2021). Because health and social care providers and health services users (patients, families, communities) have different and intersecting identities, deliberate measures must be taken to remove barriers and provide opportunities to ensure fair

processes and outcomes. To address issues of equity within IPECP, inclusion must be recognized as an active, intentional, and continuous process, bringing historically marginalized individuals and/or communities into collective processes, activities, and decision-making to address inequities in power and privilege. By doing so, respectful and diverse communities that are welcoming, accessible, and provide equitable opportunities are possible.

Accessibility

From a broad perspective, accessibility is the commitment of everyone along the continuum of human ability and experience to be included in all programs and activities (Mullin et al., 2021). From a higher education perspective, which includes IPE, accessibility refers to the design of courses and the development of teaching styles that meet the needs of diverse people. Accessible education considers the diversity of student identities, while maintaining academic rigor and eradicating barriers (Council of Ontario Universities, 2017). In accessible education, the course content is explicitly articulated, and students can demonstrate their understanding of course material in multiple ways. Accessible education supports the use of Universal Design for Learning (UDL) and Culturally Responsive Pedagogies (CRP).

Universal Design for Learning is an andragogical approach that addresses students' needs and abilities. By implementing UDL, content is delivered in multiple ways and students can engage and demonstrate their learning in multiple ways that benefit them. In UDL, teaching considerations are based upon perception (teachers using flexible and various presentation options), expression (students demonstrating knowledge and skill in different ways), and comprehension (providing multiple ways to engage in course content) (Center for Teaching Innovation, 2023).

Culturally Responsive Pedagogies have a transformative capacity to address inequities in education through the implementation of practices that are culturally supportive, learner-centered, and strength-based, resulting in greater academic success for students who are historically marginalized (Cruz et al., 2020). The principles of CRP are threefold and align well with IPE: 1) high academic standards apply to all students, ensuring appropriate scaffolding and support; 2) the curriculum incorporates students' cultural knowledge and "home-school connection" (i.e., the collaboration between families and schools) to make use of their backgrounds and competence; and 3) students' critical consciousness about power relations is fostered (Cruz et al., 2020, p. 198).

From the viewpoint of CP, accessibility supports the universal access to health and social care services and the social inclusion of people with various health-related disabilities and/or other considerations such as situational disabilities and socio-economic restrictions that negatively impact accessibility (e.g.., older adults, people living in rural and remote areas, and traditionally marginalized communities) (Burger & Christian, 2020). Accessibility is the inclusive practice of ensuring there are no barriers that prevent interaction with, or access to, health and social care services. Three dimensions of accessibility in healthcare that are relevant in our discussion of accessibility in CP are those of *availability, affordability, and acceptability* (Burger & Christian, 2020). Availability issues concern not only the distance and time to get to the nearest healthcare facility, but also the number and quality of services offered. This has direct ties to IPE in its attempt to improve the quality of outcomes and services. Affordability relates to costs; the costs of the services, a person's ability to pay, value-for-money, loss of income, and health care financing. Acceptability refers to patients'/family's "attitudes to and expectations of" health and social care providers (e.g., client responsiveness, behaviors) (Burger & Christian, 2020, p. 45).

To expect that health and social care providers have the knowledge, skills, and abilities to provide collaborative culturally sensitive care that is equitable, inclusive, accessible, and socially just should not be the exception, it should be the norm.

Social Justice

Social justice is a complex concept, involving a variety of perspectives and ideological differences related to fairness in communities, and to equal rights, opportunities, and the fundamental right to good health (Liao & Dordunoo, 2022). It has been suggested that social justice can be synonymous with the principles of equity (Annie E. Casey Foundation, 2021).

Aligned with IPECP, and the principles and values of equity, diversity, inclusion, and accessibility, social justice can be viewed as an ethical framework that can underpin the core principles of collaboration between diverse health and social care professions. When viewing IPECP through the lens of inclusion, diversity, equity, accessibility, and social justice, the sense of belonging within and beyond interprofessional boundaries and professional jurisdictions can be enhanced, creating a safe and inclusive space for interprofessional learning and effective collaborative practice. Because of its complexity and multiple characterizations in the literature, the concept of social justice will be fully explored from a theoretical perspective later in this discussion paper.

Interprofessional Education and Interprofessional Collaborative Practice

Interprofessional education occurs "when members or students of two or more professions learn with, from and about each other, to improve collaboration, and the quality of care and services" (Centre for the Advancement of Interprofessional Education [CAIPE], 2023, para. 3). Interprofessional education is the beginning of a continuum of collaboration spanning interprofessional learning and woven into IPECP (Khalili et al., 2021). IPECP happens when health

and social care providers from different professional backgrounds work in concert with one another and patients, families, carers, and communities to provide the highest quality of health and social care services along the continuum of healthcare settings (WHO, 2010; National Academies of Practice, 2022).

The development of an inclusive, diverse, equitable, accessible, and socially just strategy for IPECP is necessary; thus far the literature provides scant evidence or consideration of these constructs, suggesting that the IPECP community would benefit from critically reflecting on its own implicit biases, assumptions, priorities, and practices. Not doing so poses a threat to psychological safety, damaging professional judgment, teamwork, and decision-making and ultimately adversely affecting care provision (Sutcliffe, 2023). IPE offers an opportunity to promote inclusion, diversity, equity, accessibility, and social justice and embed anti-discriminatory practices into healthcare delivery by developing health and social care students to be collaborative practice ready and advance these principles into practice to create a more equitable world (Hearst & Dutton, 2021).

IPECP should be designed to serve diverse populations and engage people from across a heterogeneous workforce. Introducing these constructs into interprofessional strategies requires integrated planning, and challenging people to fully account for making decisions about programs, services, systems, and practices from these perspectives. Taking a critical lens is not always easy for policymakers, health and social care providers, or educators when immersed in the tumult of day-to-day practice. However, strategies are essential to address the complex issues around inclusion, diversity, equity, accessibility, and social justice if we are to succeed in strengthening the interprofessional health and social care workforce as it learns to work together to improve health equity. Consequently and urgently, we need to reform health

education curricula to ensure the curricula promote knowledge systems that value diversity, celebrate different perspectives, and are open to alternate epistemic views of those in power (Paton et al., 2022). As interprofessional facilitators, we need to recognize these and question initiatives that maintain power structures and hierarchy in health professions education.

Globally, legislation prohibits behavior and actions which detrimentally impact people based on race and ethnicity. In the United Kingdom (UK), for example, the Equality Act prohibits discrimination, and by safeguarding and defending protected characteristics such as race, it promotes inclusivity, equality, and upholds the principles of social justice (Equality and Human Rights Commission, 2022). Professional behavior mandated by professional, statutory, and regulatory bodies across the world, underpinned by ethical principles of beneficence, autonomy, justice, and non-maleficence, also outlines the need for health and social care providers to act with integrity and respect, adopting non-judgmental and harm-reducing practices that value colleagues and patients within interprofessional teams. Notwithstanding legislation and ethical codes of practice, health inequities continue to persist. As a consequence, action is of the utmost importance.

Psychological Safety

Psychological safety (PS) is crucial for optimal learning in all health and social care education programs, including IPE. Indeed, PS has been listed as "one of ten factors that influence how a team learns" (Breso et al., 2008, as cited in Cauwelier et al., 2016, p. 2), and is a collective belief that it is safe to engage in interpersonal risk-taking in the workplace (Edmondson & Lei, 2014; Newman et al., 2017). Being psychologically safe implies that one is shielded from detrimental consequences should they speak up or ask questions, and they will not be rejected or dismissed for doing so (Lackie et al., 2022; Park, 2022). Psychological safety supports effective teamwork, enhances care delivery (Lackie et al., 2022; Lateef, 2020; O'Donovan & McAuliffe, 2020), and is vital to creating and sustaining teaching and

learning environments that are inclusive, diverse, equitable, and accessible.

In a psychologically safe environment, people are respected for their competence, knowing they are safe to experiment and take risks. When people feel psychologically safe there is an underlying belief that there are positive intentions for one another and therefore people can engage in constructive conflict without creating harm (Lackie et al., 2022; Nicolaides & Poell, 2020; Zhu et al., 2021). Other favorable outcomes of PS include enhanced individual and team learning; improved performance, creativity, innovation, and resiliency; an eagerness to share and implement new learning to support new practices; and increased engagement and commitment (Lackie et al., 2022; Newman et al., 2017; Nicolaides & Poell, 2020; Zhu et al., 2021).

At the heart of establishing psychologically safe IPECP is the desire to provide room for everyone to speak their truth without being silenced, intimidated, or chastised. However, the notion of speaking up may well be alien to those who do not hold power, nor may it be an expected norm within various professional and personal cultures. The feeling of being psychologically safe is dynamic, impacted by cultural considerations that influence individuals, teams, departments, organizations, and communities (Lateef, 2020) because the cultural environments that people grow up in create mental models that influence relationships and interactions with others (Cauwelier et al., 2016). Thus, notwithstanding the need for psychological safety, educators must recognize that the expectations for open and authentic communication may be unconventional and uncomfortable for some, creating cultural dissonance.

Cultural dissonance can be described as discomfort and disharmony with the lack of consistency between one's culture and a new culture (Shilkofski & Shields, 2016). For instance, Shilkofski and Shields (2016) found that Malaysian medical students, who were enrolled in an American-based

medical curriculum that was taught by Johns Hopkins University School of Medicine faculty, worried that the expectation of speaking up with their faculty in the classroom would be seen as disruptive and discourteous if done within the Malaysian healthcare system. Likewise, Lum et al. (2016) found that internationally educated nurses (IENs) experienced psychological and cultural dissonance when integrating into new learning and practice environments. IENs recounted that there was a disconnect between professional norms in their home country and the norms of the healthcare system in the country to which they immigrated. The dissonance that they experienced caused "culture shock", leading to difficulty adjusting to academic expectations, disappointment, frustration, disillusionment, confusion, ambivalence, and fear (p. 347). Curious as to whether team PS in learning was an applicable concept for teams outside of Western society (where much of the existing research is conducted), Cauwelier et al. (2016) used a sequential explanatory mixed-methods design to examine team PS and learning in Thailand. Their results were contrary to those found in the United States and France, finding an inverse relationship between team PS and asking for help, as well as challenges in collaboration and communication when there was diversity in knowledge, skills, abilities, viewpoints, and experiences. De Leersnyder et al. (2021) also found that students in classes with an international mix felt higher levels of cultural misunderstanding that resulted in lower levels of inclusion and PS. When cultural diversity was recognized and valued by the educator, there were less cultural misunderstandings and heightened PS. In contrast, when educators took a color-blind approach (overlooked cultural differences), cultural misunderstanding increased, and PS decreased.

Culture clearly has an impact on PS. It is therefore necessary for IPECP educators to temper their expectations that all students will speak up simply because they believe they have completed the preparatory work of establishing psychological safety with the reality of the various backgrounds and

traditions of those they are facilitating. Certainly, diversity must be considered, recognized, and respected if psychologically safe learning is to be created.

When hierarchical structures, social status, levels of authority, positional respect, and power exist, PS is repressed and student, patient, provider, and system outcomes are negatively impacted (Edmondson & Lei, 2014). When the principles of diversity, equity, inclusion, accessibility, and social justice are applied to IPECP, the factors that have been known to influence a person's PS (e.g., personality traits, interpersonal dynamics, and organizational factors) (Kim et al., 2020), can be better understood in relation to broader social issues that have disproportionately negative impacts for historically marginalized communities (Fernandez, 2019). So too can historical ethnocentric, Western, and colonial dominance, that underlies health education curricula, be disrupted to benefit all students and particularly those from historically marginalized communities (Edmondson, 2020; Lateef, 2020; O'Donovan & McAuliffe, 2020; Sanner & Bunderson, 2015).

Students with diverse identities and backgrounds are experiencing many of the same barriers to learning as patients with diverse identities and backgrounds are experiencing when accessing healthcare services. What occurs in society is mirrored in the health system (Yolci et al., 2022), including discrimination. Hierarchies found within the healthcare system are reflective of the hierarchies of power found within dominant systems, such as health education, that deny and dismiss socially constructed differences (Kelly et al., 2021). As more students with diverse backgrounds enter health and social care education programs, socio-historical issues will be important to consider in IPE to enhance learning outcomes and foster student success. Psychologically safe spaces where diverse experiences are represented, supported, celebrated, and addressed in ways that enhance patient engagement, safety, and the health of diverse populations are essential (Lackie et al., 2022). Importantly, health and social care

student learning within an educational culture that is poorly aligned with inclusion, diversity, equity, accessibility, and social justice risks graduating health and social care providers that perpetuate an ethos lacking in psychological safety. Logically, IPECP training grounded in culturally responsive andragogy reinforces psychological safety.

When PS is not promoted, established, or maintained, educational alliances that acknowledge and value socially constructed differences are weakened (Johnson et al., 2020), risking conditions where health and social care students are afraid to speak up and ill-equipped to work collaboratively or inclusively. Not feeling safe to take interpersonal risks in the interprofessional learning environment negatively impacts students' ability to learn with, from, and about others, and may perpetuate harm to those who are historically underserved and underrepresented. It is therefore critical for health and social care students to learn how to promote inclusion, diversity, equity, accessibility, and social justice in healthcare and confront educational structures that perpetuate differences in social status and relative power within traditional and normative systems. When students can engage in psychologically safe IPE, they will be better prepared to speak up when faced with exclusion, inequity, social injustices, and misunderstanding in their curriculum, by other students, and faculty. Future health and social care providers must learn to be able to lean into their discomfort and have brave conversations in order to develop strategies that will disrupt systems of discrimination in the workplace (Fricke et al., 2023).

Key Drivers in Managing Change

Key Drivers in Managing Change

The following section offers a discussion of the key drivers in managing change and translating evidence into improved IPECP that focuses on inclusion, diversity, equity, accessibility, and social justice.

Key Driver 1: Contextual Stratification

The application of a stratified systems framework is an appropriate approach to managing change, translating evidence into IPECP improvement, and assessing the drivers of inclusion, diversity, equity, accessibility, and social justice. Ferlie and Shortell's (2001) four-level systems framework for health system change provides a useful basis for analysis, comprising individual, team, organizational, and systems levels.

Health and social care providers', educators', and students' attitudes, beliefs, and practices are important drivers of inclusion, diversity, equity, accessibility, and social justice. Developing individual competencies, including cultural sensitivity and humility, can address an individual's ability to practice in a diverse context in a socially just, equitable, and inclusive manner (Campinha-Bacote, 2019). For decades, it was mandatory for health-related providers to participate in cultural competence training in an attempt to broaden their knowledge of cultures other than their own to improve the quality of health services delivery (Lekas et al., 2020). However, using an example from the United States, Lekas et al. (2020) explain that "Cultural competence training assumes that most US providers are White, non-Hispanic, male, heteronormative, and English speaking, and seek to expose them to the cultures of *othe*r social groups (e.g., Black Americans, Spanish-speaking Latinx, or LGBTQ+ persons)" (p. 1). This assumption perpetuates "othering", furthering stigmatization and stereotyping.

Cultural humility is distinguishable from cultural competency as it represents a "lifelong commitment to self-evaluation and (self-)critique" in order to "redress the power imbalances in the provider-patient dynamic, and to developing *(sic)* mutually beneficial and non-paternalistic partnerships with communities on behalf of individuals and defined populations" (Tervalon & Murray-Garcia, 1998, p. 123). When practicing cultural humility, health and social care providers acknowledge that they do not know another person's culture but are open to learning from patients (Lekas et al., 2020). Creating diverse, inclusive, and culturally aware health and social care teams that practice cultural humility can facilitate equitable and inclusive care to patients and communities, including those from underserved and marginalized populations.

The policies and practices of healthcare organizations and educational institutions can positively or negatively influence inclusion, diversity, equity, accessibility, and social justice. Further, the absence of diversity in leadership positions (WHO, 2021a) may also limit the ability of organizations to effectively address issues related to these constructs. Efforts to facilitate equity and social justice include the development and implementation of organizational policies that not only commit to change but do something about it, as well as organizational hiring and promotion practices that ensure a diverse workforce (White et al., 2022). When embarking on becoming a more inclusive and equitable organization, it is imperative that there are support services available to retain the diverse population of providers and/or faculty.

Todic et al. (2022) provide an example of how equity can be facilitated at the organizational level. They have developed and implemented an organization-wide, theoretically grounded, and systems-based diversity, equity, and inclusion theory of change process with the expectation that all employees will have the power to identify and transform organizational dynamics that reproduce health inequities. This critical consciousness is engendered by raising awareness and understanding

of the social and historical context of patients and how societal inequities can affect health. Employees are motivated to become agents of change and be directly involved in the removal of barriers to equitable health. Importantly, the 10-year program of work is monitored through a comprehensive set of quality measures that span both processes and outcomes (Todic et al., 2022).

Finally, social system factors such as government policies, cultural attitudes, and historical injustices are known to lead to systemic inequalities and inequities in healthcare and education. Cultural, language and contextual factors can impact political and social priorities that drive healthcare and education policies. These factors can also intersect, as cultural attitudes towards race, gender, disability, and socio-economic status shape policies and funding priorities that support IPECP. A key mechanism to foster equity and social justice includes the use of legislation to address the social and institutional factors that create discriminatory practices and processes resulting in health and social inequity.

The infrastructure of many healthcare systems gives rise to health inequities, defined as differences in health outcomes that are systematic, avoidable, unnecessary, unfair, and unjust (Baker et al., 2018). They result in preventable outcome differences in individual and community health that are not attributable to patient preference or clinical appropriateness. These differences are determined by circumstances beyond an individual's control that are rooted in social, economic, and environmental conditions, referred to as the social determinants of health (SDoH). Research shows that while the SDoH plays a significant role in health outcomes, more action is needed to attenuate their impact on health inequities (Marmot et al., 2008), in ways that are not tokenistic. To do so, collaborative community engagement, where communities actually *feel* engaged, is imperative (Aguilar-Gaxiola et al., 2022).

Key Driver 2: Experiential Factors in IPECP

Interprofessional practice and education offer opportunities to address hierarchy and discrimination through the incorporation of inclusion, diversity, equity, accessibility, and social justice principles. Occasions, when health and social care students, providers, and educators collaborate and learn from each other, have the potential to address larger health equity goals and initiatives within communities of practice. However, there are several key considerations to understand that pose barriers to implementing inclusion, diversity, equity, accessibility, and social justice initiatives.

Language

Health and social care providers lack a common language to talk about their profession within the context of other professions and use different languages to discuss healthcare experiences (Bogossian et al., 2023). Professional and cultural beliefs and attitudes, positional power, and relative status within individual professions and across the health and social care sector create psychologically unsafe environments that can negatively impact the ability to discuss and address health equity (Bogossian et al., 2023; Khalili & Price, 2022). Ensuring that IP facilitators have the knowledge and skill to guide these critical discussions is paramount in creating a safe place to discuss these constructs.

Socialization

Interprofessional experiences are primarily focused on group or collective learning models with the opportunity for planned and unplanned or naturalistic experiences (Bogossian et al., 2023; van Diggele et al., 2020), providing students with a variety of opportunities to practice and further develop health equity skills. Yet, according to Stage 1 of the Interprofessional Socialization Framework (Khalili et al., 2013, Khalili, 2021), breaking down barriers *before* health and social care students and providers begin learning and practicing how to collaborate to address health equity is essential. Students and providers first need to learn about, critically reflect on, and acknowledge their respective

professions' roles and responsibilities in historical events and systems that might have negatively impacted patient populations, society, and the healthcare system (e.g., historical trauma, discrimination), as well examine their implicit biases (Corbie, Brandert, Noble, et al., 2022).

Collaborative Competencies

The use of collaboration competency frameworks within IPECP can provide a common understanding and language to address inclusion, diversity, equity, accessibility, and social justice as long as IPE facilitators have the capacity to manage hierarchy, turf protection, relative power, and systemic inequities that arise in interprofessional learning, while at the same time knowing how to establish and maintain students' psychological safety. We acknowledge that IP facilitators have been doing the best they can with the resources they have been given but a lack of IP facilitator training is noted worldwide (Khalili et al., 2022a & 2022b). Organizations that host IPE must ensure that their IP facilitators are supported to gain the knowledge and skills required to navigate these challenging discussions. Although competency frameworks provide a basis for IPECP, without the ability to address exclusion, homogeneity, inequity, inaccessibility, and social injustices within the context of using the interprofessional core competencies there is a risk that students will not be able to translate these principles into equitable and inclusive practice (van Diggele et al., 2020).

Representation

Healthcare systems and providers need to be representative of society and the communities in which they serve. Patients from diverse backgrounds deserve to be cared for by health and social care providers with similar diversity; they need to see themselves in the people who provide health services. When people are cared for by providers of the same race, for example, they experience greater mutual respect and more ease when having to divulge health information (Wilbur et al., 2020). As well, a diverse patient population requires healthcare organizations to provide resources that enable

accessibility, such as interpreter language services for cultural and disability-appropriate care to be provided (Perez et al., 2016).

Interprofessional Experiences

Community-based experience in interprofessional clinical rotations and fieldwork holds the potential for health and social care students to implement and address health equity. The importance of learning about, acknowledging, and integrating the local socio-cultural practices and societal contexts into the interprofessional learning experience is an important consideration when implementing community-based interprofessional experiences (Samarasekera et al., 2022). Interprofessional experiences that appreciate society as a larger construct are able to ensure that health equity is an explicit goal rather than an underlying factor that may be missed by some health and social care students and providers (Farrell et al., 2022).

Key Driver 3: Healthcare System Factors

The way healthcare systems are organized and funded can have a significant impact on whether IPECP is inclusive, diverse, equitable, accessible, and socially just as well as if it is conducted in a meaningful and authentic fashion. Who, what, where, when, and how IPECP is delivered is determined by opportunities for interprofessional team-based care. Whether services are funded by the public purse, paid out-of-pocket by citizens, or by third party insurers will impact accessibility and dictate which health services are available, where these services are available, and the number of services that are available (Alkhamis, 2017; Flood & Gross, 2014; Webber et al., 2022).

How healthcare systems distribute and focus services across primary, secondary, and tertiary care also impacts the timely response of the system to public needs. Corbie et al. (2022) identify core knowledge, skills, and attitudes/abilities for equity-centered leadership, from personal, interpersonal, organizational, and community/system perspectives that would be useful to IPECP.

Personal competencies require that healthcare leaders commit to building self-awareness of leadership styles, strengths, and emotional intelligence to competently examine diversity and social justice in the organization. Interpersonal competencies require skill development for building and leading diverse relationships, including communication, conflict management, negotiation, and visioning, strikingly similar competencies to IPECP. Organizational competencies require system-level inquiry and evidence-informed knowledge of strategies to shift the predominant normative culture. The knowledge, skills, and abilities/attitudes at this level include a working knowledge of organizational culture, political and systems thinking, change management skills, performance management skills, and organizational capacity to advance equity, diversity, and inclusion. Engagement, collaboration, and partnering with historically marginalized communities and stakeholders are essential competencies at the community- and systems-level, coupled with stakeholder analysis of, and advocacy for, the SDoH that underlie health equity (Corbie, Brandert, Fernandez, et al., 2022).

Canada provides an example of a multi-tiered health system and the impacts of inclusion, diversity, equity, accessibility, and social justice, and IPECP. Healthcare in Canada is under the jurisdiction of the provinces and territories as set out in the Constitution (Phillips-Beck et al., 2020). The public health system, co-funded by federal and provincial governments, must ensure that the five principles of the Canada Health Act are maintained, that is, public administration, comprehensiveness, universality, portability, and accessibility. However, comprehensiveness only includes those insured health services that are provided in hospitals and by physicians, resulting in a fractured and sometimes costly system, where IPCP can only take hold in certain circumstances. The decision of what is a publicly insured service is left to the discretion of the governing political party in each jurisdiction. For example, healthcare for individuals recognized within the *Indian Act* of Canada is under the jurisdiction of the federal government, the primary law that identifies government obligations to status First Nations

people but does not specifically mention the Métis or Inuit (considered non-status) (The Canadian Encyclopedia, 2022). First established in 1876, with numerous revisions since, the *Indian Act* has caused intergenerational trauma, inequity, and human rights violations. It only pertains to people with Indian status but only to those people living on reserve (equivalent to reservations in the USA) or in the Arctic regions of Canada (Phillips-Beck et al., 2020). For communities designated as Indigenous lands, federal bureaucrats decide which health services are available and how often. The jurisdictional boundaries are complex and poorly understood by health and social care providers. How, where, and when one health and social care provider can reach out to collaborate with another is very much dependent on the system in which they function. As such, where health systems rely heavily on individual health and social care providers to refer to other care providers, perceived and/or real biases may impact referral patterns and access to quality care (Bognar, 2010; Chapman et al., 2013; Levy et al., 2020; Rapp, et al., 2021; Tabaac et al., 2020).

Addressing Inclusivity, Diversity, Equity, Accessibility, and Social Justice through a Quality Improvement Lens

Addressing Inclusivity, Diversity, Equity, Accessibility, and Social Justice through a Quality Improvement Lens

This section addresses inclusivity, diversity, equity, accessibility, and social justice through a quality improvement lens with an emphasis on implications for IPECP. Though it is recognized that in health and social care, there are numerous quality improvement models, five concepts are used to inform this discussion: 1) the person's experience and person-centered care, 2) improved outcomes, 3) cost efficiency, 4) health provider wellbeing, and 5) health equity. These five concepts are based upon the Quintuple Aim (better health, better care, better value, better work experience, and better health equity) from the Institute for Healthcare Improvement (IHI) (Nundy et al., 2022). Although the IHI is an American institution, this framework serves as a global resource on quality improvement science. The Quintuple Aim is conceptually transferable and informative, serving as a guide to improving global IPECP. Still, one must attend to inferences regarding the applicability of Global North initiatives to Global South initiatives (Reidpath & Allotey, 2018).

Importantly, the *healthful* system and people therein focus on competency in Universal Health Coverage (UHC) aligned to the WHO Global Competency Framework (2022), including access to health and social care that is effective, efficient, equitable, inclusive, integrated, people-centered, safe, and timely. Key to UHC and quality improvement is that health providers' education and practice activities (roles and responsibilities) and competencies (ability to integrate and apply knowledge, skills, and attitudes) are rooted in the domains of person-centeredness, collaboration, communication, decision-making, evidence-informed practice, and personal conduct. The domains encompass inclusivity, diversity, equity, accessibility, and social justice, and emphasize both system level and health provider accountability to UHC. Application of quality improvement concepts to inclusion, diversity, equity, accessibility, and social justice offers valuable insight contextual to IPECP.

Improving Care Experiences

In many countries, language is shifting away from the *patient* to *person* in both health and social care service delivery, as well as in educational contexts (McCormack, 2020). The term *person* is used to denote an equal partnership in the care process or in the educational realm. Understanding the social and historical contexts and their impact on quality care and the person's experience is important and recommended globally (WHO, 2022b).

In his seminal work on healthcare quality, Avedis Donabedian noted that patient (person) satisfaction was a key indicator of healthcare quality, prompting a great deal of research in the 1970s and 1980s that explored this area (Cleary, 2016). Donabedian described two elements in the "art and science" of healthcare quality as: interpersonal and technical (Cleary, 2016; Donabedian, 1966, 1988). He defined technical excellence as the knowledge, judgment, and skills (read: competencies) in providing best practices of quality care and defined interpersonal excellence as care that meets the informational, emotional, and physical needs of the person in a way that is consistent with their preferences and expectations. Understanding someone's lived experience is a key step in person-centered care. By looking at various aspects of experiences, it is possible to assess the extent that which care is respectful of and responsive to personal preferences, needs, and values (Agency for Healthcare Research and Quality [AHRQ], 2022). Whereas satisfaction is about whether the person's expectations about a health encounter were met, to assess experience, it must be determined if something that should have happened in a healthcare setting (i.e., technical and interpersonal preferences, needs, values, quality) *actually* happened or how often it happened (AHRQ, 2022). The person's experience of care is at the heart of IPECP and health and social care quality improvement. In their framework for person-centered practice, McCormack and McCance (2006) outline central person-centered outcomes (good care experience; involvement in care; feeling of well-being; and existence of a healthful culture)

that are influenced by person-centered processes (working with the person's beliefs and values; engaging authentically; sharing decision making; being sympathetically present; and providing holistic care). Noteworthy for this discussion is the central role of a healthful culture and the importance of working with the individual's beliefs and values.

Delivering person-centered care requires whole-system thinking with essential partnerships between healthcare organizations and higher education institutions (McArdle & Luiking, 2022). Care needs to be integrated into its design, infrastructure, and operational delivery; for example, in England, Integrated Care Systems (ICS) are legal statutory boards and partnerships recently introduced with the 2022 Health and Care Act (King's Fund, 2022). The 42 ICSs across England align with person-centered principles by focusing on improved population outcomes, tackling inequalities, and focusing on collaboration, places, and local populations to drive health and social care improvement.

Enacting person-centered care requires normative cultures within health and education systems to change and adapt to be able to provide not only the necessary care but also the care that is wanted by the people served. *Healthful* systems are grounded in equitable access to healthcare, yet inequities persist and are in fact significant factors leading to poor health outcomes. The Institute of Medicine (2003) highlighted how individuals from historically marginalized communities were less likely to receive healthful or optimal care. Further, health systems perpetuate these inequities by under-reporting patient safety incidents among marginalized populations, such as those lacking health insurance or having lower health literacy whereby they are unable to advocate for themselves, potentially leading to limited access or suboptimal care (Schulson et al., 2021).

Cahn (2020) argues that cultural competence, when addressed, must also address systems through structural competency; yet as was discussed earlier in this paper, many cultural competence programs may not move beyond promoting cultural awareness thereby risking the perpetuation of

trauma to students, educators, and patients from historically underrepresented and marginalized communities. Metzl and Hansen (2014) argue that cultural competency is implicated in the perpetuation of stigma and inequality because it does little to address social, political, and economic systems. They suggest that a mind shift towards understanding structural competency is warranted as it refers to "the capacity for health professionals to recognize and respond to health and illness as the downstream effects of broad social, political, and economic structures" (Okoro, Friberg, Chiu, 2023, p1). Metzel and Hansen (2014) argue that health and social care providers must learn to consider how race, class, gender, and ethnicity are impacted not only through person-to-person interactions but also by larger structural factors (e.g., zoning laws, economics, schools, law, transportation, food distribution, etc.), also known as the SDoH.

Conceptually, while the *notion* of diversity aligns well with IPECP, the *concept* of diversity has more typically been applied to a diversity of perspectives from those of different professions. With an increased focus on principles of inclusion, equity, accessibility, and social justice, diversity must consider racial, gender, ability, and sexual identity perspectives; inclusion of alternate ways of knowing, as expressed by Indigenous individuals; as well as the diversity of ideas linked to national identities. Extending an understanding of diversity is central to how health and social care students and providers learn about the experiences of those they serve and of fellow team members. Concepts of inclusion are also central. Evolving practice models have promoted increased partnership with persons and families on the health and social care team, moving beyond earlier efforts for patient-centered care towards person-centered care. Furthermore, patients are increasingly becoming more included in the education realm, helping to shape, deliver, and evaluate curriculum ensuring that health and social care students appreciate and develop important strategies to advance patient and family participation as members of their healthcare team.

Interprofessional collaboration needs to be inclusive of all team members, with or without a professional designation, who contribute to the health and well-being of the population being served. For example, personal support workers play a critical role in the support of patients in both community and healthcare settings yet are usually excluded from team discussions and educational scenarios (Giosa et al., 2015). Other roles are new and evolving, for example, patient navigators and integrated care leads, who support patients in negotiating the complexities of the health and social care system. Others have advocated for the inclusion of professionals such as lawyers to promote both health and equity (Scott, 2017). Ensuring inclusion of, and collaboration with, team members who have a relevant role in both practice and education settings will improve the experience of persons seeking care, either directly or indirectly.

According to the WHO (2023a), health inequities are avoidable inequalities in health among groups of people within and between countries. Social and economic conditions, and their accumulating effects, on people's lives determine their risk of illness and the actions taken to prevent them from becoming ill or to treat illness when it occurs (WHO, 2023a). In 2023, the WHO will publish a new World Report on Social Determinants of Health Equity, as requested by Member States in resolution 74.16 of the 2021 World Health Assembly:

> ...prepare, building on the report of the WHO Commission on Social Determinants of Health (2008) and subsequent work, an updated report based on scientific evidence, knowledge and best practices on social determinants of health, their impact on health and health equity, progress made so far in addressing them, and recommendations on future actions (Alliance for Health Policy and Systems Research & WHO, 2021b, p. 2)

The World Report will provide an agenda for action for the next 10 years on the SDoH and a new monitoring framework to enable progress, with actions prioritized to advance health equity.

At the same time, the WHO Multi-Country Special Initiative for Action on the Social Determinants of Health for Advancing Health Equity "has the goal to improve the SDoH for at least 20 million disadvantaged people in at least 12 countries by 2028" (WHO, 2023b).

It has been argued that incorporating an explicit focus on social justice in health and social care education will lead to the training of health and social care providers who understand that to advance the goal of health for all they must work toward equitable distribution of health and social care and the elimination of health disparities (Hixon, et.al., 2013). Learning to understand the SDoH, advocate for equitable health and social system change, and advance social justice throughout their careers should be the focus of this health and social care training (Hixon, et.al, 2013). IPE is the ideal platform with which to ensure that health and social care students are learning these skills collaboratively.

Elevating Collaborative Relationships and Health Outcomes

Interprofessional collaborative practice does not automatically or solely encompass inclusivity within interprofessional teams. Diversity accentuates the need for space to broaden viewpoints and embrace sociocultural ideologies. Its impact is deeply rooted in our ability to view the world through the eyes of others by listening to learn, rather than listening to respond. Each person has a different background and a unique story to tell, but it is up to each of us to listen. A welcoming, inclusive, and psychologically safe environment must be created that applauds and seeks diverse representation, expanding the palette for cultural awareness, humility, and sensitivity (Gibson et al., 2022). Practice transformation, from volume-based care to value-based care, can create space for richer dialogue to garner a deeper understanding of how to best care for and recognize sociocultural needs. In response, empathetic engagement empowers the community to feel heard and valued (Markey & Okantey, 2019).

Exposure to IPE that role-models inclusion, diversity, equity, accessibility, and social justice may elevate health and social care student and provider cultural awareness, humility, and sensitivity leading to a greater understanding of patients' decisions based on the intersection of their diverse identities, backgrounds, and belief systems. Immersion in these constructs in the interprofessional learning environment may help decrease health disparities and have a cascading effect on improving patient outcomes and satisfaction (Gomez & Bernet, 2019). It allows providers and students the opportunity to reflect on and introspectively navigate how to mitigate their implicit biases. In turn, through cultural humility, students and providers may be better able to shape their attitudes and behaviors to become more emotionally invested in patients and exude more compassion, respect, understanding, and empathy in response (Gradellini et al., 2021; Tucker et al., 2011). This growth in cultural edification lends prominence to cultural humility, encouraging internal reflection on our external attitudes and actions (Greene-Moton & Minkler, 2020).

Having the desire to actively listen and provide care that is respectful of a patient's identity and belief systems establishes the essence of person-centered care and builds trusting person-provider relationships (Interprofessional Education Collaborative, 2016). Trust is paramount. Without authentic, safe, and transparent communication, synergy for person-centered shared decision-making may not be possible. More so, there must be sincerity in the words used, diversity in representation, and active listening at the forefront. When providers create and nurture psychologically safe spaces for persons and their families, people garner freedom from judgment to be more openly vulnerable. As noted by Tucker et al. (2011), emotional connectedness can improve a patient's capacity to engage in care planning, aid in reducing disparities, and further support their satisfaction and experience.

Health outcomes are greatly impacted by patient health literacy, socioeconomic status, demographic location, education, sociocultural belief systems, and ideological worldviews.

Situating these factors within current global events may help to shed light on the reasons why these factors are important to acknowledge. For example, during the COVID-19 pandemic and well after, the debate about mandatory vaccinations proliferated. Studies conducted to explore why vaccine hesitancy was happening highlighted the distrust people from historically underserved and marginalized communities had towards scientists and health and social care providers (Cadeddu et al., 2020; Cuellar et al., 2021; Marcelin et al., 2021; Vardavas et al., 2023). In a systematic review conducted by an international team of researchers from Greece, the United States, the United Kingdom, Spain, and Sweden, findings revealed that there were significant differences in vaccine uptake depending on age, socioeconomic status (i.e., income, employment, poverty, deprived communities), education, availability of health insurance, housing, disability, and race/ethnicity. Higher vaccination rates were correlated with people who had higher education, whereas lower vaccination rates were seen in people with lower socioeconomic status (Vardavas et al., 2023). Similarly, Cadeddu et al. (2020) reported that approximately 20% of male Italians who had minimal education, right-wing political orientation, and poor attendance to politics and culture distrusted scientists, believing that vaccines were harmful, despite the reemergence of communicable diseases that were once eradicated. From these examples it is difficult to deny that better and much more communication that respects and honors diversity is warranted between researchers, providers, and patients to practice in an evidence-informed way and address health disparities and inequities.

By incorporating the principles of diversity, equity, inclusion, accessibility, and social justice in IPECP, students' and providers' levels of cultural humility and sensitivity, interprofessional communication skills, and confidence to lead culturally sensitive conversations strengthen (Gradellini et al., 2021; Greene-Moton & Minkler, 2020; Lukoschek, 2003). Reciprocally, these learned skills improve patient health outcomes, satisfaction, and experience, in addition to increasing adherence to

treatment due to feeling free from judgment or discrimination, mitigation of biases or racial/gender profiling, and establishing trust. Patient outcomes improve when we start at the foundation and educate interprofessional students on how to lead inclusion, diversity, equity, accessibility, and social justice engagements with confidence and professional poise.

Equitable Healthcare to Lower Costs

Existing evidence reports increased healthcare costs resulting from healthcare discrimination by race and ethnicity (LaVeist, et al., 2011; Elias & Paradies, 2016), age (Levy et al., 2020), (dis)ability (Bognar, 2010), gender (Rapp, et al., 2021), sexual orientation (Tabaac et al., 2020), and weight (Singh et al., 2019). The intersection of these multiple social identities further compounds health inequities and disparities (Sabik, 2021). A recent study specific to Texas, USA, found that differences in health status, disease prevalence, and life expectancy by race and ethnicity cost US$2.7 billion in excess annual medical care spending in 2020 (Turner et al., 2021). The study indicated further costs of US$5 billion in annual lost productivity, and 452,000 life years lost due to premature deaths, conservatively estimated at US$22.6 billion in monetary value. Turner et al. (2021) estimate that if current inequities persist, the figures will rise by 22% by 2030. The authors went on to estimate the additional costs of the COVID-19 pandemic in Texas, where Black and Hispanic populations were found to experience more frequent and severe cases of COVID-19.

The additional burden of hospitalization represented an estimated US$558 million in healthcare spending that could have been saved, notwithstanding the emotional burden and loss experienced by the involved families, time away from work, and long-term health outcomes. Further, the additional 30% death toll due to COVID-19, represented 60,000 life years lost, at a conservative estimate of US$ 3 billion (Turner et al., 2021).

Likewise, in an Australian study, Elias and Paradies (2016) estimated the impact of racial discrimination on the direct health costs related to negative health outcomes, including depression, anxiety, and post-traumatic stress disorder. The authors estimated that discrimination based on race costs Australia 235,452 in disability adjusted life years lost (DALYs), equivalent to Aus$37.9 billion per year, or roughly 3% of the annual gross domestic product (GDP) from 2001-11 (Elias & Paradies, 2016).

When considering cost savings in the healthcare system from a health equity lens, costs must necessarily include monetary savings, but should also include the human cost (e.g., social, cultural, legal, and environmental spheres) (Elias & Paradies, 2021). There is much to be argued financially and ethically that taking action to address inclusion, diversity, equity, and accessibility is a necessary step for social justice for all. Healthcare teams working collaboratively are well positioned to challenge such systems that perpetuate barriers to health equity (Cahn, 2020), thereby improving health outcomes and overall system efficiencies.

Fostering Providers' Well-being

Provider health and well-being in the workplace matters; it is the cornerstone of a healthy and functioning healthcare system (Gavin et al., 2020; Moazzami et al., 2020). Indeed, health and social care providers who feel included, safe, supported, and are treated equitably by the healthcare system, and the people in it, are better able to deliver quality care (Hume, 2018; National Academy of Medicine, 2022), and promote access to care for service users (WHO, 2022b). However, underrepresented and marginalized health and social care providers' physical, mental, and emotional well-being are being impacted by the same discriminatory beliefs and practices that affect patients and families from similar communities.

In a systematic review of RCTs pertaining to wellness initiatives for physicians and nurses in the healthcare setting, Melnyk et al. (2020) reported that mindfulness and cognitive behavioral therapy may help address work-related burnout, depression, and anxiety. That may indeed be true if one does not consider the root causes of these symptoms; however, for those who are experiencing discrimination (Wang et al., 2020; Ko & Dorri, 2019) and ableism (Lindsay et al., 2023), one could argue that no amount of mindfulness will help, unless of course it is made incumbent upon the aggressors to use these techniques to explore the root of their discriminatory behavior. It is evident that much more exploration is needed to understand such experiences and how healthcare systems and settings can end discrimination to ensure workplace health and wellbeing.

Rosa et al. (2022) described a meaningful-centered approach to facilitate teams' ability to address health and social care provider distress, explore meaningful moments, and create a sense of belonging through shared meaning and purpose. For example, flattened hierarchy and the abolition of relative power and status would support health and social care provider autonomy, engagement in collaborative practice, contribution to decision-making, and ultimately improve patient care and workplace satisfaction (van Bogaert et al., 2016; Fernandopulle, 2021).

There are gaps and more needs to be known about how IPECP impacts provider well-being (Turcotte et al., 2022) and whether it supports inclusive, diverse, equitable, accessible, and socially just workplaces; however, the essence of the collaborative and UHC competencies imply that health and social care providers should work collaboratively to challenge health care systems and healthcare cultures that disrespects and discriminates against the health and wellbeing of providers.

Promoting Health Equity

Health equity has been defined as, "[t]he state in which everyone has the opportunity to attain full health potential, and no one is disadvantaged from achieving this potential because of social position or any other socially defined circumstance" (National Academies of Sciences, Engineering, and Medicine, 2017, p.xxiv). A further definition states that health equity is "the absence of unfair, avoidable and remediable differences in health status among groups of people. Health equity is achieved when everyone can attain their full potential for health and well-being" (WHO, 2021b, p.2). However, health inequities for individuals and populations continue to exist and are complex, arising from the interaction of structural, relational, individual, and physiological factors (Peterson et al., 2021).

Globally, health equity remains elusive for many people. The COVID-19 pandemic revealed the extent of structural drivers of these inequities globally. SDoH, such as insecure and uncertain working conditions and economic disparities, coupled with ethnicity, class, gender, education, and other factors, have served to widen health inequities (Paremoer et al., 2021). Nundy et al. (2022) reported that individuals from historically marginalized populations experienced significantly higher COVID-19 mortality rates, and greater disruptions to their care, during the pandemic. And this is a global phenomenon. In the United States, ethnic minorities experienced more COVID-19 cases and death than non-minority peoples; in the United Kingdom, the death rate in black communities was double that in white communities; and in India, where migrant workers lost their employment due to lock-downs, almost 971 deaths occurred amongst this group due to starvation, financial hardship, injury, suicide, police brutality, and limited access to healthcare (Paremoer et al, 2021, para. 6). The WHO (2023) has called for action to address the systemic causes of these health inequities within clinics, communities, and systems.

The pandemic also revealed digital inequities which affected health and social care practice, and education of the future workforce, including IPE provision (Power et al., 2021). Health inequity is adversely affected by digital inequity. At a time of rapid digital transformation within healthcare, Lyles et al. (2021) highlight the opportunities to address core health inequities for populations that have been marginalized but they warn that digital advancements must be planned and implemented with proactive engagement from others.

With consideration of IPECP, Coleman et al. (2016) articulate that high-functioning teams that effectively collaborate are needed to provide quality care and services. Scrutiny of health disparities, considered from a SDoH lens, may provide operational outcomes by which health equity can be measured. With 70% of healthcare outcomes impacted by the SDoH (Itchhaporia, 2021), and effective collaboration by interprofessional teams associated with improved patient outcomes (i.e., higher quality of care, improved patient experience, and increased patient safety) (WHO, 2010), there is a logical argument for the role of IPE in preparing a future collaborative practice-ready workforce. IPE is well positioned to educate and create a highly skilled, knowledgeable workforce to provide high quality care safely and holistically (Khalili et al., 2022a; 2022b; 2023; 2024). The provision of IPE through an inclusion, diversity, equity, accessibility, and social justice lens can raise awareness and find ways to recognize and overcome discrimination and inequity in health and education for those who are historically underserved, underrepresented, and marginalized.

Social Justice Theories to Support Inclusion, Diversity, Equity, Accessibility in IPECP

Theory can provide a foundation for considering and developing actionable steps, thus a discussion of relevant social justice theories for the interrogation of inclusion, equity, diversity, and accessibility in IPECP is apropos.

Social justice is a concept that is both complex and multi-faceted as it involves a variety of perspectives and ideological differences. Many of these differing interpretations can lead to disagreement on what social justice entails and how it is best achieved. In its basic form, it is defined as "a political theory or system of thought used to determine what mutual obligations flow between the individual and society" (Almgren, 2017, p. 1). Beyond this simplistic definition, there is not one prevailing or agreed-upon consensus for how social justice should be achieved, or the outcome desired (Almgren, 2017). From a more comprehensive perspective, social justice requires political advocacy and associated strategies that are informed by the experiences of historically underserved, underrepresented, and marginalized communities (Collins, 1990; 1998).

Several traditional theories provide frameworks for addressing inequity and injustice within society including retributive justice, restorative justice, and procedural justice. When addressing concerns related to healthcare, distributive justice, or the theory focused on fair distribution of resources and benefits within society, emerges as a priority for discussion.

Improving population health encompasses many factors beyond individual access to health interventions, including those that can be found in the business sector (Kindig et al., 2013). A commitment to social justice in the workplace can result in improved employee morale, greater diversity and inclusion, and a more positive reputation among consumers and stakeholders. Additionally, promoting social justice through business practices can contribute to broader societal goals, such as reducing poverty, improving employee wellbeing, and promoting community health (Kindig et al., 2013).

When applied to healthcare, social justice concerns fair and equal access to healthcare services as a basic human right critical to achieving overall health and well-being (Almgren, 2017). In an effort to achieve fair and equal access to healthcare services for all members of society, principles of social

justice involve addressing root causes of health disparities, such as income inequality, lack of access to education, discrimination, and allocation of healthcare resources. Social justice also concerns how patient autonomy can be fostered so that patients have access to information necessary to make informed decisions, particularly with respect to their cultural beliefs and values (Olejarczyk & Young, 2022). Addressing concerns of social justice requires a collective response, which can be difficult due to differing societal values, worldviews, experiences, goals, and interests. Dominant theories of social justice prioritize strategies that reflect these differences. Five of these social justice theories are represented here.

Libertarian

The *Libertarian* perspective on social justice in healthcare is one that is focused on promoting individual liberty and free market principles and is typically restrictive of government intervention arguing that individuals should be free to make their own healthcare choices without interference (Almgren, 2017). From a Libertarian perspective, social justice in healthcare is not supportive of redistributing resources or ensuring equal access to care, but rather allowing individuals to exercise their freedom of choice and benefit from market competition and innovation. While libertarians may recognize the importance of providing healthcare services to those in need, they tend to view healthcare as a private commodity rather than a public good. When addressed from this perspective, individual choice and freedom are prioritized over collective responsibility (Almgren, 2017).

Consider the Libertarian perspective in a scenario where a patient who is uninsured requires urgent medical care. This position would view the patient as responsible for paying for their medical expenses through their own resources or seeking assistance from charities, private organizations, or crowdfunding platforms.

The government's role would be to ensure a free and competitive market for healthcare services where individuals can choose their own providers and negotiate prices directly. This approach may be controversial to some, as it can lead to unequal access to healthcare services for those unable to afford medical care. However, proponents of this viewpoint argue that a free and competitive market leads to better quality and affordable healthcare services by incentivizing providers to improve their services and reduce their costs in order to attract patients.

Utilitarian

Another social justice theory is the *Utilitarian* approach. In this framework, the desire is to achieve maximum health, happiness, and well-being for the greatest number of people. When considered in the context of healthcare, Utilitarians believe that resources should be allocated in a way that maximizes the overall benefit to society. From this perspective, health and social care interventions or services that improve health outcomes, reduce morbidity and mortality, and prevent the greatest amount of suffering are the priority (Almgren, 2017). One example of this approach in healthcare might be a policy decision regarding the allocation of resources for a specific condition. A Utilitarian would advocate for investing in resources into preventative measures to reduce a specific health condition, such as cancer or heart disease, as these major public health concerns affect the happiness and well-being of a significant portion of the population. Allocating resources for rare or complex conditions that do not ensure the greatest amount of good would therefore be viewed as inefficient and less equitable. The Utilitarian perspective is ultimately focused on outcomes, but fails to address conflicting needs, especially when one outcome is achieved at the expense of others (Almgren, 2017).

Marxist

Another perspective on social justice can be derived from a variety of interpretations completed on the works of Karl Marx. The *Marxist* perspective on social justice concerns the capitalist system, which is based on profit, and its role in the creation of an unequal distribution of resources among social classes (Almgren, 2017). From the Marxist viewpoint, health inequities arise between social classes which results in higher risks of illness, disability, and a lower life expectancy for those on the lower end of the class system (Mechanic, 1990). When viewed from the lens of healthcare, the Marxist perspective requires addressing the underlying social and economic structures that contribute to health disparities and inequities. This position considers healthcare improvements as being inseparable from problems faced in society, and therefore, societal needs must be addressed for health conditions to improve (Mechanic, 1990).

In a Marxist healthcare scenario, proponents would advocate for universal healthcare services that are accessible regardless of income or social status. Marxist policies are those that address structural inequalities or challenge power dynamics in healthcare systems to ensure that all individuals have access to care. This viewpoint has drawn criticism in part due to the strong political influence needed and the resulting limitations of choice for patients (Mechanic, 1990).

Liberal Theory of Justice

The fourth social justice theory comes from Rawls' *Liberal Theory of Justice*. This perspective recognizes the importance of individual rights and liberties, but also acknowledges that there exists an inherent hierarchy of advantages that create social and economic inequalities in society (Almgren, 2017; Ekmekci & Arda, 2016). Rawls' (1999) work is based on the principle of "fair equality of opportunity" as the highest priority for preserving social justice (p. 245). Extending the theory, health is regarded in

terms of specific needs that are considered normal opportunities for human functioning, emphasizing the importance of fairness and equality and supporting the need to provide transparency and input from all stakeholders (Ekmekci & Arda, 2016).

An example of this Liberal Theory of Justice in healthcare would be a community implemented policy allowing individuals with chronic diseases access to care, treatments, and medications, in order to maintain their health. Public health interventions such as healthy food programs or community health education would be supported under this perspective. Strategies may even include providing financial assistance for individuals who cannot afford healthcare services or expanding access to underserved areas. Additionally, the Liberal Theory of Justice would support establishing a community health council, with input from multiple stakeholders, in a transparent and fair manner in an effort to preserve equality of opportunity and promote social justice in healthcare.

Intersectionality Theory

Intersectionality Theory (IT) is the fifth social justice theory to be presented in this paper. Intersectional Theory surfaced from Black feminist scholarship, particularly to the lived experiences of Black women, as a means to disrupt dominant ideology that normalized power dynamics which ultimately impact access to resources, such as health services (Collins, 1990, 1998; Collins & Bilge, 2020; Crenshaw, 1989; Waldron, 2002, 2020). A predominant feature of IT is its ability to lay bare the dominant hierarchies that reduce power to a finite construct that only exists in a dichotomy of oppressor and victim and thus allows for a close examination of how oppression is influenced by fluctuations of power (Collins, 1990, 1998). When power, and the resulting oppression, are not scrutinized to this level it risks a superficial understanding of unequal power relations and expunges and eliminates the very social differences that are the lifeforce of marginalization (Lane, 2023).

In IT, identity is interminably complex allowing for systematic questioning of power from dominant cultures, and the structures that promulgate it, to identify opportunities for change (Bourdieu, 1977; Collins, 1990; Collins & Bilge, 2020; Lane, 2023; McCall, 2005; Metzl & Hansen, 2014; Waldron, 2020). Collins (1998), Waldren (2002), and Lane (2023) suggest that IT is useful for uncovering structural inequalities that are supported by power within different conditions, making it a useful theory to uncover contextual power relations that influence IPECP.

The underpinnings of IT can embellish other social justice theories to demonstrate strategies that support allyship, interrupt power dynamics, and address the implications of social differences. To illustrate, layering IT with a Libertarian perspective allows for acknowledgment of the structural root causes of unequal access to resources, rather than merely attributing inequity to individual responsibility, and thus individual failure. Likewise, to avoid achieving one outcome at the expense of others, as in a Utilitarian approach, utilizing IT can help to identify collective strategies. Similar to the Marxist position of social justice, IT addresses structural inequalities by challenging hierarchies that influence access to resources.

These social justice theories provide multiple frameworks for how health and social care providers can work toward reducing health disparities and promoting social justice in healthcare. Efforts toward addressing the SDoH, advocating for public health policies that prioritize the health of all members of society, collaborating with community stakeholders, and implementing strategies that address the root causes of health inequities are essential. Interprofessional teams can have a significant impact on social justice. Health and social care providers can collectively bridge communication barriers that may exist and provide a more comprehensive and holistic approach to healthcare. The inclusion of interprofessional teams—comprised of different social and professional identities, lived experiences, and areas of expertise—can address a wider range of health issues and be used as a source

of knowledge on how to support a diverse workforce that reflects those who are being served. In doing so, more effective person-centered care that addresses healthcare needs can be provided to patients in ways that are equitable and accessible to those from historically underserved and marginalized communities. Advocating for policies and practices that promote health equity and access to care is one way that interprofessional teams can play a critical role in the promotion of social justice in healthcare. Moreover, paying attention to hierarchies of power that contribute to the underrepresentation of historically underserved and marginalized communities within the health professions is paramount. Such efforts and others can benefit from the utility of IT because it supports a fundamental shift in how power and its implications are explored. IPECP can thus become the means by which structural inequalities are identified and acted upon to bring about equitable change within the health and education systems and beyond.

Novel Strategies

Novel Strategies

The incorporation of meaningful inclusion, diversity, equity, accessibility, and social justice strategies into IPECP requires creative, forward-looking thinking. The field of social sciences and humanities (SS&H) may offer insights into health professions education that can be incorporated into IPE. Critical reflection and critical reflexivity are SS&H approaches that may prove useful (Ng et al., 2019) when transforming IPECP into equitable, inclusive, accessible, and socially just learning environments that support diversity. The word 'critical', denoting actions that challenge assumptions, power, and structural/systemic impacts, is worthy of consideration in IPECP.

Critical reflection requires the examination of the beliefs and values of people and society and how they may influence everyday practice. Some examples of critical reflection in action might be to teach health and social care students and providers to act upon their critical reflections of clinical work to change policies that could be discriminatory. From an academic organizational perspective, admission criteria that are exclusionary and inequitable can, and should, be identified and then challenged. Critical reflection may be one step toward shifting the focus from normative educational structures and practices to those there are more equitable, accessible, diverse, and inclusive. Examining the impact of current equity, diversity, and inclusion initiatives on students' sense of belonging and exploring discrepancies between the intent of the initiatives and their impacts are worthy of critical reflection.

It is also necessary to teach health and social care students, and educators to challenge assumptions, power and hierarchy, and to question systemic and structural obstacles. There is a need to reform health education, including IPE, to question and cross-examine constructed differences, explore who is advantaged by these social constructions, critically reflect on how colonialism has manifested in education and practice, and determine how inequities continue (Paton et al., 2020). In order to do that,

students must experience learning environments that are psychologically safe. They should be socialized to understand their dual identities (professional and personal) to learn how to work together as a team to complement each other's roles (Khalili, 2021). Simulation, case-based group discussions, role-playing, and storytelling are useful teaching practices by which to assist students in critical reflection and to facilitate robust discussions (Ng et al., 2019).

Critical reflexivity, on the other hand, is to turn inward, to better understand one's *own* world position and the limitations imposed by personal consciousness, thereby enhancing an appreciation of other people's social realities. Through critical reflexivity, long-lasting system change is possible where norms can be challenged and re-defined (Ng et al., 2019). Teaching practices that support this approach include facilitating experiential dialogue, rather than topic-based discussions; embedding critical and social theory in content; and using art-based assignments that invite students to express themselves in ways that have meaning for them (Ng et al., 2019). The interactivity that occurs in these types of IPE forums must be psychologically safe spaces to support the development of self-reflection, self-awareness, and teamwork (Lackie et al., in press).

Simulation-based education can act as "a bridge between classroom learning and real-life clinical experience" (Society for Simulation in Healthcare, 2023, para. 1) and has been embedded into uniprofessional health education curricula such as medicine, nursing, pharmacy, physiotherapy, and so on (Davies et al., 2022; Cant & Cooper, 2017; Kononowicz et al., 2019). Whilst simulation-based activities were traditionally used to develop student communication and clinical skills in a low-stakes environment, it has great potential to teach students how to provide inclusive, equitable, accessible, and socially just healthcare, as well as build the capacity for them to question when these principles are lacking (Khalili, 2015). Simulation-enhanced IPE (Sim-IPE) is a form of IPE that is often used to teach interprofessional groups of health and social care students and/or providers how to collaborate (Lackie et al., in press).

For example, at a university in Minnesota, United States, midwifery and women's health nurse practitioner students and obstetrics and gynecology medical residents participated in Sim-IPE to improve their comfort and skills in taking health histories in partnership with transgender and nonbinary persons (Ruud et al., 2021). Targeted and diverse Sim-IPEs such as this are essential because health disparities are being experienced by underserved, underrepresented, and marginalized 2SLGBTQ+ people. As Ruud et al. (2021) rightfully acknowledge "[t]hese health disparities are not innate but rather are unjust and remediable because many of the negative outcomes are not related to one's personal identity but are the result of society's reaction to it" (p. 778).

In Canada, Sim-IPE, using standardized participants (people who are trained to portray patients and families, and to provide feedback to students), and role playing has been successfully utilized by pre- and post-licensure occupational and physical therapists to practice addressing Indigenous-specific microaggressions in the practice setting (Fricke et al., 2023).

Similarly, in Australia, where up to 47% of reported health disparities between Aboriginal and non-Aboriginal people occur due to institutional and interpersonal racism and intergenerational trauma, Garvey et al. (2022) present an innovative approach that improved IPECP, interprofessional attitudes, and cultural capabilities of nursing, dietetic, and occupational therapy students. Tag team simulations allowed for students to 'tag in or out' of either participant or observer roles, in this case within a family meeting to discharge plan for an Aboriginal grandmother with multiple comorbidities. Findings suggest that this approach "positively impacted self-reported cultural capabilities and interprofessional attitudes of nursing, occupational therapy, and dietetics students" (Garvey et al., 2022, p. 88). From a psychological safety perspective, the ability to 'tag in-out' provides an opportunity for students to withdraw from an active role when feeling lost or uncomfortable, yet still be able to participate in the simulation via the observer role.

A uniprofessional discussion-based approach, adopted by the University of North Texas System College of Pharmacy, incorporated a patient-led Cultural Sensitivity Panel into the pharmacy undergraduate programs (Gibson & White, 2019). Although it originated as a uniprofessional approach, it could be easily adapted for interprofessional learning. The panel was comprised of patients or representatives whose work intersected with various historically underrepresented and marginalized populations. Panelists shared knowledge, pearls, experiences, and attitudes they felt were most important for future pharmacists to learn from populations that the panelists represented. This patient-as-teachers approach highlighted that patients are experts in their own cultural and personal backgrounds, which influence healthcare needs. Evaluation of the approach showed improved student self-reported understanding of cultural sensitivity.

Impacts, Outcomes, and Recommendations

Impacts, Outcomes, and Recommendations

This paper has discussed the context for, and importance of, explicitly incorporating the principles of inclusion, diversity, equity, accessibility, and social justice in IPECP. Yet, beyond the isolated examples provided in this paper, there remains a dearth of empirical evidence, specifically in interprofessional literature, that evaluates the impacts and outcomes of including these constructs in IPE. When the interprofessional academy has evaluated these impacts, outcomes, and related concepts, the focus has usually been on promoting 'cultural competence' – developing empathy and understanding of alternative cultural perspectives (e.g., Ozcan Edeer & Rust, 2022; Pecukonis et al., 2008) and the involvement of patients/clients, service users, and experts by experience (e.g., Coleman et al., 2023; Romme et al., 2020). However, the interprofessional community may benefit from more consistent and explicit evaluation of the impacts and outcomes of inclusion, diversity, equity, accessibility, and social justice initiatives so that credible recommendations can be made for research, education, and practice change.

Impact on Students' Satisfaction and Attitudes

IPECP provides a platform to explicitly discuss and explore positions of power and the intersectionality of power and hierarchy with social categories of identity. Activities grounded in social justice can have a lasting impact on students as well as educators and facilitators, where these endeavors are purposefully undertaken with the authentic engagement of those with lived experiences of health disparity. While providing psychologically safe teaching and learning environments for all is important, brave conversations may naturally cause discomfort for many when long-standing attitudes and perceptions are challenged. These are not to be avoided; instead, psychologically safe spaces must be created that are unambiguous and unmistakable to have these discussions. It requires transparency, preparation, and facilitator skills. Emboldening students to speak up, disagree, and/or challenge each

others' thinking, takes knowledge, skill, and ability; competencies that must be learned and adopted by IP facilitators (Banfield & Lackie, 2009; Egan-Lee et al., 2011; van Diggele et al., 2020). Several papers have been published about the role of IP facilitation. Banfield and Lackie (2009) published one of the few comprehensive IP facilitation competency documents that outlined not only the competencies, but also the performance criteria ("behaviours necessary to achieve performance of the competency") and behavioural indicators ("critical examples of specific, observable, and measurable behaviours that indicate achievement of the performance criteria associated with each competency") (p. 613).

Although several papers discuss the knowledge and skills required by facilitators (Abu-Rish et al., 2012; Davis et al., 2015; Derbyshire et al., 2015), few have articulated the necessary performance criteria and behavioural indicators. As Derbyshire et al. (2015) explain, because IP facilitation can be unpredictable and complex, educators must be committed to IPE, role model IP competencies, and be reflexive, underscoring the need to understand the competencies necessary to facilitate IPE (LeGros et al., 2015). Learning with, from, and about one another in the context of collaborative care should occur in a safe environment to expose both students and educators to the intersection of inclusion, diversity, accessibility, equity, social justice interventions, and IPECP.

Many IPE activities are assessed for their impact on students' attitudes and perceptions, using such tools as the Attitudes Toward Health Care Teams scale (ATHCT) (Heinemann et al., 1999) or the Interprofessional Socialization and Valuing Scale (ISVS-21) (King et al., 2016). However, where IPE integrates content on inclusion, diversity, equity, accessibility, and social justice, whether implicitly or explicitly, assessment must include the impact on students' attitudes towards those who are historically marginalized. The myriad of assessment tools currently in use in IPECP related activities and research should be re-assessed for their validity and relevance in the context of social justice. Where new assessment tools are developed, educators and researchers who self-identify as historically marginalized

need to be engaged from the outset; that is, in the ideation, creation, implementation, and evaluation of appropriate assessment tools and measurements that are valid for all stakeholders.

Impacts on Individual or Team Behaviors

The impacts of exclusion, homogeneity, inequity, inaccessibility, and social injustice are reflected within the health and social care professions. This includes direct racial discrimination and is pronounced by the under-representation of several groups. A report from the United States found that racial discrimination was a substantial problem for nurses, where 63% of nurses stated they personally experienced racial discrimination in the workplace involving peers (66%), patients (63%), or a manager/supervisor (60%) (American Nurses Association, 2022). From a workplace perspective, this direct harm resulted in stress, anxiety, and depression (American Nurses Association, 2022). This is not an issue limited to the nursing profession, as many historically marginalized health and social care providers also experience these injustices. For example, physician diversity is defined by sex and gender; identity as an Indigenous person or belonging to non-dominant racialized, ethnic, cultural, or religious communities; by various (dis)abilities; and by familial socioeconomic status (Ruzycki et al., 2022; Spector et al., 2019; Young et al., 2012). In the Global North (United States, Canada, and the United Kingdom), physicians and nurses reported that racial discrimination was a daily occurrence, negatively affecting career progression, increased disciplinary actions, and no remuneration for overtime (Yolci et al., 2022). Dental hygienists likewise experience discrimination in the form of gender microaggressions resulting from implicit and explicit biases, such as those experienced by male hygienists in a predominantly female profession (Diaz et al., 2021), similar to experiences reported by male nurses (Zamanzadeh et al., 2013; Zhang, 2020). Interestingly, while male nurses experience better career expectations and promotions compared to female nurses, there remains prejudice and low professional status in this group of care providers (Zhang, 2020).

The significance of inclusion, diversity, equity, accessibility, and social justice for health and social care students and providers, persons, and communities that have been historically marginalized are continuing to emerge; these issues become more complex when they intersect with IPECP. There is little evidence about specific considerations of these principles that have been captured in the IPECP literature (Dowell et al., 2022). Given the nature of IPECP, it could be opportunistic to promote these principles within the curriculum and organizational culture. Health and social care providers situated within practice settings allow for natural interventions that support equity, diversity, inclusion, and accessibility factors using a team-based model.

Impacts for Service Users, Citizens, and Society

Bridging equity, diversity, inclusion, and accessibility principles with IPE andragogy must be implemented within the healthcare system to lessen societal health disparities and advance the ability to achieve health equity. By engaging with marginalized communities and expressing the cultural desire to learn more about their communities' lifestyles, cultural beliefs, and disparities the health system can heighten its cultural awareness, humility, and sensitivity to seek a deeper understanding of health inequity at its roots. This can lend greater insight into health system improvements to better support the needs of underserved, underrepresented, and marginalized communities through IPECP (Cahn, 2020; Interprofessional Education Collaborative, 2016; Oelke et al., 2013; The Sullivan Commission, 2004).

At the organizational level, the healthcare sector and its leadership should collaborate with programs and organizations across communities that have been under-resourced. Working together to strengthen health-legal partnerships to further support people and communities that have been minoritized needs policy reform (Cahn, 2020). Furthermore, to cultivate an enhanced understanding of and sensitivity to cultural beliefs, IPE should extend beyond cultural sensitivity training with educational immersion for structural competency. This added focus lends a stronger exploratory

understanding of factors associated with promoting accessibility. "Structural competency lifts the level of analysis from the interaction between individual health professionals and patients to consider the governmental policies, residential patterns, and environmental inputs outside the clinical setting that impact health" (Cahn, 2020, p. 432).

Training providers on how to lead these conversations can strengthen interprofessional person-provider relationships and heighten providers' confidence to have these difficult conversations. This, in turn, allows patients' voices to be heard, valued, and respected, establishes person-centered care, and advances trust among communities that have been marginalized. By garnering trust, societal health outcomes, as a whole, may improve through the reduction of medical mistrust (Cahn, 2020; Interprofessional Education Collaborative, 2016; The Sullivan Commission, 2004). To best support peoples' needs, providers must fully grasp the needs of populations that have been under-resourced, underserved, underrepresented, and marginalized. To aid in understanding and support, providers could use a structural vulnerability assessment tool to promote health equity by identifying and mitigating social factors plagued by discrimination (Bourgois et al., 2017; Cahn, 2020).

To further strengthen trust and cultural sensitivity at individual, team, organizational, and systems levels, a diverse workforce that represents the people and communities they serve, including those from historically marginalized populations, is essential (Hammond, 2010; The Sullivan Commission, 2004). Representation of historically excluded populations at leadership and provider levels could enable organizations to develop community connectedness and trust because they understand the social experiences and lives of community groups. Through this approach empathy, structures, and processes can be built to meet diverse needs. Social justice can then be heightened as the system is held accountable to ensure the needs of marginalized communities are actively and intentionally identified and addressed (Cahn, 2020; The Sullivan Commission, 2004).

With a greater understanding of how marginalization occurs, health and social care providers can reflect on person-provider power inequalities to address trust in the healthcare community and better tackle factors that impede health equity and health outcome improvements.

Recommendations

To assist in the development of recommendations, the five concepts discussed earlier in this paper, which are based upon the Quintuple Aim, are used to inform this discussion. These include 1) the person's experience and person-centered care, 2) improved outcomes, 3) cost efficiency, 4) health provider wellbeing, and 5) health equity (Nundy et al., 2022), with emphasis on inclusion, diversity, equity, accessibility, and social justice in IPECP. Table 1 offers recommendations and potential outcomes for each of the five concepts.

Table 1: *Aims, Recommendations, and Potential Outcomes*

Aim	Recommendations	Outcomes
Improve care experiences (person-centered care)	- Identify and develop strategies to address barriers to equitable and accessible healthcare, especially for those with complex health conditions and who are historically marginalized in the health and social care system. - Increase representation of those from historically marginalized communities within IPE (e.g., faculty, educators, SPs), IPECP (preceptors, instructors), including in simulation-based education/Sim-IPE and clinical experiences. - To advance understanding of person-centered care, include patients and families as equal partners in the interprofessional team. - Respect and incorporate the person's preferences, needs, values, and expectations in all care decisions. - Ensure that all patient safety incidents are reported, regardless of a person's identity. - Implement patient advocates that can assist patients with low health literacy to make informed choices about their healthcare experience. - Shift IPE from a cultural competency focus to one that addresses cultural sensitivity/humility and structural competency.	- More inclusive and psychologically safe care. Students who actively participate and practice strategies for addressing inequities and accessibility will be more responsive providers upon entering practice. - Students and early practitioners have the opportunity to see accurate representation of populations and develop strategies to ensure care is consistent with healthcare needs. - Interprofessional teams that address person-centered care have increased input from and understanding of the person, family, and/or community being served.

Table 1: *Aims, Recommendations, and Potential Outcomes*

Aim	Recommendations	Outcomes
Improved collaboration and outcomes	• Create psychologically safe spaces that seek diverse representation. • Include local social and community agencies and non-traditional practitioners to partner with health and social care teams to enhance patient and system outcomes. • Collaborate with representative community stakeholders and advisory groups to enhance data-driven approaches to care. • Provide scaffolded opportunities for IPE from the classroom to community practice, including a variety of practice settings. • Provide interprofessional teams of students with opportunities that immerse them in and expose them to structural and social determinants of health. Create opportunities for students to critically analyze how to address these inequities to improve outcomes. • Challenge health and social care students and providers to face, challenge, and navigate their biases and the impact of colonialism. • Incorporate principles of diversity, equity, inclusion, accessibility, and social justice in IPECP to improve health outcomes.	• Expanding the care team beyond the traditional health and social care providers (e.g., traditional healers, complementary and alternative medicine practitioners) improves community responsiveness to individual and population health needs. It also can develop health and social care students' ability to collaborate with a variety of team members. • Outcome measures for care are driven by data informed by the community as a whole. • Students who participate in IPE scaffolded experiences develop core collaborative competencies. Including a variety of experiences ensures that students have opportunities to develop dual professional and interprofessional identities and the skills needed for inclusion, diversity, equity, accessibility, and social justice.

Table 1: *Aims, Recommendations, and Potential Outcomes*

Aim	Recommendations	Outcomes
Equitable care to lower costs	• Develop an IPE that emphasizes the monetary and human costs to the healthcare system. • Develop opportunities for IPECP thereby decreasing the workload burden (i.e., overtime) and/or cost of co-pays. Consider social and community agencies as part of the IPECP team. • Emphasize IPECP and communication within the care team. Evaluate the roles, responsibilities, and scope of practice of care providers to increase efficiencies and reduce redundancies. • Provide students with the opportunity to practice at the top of their scope of practice (Farrell et al., 2022)	• Engagement with community agencies as part of collaborative practice models decreases the burden on individuals but also provides students with the opportunity to address areas that are in best alignment with their scope of practice. • Increased communication and collaboration decrease the cost and burden of care for people/families and model practices that enhance and value individual provider contributions to the care team.
Provider well-being	• Support the creation of affinity groups for health and social care students from marginalized backgrounds and provide mentorship opportunities with providers from these same underrepresented communities. • Create systems for care providers to report discrimination as well as institutional support once reported. • Develop and implement inclusion, diversity, equity, accessibility, and social justice training for all employees. • Challenge the hierarchy, relative power, and status within the healthcare system to support care provider autonomy, engagement, and contribution. • Create wellness initiatives for care providers that address and mitigate discriminatory practices.	• Increases support for care providers and students by providing a safe space for mentorship and learning where microaggressions, bias, and discrimination are identified. Provides a model for support for early practitioners. • Modeling and ensuring institutional practices are focused on equity, diversity, and inclusion ensures that students learn, and are supported within, this framework and are able to bring these principles into practice.

Table 1: *Aims, Recommendations, and Potential Outcomes*

Aim	Recommendations	Outcomes
Provider well-being	• Develop and implement policies, practices, and culture change to actively enhance representation, retention, accessibility, inclusivity, and bias-free language within academic and clinical settings. • Partner with community sites that actively support and address inclusion, diversity, equity, accessibility, and social justice within their practice settings. • Facilitate and promote a culture of shared accountability across interprofessional student teams (Farrell et al., 2022). • Support and embrace differences in experiences and promote collaboration and sharing of experiences to decrease burnout (Farrell et al., 2022). • Teach educators and providers critical reflection and critical reflexivity skills.	• Care providers gain the skills necessary to address health equity in practice. • Care providers develop a mindset of curiosity as they interact with others in the healthcare team and patients.
Promote Health Equity	• Recruit, retain, and support faculty, clinical instructors, and students from historically marginalized communities (Farrell et al., 2022). • Teach measures and outcome strategies within IPE that address diverse, inclusive, and equitable care with a social justice lens (Farrell et al., 2022). Identify underlying causes for inequities beyond race to include discrimination, mistrust, housing, and food insecurity.	• Increases diversity of thoughts and ideas as well as experiences to address the needs of providers, students, and patients/families. • Outcome measures that emphasize diverse, inclusive, and equitable care give health and social care providers and the students necessary structures and processes to address and advocate for health equity practices. • Use of assessment tools for interprofessional activities, engage students in responsive initiatives, and incorporate quality improvement and patient safety aims.

Table 1: *Aims, Recommendations, and Potential Outcomes*

Aim	Recommendations	Outcomes
Promote Health Equity	• Incorporate pipeline programs that target diverse representation within health and social care. [The term "pipeline programs" is a commonly used term to describe initiatives furthering to increase recruitment and retention into educational programs; however, language such as this is problematic within Canada due to the risk of harm it carries for Indigenous peoples. Oil companies further the historical and intergenerational trauma committed by the Government of Canada by using oil pipelines to steal protected land (The Economist, 2020)]. • Utilize program assessment tools in IPE that emphasize inclusion, diversity, equity, accessibility, and social justice concepts. • Develop/use screening tools to develop health and social care student and provider skills to talk with patients about SDoH that impacts their equitable access to healthcare. • Collaborate on the development of incentivization strategies for health organizations to achieve health equity. • Advocate for professional standards of practice related to inclusion, diversity, equity, accessibility, and social justice within healthcare program accreditation.	• Using screening tools increases health and social care providers' and students' understanding of SDoH and can guide discussions within the interprofessional team and with patients. • Demonstrates that emphasis is being placed on health equity as a key component of success within healthcare teams and for patient outcomes. • Students who participate in active education on health equity are able to make stronger connections to practice and are able to demonstrate the value of health equity in achieving patient outcomes. • Professional standards that incorporate inclusion, diversity, equity, accessibility, and social justice into accreditation requirements ensure that students are being educated and are competent practitioners upon graduation to practice in current healthcare settings.

Conclusion

Conclusion

In this paper, members of InterprofessionalResearch.Global discussed the implications of inclusion, diversity, equity, accessibility, and social justice in IPECP. Working definitions of each term were presented to provoke critical reflection and critical reflexivity within the IPECP community to enhance understanding and support action. The creation of psychologically safe IPE and IPECP learning environments is critical to inclusion, diversity, equity, accessibility, and social justice. Doing so promotes, establishes, and maintains representation, recruitment, retention, and successful graduation of historically marginalized health and social care providers, leading to the provision of safe, equitable, and inclusive health services. Key drivers of inclusion, diversity, equity, accessibility, and social justice were presented, and foundational theories were examined. Novel strategies for incorporating these concepts into IPECP were offered along with impacts, outcomes, and recommendations to support health and social care education and practice organizations.

Together, as a community of health and social care providers, students, scholars, researchers, patients, families, and community members, we can and must move forward to eliminate discrimination and health inequities within education and practice. We must.

"Knowing is not enough; we must apply. Willing is not enough; we must do." – Goethe

(Aguilar-Gaxiola et al., 2022)

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DISCUSSION PAPER