2026; 17(1): https://doi.org/10.36834/b2f1r897

BRIEF REPORTS

Equity, Diversity, and Inclusion in admissions: a critical qualitative inquiry on faculty leaders' perspectives on barriers and facilitators at a Canadian health sciences institution

Jiale Xie,[1] Helen GE Smith,[1] Nicole Hajjar,[1] Rylan Egan[1]

*Author information is provided in the back matter of this manuscript

Abstract

Background: There is an ongoing need for Equity, Diversity, and Inclusion (EDI)-focused admission reform in Canadian health sciences programs. Extensive literature on critical race Theory (CRT) and Postcolonial Theory (PCT) have provided frameworks to understand and challenge existing inequities. However, there is a lack of research regarding specific challenges and dynamics involved in the application of CRT and PCT to admissions in health professions education.

Methods: This study investigates systemic factors influencing EDI-focused admission reform through the perceptions of Canadian health sciences faculty leaders. Using a critical constructivist lens informed by CRT and PCT, we conducted semi-structured interviews with six leaders and applied critical thematic analysis, which uses theories of racism, coloniality, and power, to interpretate participants' views and institutional discourses.

Results: Participants acknowledged bias in traditional admission metrics (e.g., GPA, MCAT) but continued to prefer them over equity-based alternatives, perceiving the former as better indicators of curricular and professional success. Admission reform was perceived to be a resource-intensive add-on that was difficult to prioritize. Broader societal and institutional forces, such as accreditation, peer institutions, and leadership discourses shaped support for equity initiatives.

Conclusion: We conclude that the concurrent reliance on traditional measures of merit in admissions, curriculum, and practice reinforces the cultural currency of those colonial measures. Admission reform efforts should be accompanied by parallel initiatives across other academic domains and appropriate funding and regulatory support to break the self-fulfilling cycle of bias and inequity.

Équité, diversité et inclusion dans les processus d'admission : une enquête qualitative critique sur les perspectives des responsables universitaires concernant les obstacles et les facilitateurs dans un établissement canadien en sciences de la santé

Résumé

Contexte : Il existe un besoin constant de réformer les processus d'admission afin de les rendre davantage axés sur l'équité, la diversité et l'inclusion (EDI) dans les programmes canadiens en sciences de la santé. De nombreux écrits sur la théorie critique de la race (Critical Race Therory-CRT) et la théorie postcoloniale (Postcolonial Theory-PCT) ont fourni des cadres permettant de comprendre et de remettre en question les inégalités existantes. Cependant, il existe un manque de recherches sur les défis et les dynamiques spécifiques liés à l'application de la CRT et de la PCT dans les processus d'admission **en** formation des professions de la santé.

Méthodes : Cette étude examine les facteurs systémiques qui influencent la réforme des processus d'admission axés sur l'EDI à travers les perceptions des dirigeants des facultés de sciences de la santé canadiennes. À l'aide d'une approche constructiviste critique inspirée de la CRT et de la PCT, nous avons mené des entretiens semi-structurés auprès de six dirigeants et appliqué une analyse thématique critique, qui mobilise les théories du racisme, de la colonialité et du pouvoir, afin d'interpréter les points de vue des participants et les discours institutionnels.

Résultats : Les participants ont reconnu l'existence de biais dans les critères d'admission traditionnels (par exemple, la moyenne cumulative (GPA), le MCAT), mais ont continué à les préférer aux alternatives fondées sur l'équité, les percevant comme de meilleurs indicateurs de la réussite académique et professionnelle. La réforme des admissions a été perçue comme un ajout coûteux en ressources, difficile à prioriser. Des forces sociétales et institutionnelles plus larges, telles que l'agrément, les établissements homologues et les discours des dirigeants, ont façonné le soutien aux initiatives en faveur de l'équité.

Conclusion : Nous concluons que le recours simultané aux mesures traditionnelles du mérite dans les processus d'admission, le curriculum et la pratique renforce la valeur culturelle de ces mesures coloniales. Les efforts de réforme des admissions devraient s'accompagner d'initiatives parallèles dans d'autres domaines académiques ainsi que d'un financement et d'un soutien réglementaire appropriés, afin de briser le cercle vicieux des préjugés et des inégalités.

Introduction

Critical race theory (CRT) and postcolonial theory (PCT) provide insights into contemporary impacts of colonial and racist foundations of health sciences education in the domains of curriculum, culture, research, and scholarship.[1–4] To date there has been limited investigation into their application in the context of systemic challenges to admission reform. A foundational tenet of CRT is that racism has (and continues to) shape the distribution of economic, cultural, and ideological resources across generations.[5,6] This perspective is crucial to understand barriers experienced by students from equity-deserving groups, including but not limited to Indigenous peoples, other racialized communities, people with disabilities, and 2SLGBTQI+ individuals. Some barriers include costs of admission evaluations,[7,8] cultural, familial, and economic obligations,[9,10] limited role models and/or mentors,[11–13] and microaggressions and isolation in the social/academic environment.[12,14]

PCT outlines how colonial legacies have perpetuated inequitable control of resources, cultural narratives, and educational framework by slandering non-colonial knowledge systems as inferior.[15,16] These legacies are embedded in health sciences admissions, where Eurocentric standards of merit such as standardized scores continue to take precedence while equity-focused initiative such as admission streams,[17–19] reserved seats,[20,21] holistic review,[17,22] workshops, mentorship, financial aid,[23,24] and reviewer diversification and equity training[17,18] are not uniformly adopted across Canadian health sciences programs. Moreover, admissions, staff faculty, and student members continue to dismiss these initiatives as formulaic, tokenistic, or performative and equity-deserving students as less competent or deserving.[25,26]

In this context, critical constructivism offers a useful theoretical synthesis. It recognizes knowledge as socially constructed but shaped by systemic power relations, allowing researchers to examine how institutional actors internalize, resist, or reproduce racial and colonial logics.[27,28] While systemic barriers to equity in admissions have been documented, there is limited understanding of how institution leaders' perceptions influence the advancement or resistance of equity-focused reforms. To address this gap, the current study uses a critical constructivist approach informed by CRT and PCT to examine how leaders at a Canadian health sciences faculty perceive and navigate contextual or system factors such as resources, policies, and societal perspectives influencing admission reforms. Through this lens, we aim to uncover the discourses that pose a challenge to enacting tenets of CRT and PCT to address admission inequities.

Method

Study context, participants and recruitment

This project was situated in a Canadian University's Faculty of Health Sciences including programs such as undergraduate and graduate levels in Medicine, Nursing, and Rehabilitation. Six participants who hold or held leadership roles at different health sciences programs represented across the faculty were chosen through a convenience sample. This sample size is justified by Malterud et al.[29]'s concept of information power given our specific research question, theory-informed analytical approach, dialogue quality, and focus on case depth over variation.[29] To protect participants' confidentiality, their names and academic programs were de-identified. Participants were recruited directly through targeted emails with a letter of consent without monetary incentives. This study received ethics approval from an institutional Research Ethics Board (No. 6032363). Participants responded to the email invitations and provided recorded verbal consent prior to the interview given pandemic restrictions.

Data collection

Participants completed one 25–45-minute semi-structured interview via zoom or in-person. The interviews were audio-recorded and transcribed verbatim. The primary research team developed questions and prompts based on our unpublished literature review on equity, diversity, and inclusion (EDI)-focused admission reform (Supplementary Material 1. Interview Guide). Interview questions

prompted participants to rationalize how contextual factors such as resources, policies, faculty, staff, and student perspectives influence admission reform. Acknowledging the complexity and diversity of perspectives on this subject, a group of faculty and students with diverse sociodemographic backgrounds, experience with admissions, levels of formal power, and academic disciplines provided feedback on the interview guide to ensure content and face validity.

Data analysis

We used a critical, reflexive, thematic analysis approach informed by Braun & Clark[30] and Lawless & Chen[31] using NVivo 12. Three team members (JX, HS, RE) reviewed the interview transcripts multiple times prior to coding. JX conducted and transcribed all interviews. HS reviewed the transcriptions for accuracy. JX, HS coded four transcripts independently after completing most interviews, then collaboratively refined the codebooks to ensure the coding was rich, coherent, and plausible.[30] Consistent with critical thematic analysis, we applied a two-stage, interactive, coding process: initial open, inductive coding to capture participants' experiences and identify recurrence and repetition, followed by deductive coding to interlink interview discourses with societal ideologies, power relations, and status-based hierarchies critiqued in CRT and PCT.[31] We analyzed participants' language in relevance to their roles; vigilant to contradictions, stuttering/uncertainty, "othering," expressions that support or subvert power dynamic over a group, culture, or way of knowing, and ideas missing in the data.[31,32] The two remaining transcripts were coded by JX, but all team members contributed to theme generation through visual mapping and several discussion rounds. The analysis revealed substantial overlap in codes and thematic ideas across participants. Though nuanced disciplinary distinctions were also evident, follow-up interviews to explore these variations were impracticable due to participant turnover. Consistent with reflexive thematic analysis, we invited all participants to provide feedback on the manuscript before journal submission.[30]

Research team reflexivity

Authors have experience planning EDI-focused admission reform and are versed in CRT and PCT. This study was conducted through these established lenses, with prior experience informing understanding of participants' level of formal power and admissions reform approaches and logistics. This information helped contextualize participants comments, rather than assuming specific opinions towards the topic. We used reflexive debriefing, analytic memoing, and independent transcript review before group discussions, revisiting raw data when interpretations diverged. These steps ensured findings were theoretically informed yet grounded in participants' narratives, supporting trustworthiness and credibility.

Results

Participants identified several challenges to implementing EDI-focused admissions, including reliance on traditional merit measures, the perception of reform as costly, and societal attitudes that can either support or hinder change. Key themes and supporting quotes are detailed below; full quote sets are in Supplementary Tables S2–S4.

Contemplating the predictive validity of admission metrics for student success

Although all participants acknowledged that traditional admission metrics inequitably measure student achievement and stressed the need to *"remov[e] the reliance on key metrics of performance that have been dictated by privilege."*(P4)), some expressed reservations about compromising *objectivity* or candidate *quality*. The latter was linked to students' success in curriculum and perceived effectiveness in practice. One participant stated that "*the admissions committee isn't, or shouldn't be, happy to achieve a certain admissions [demographic] profile, it should [aim to admit] people who are going to have careers that are productive and satisfying to them.*" (P3). EDI-reform was sometimes framed as benevolent intervention instead of justice re-storing: *"if they got the one chance, things could turn for them…it's trying to appreciate what that balance is, um, to give an opportunity to somebody, who otherwise would not have had it"* (P1).

Participants also noted faculty and staff concerns that equity measures lower standards: "*they feel like we are reducing standards in order to reach quota"*(P4); "*There is always this debate…are we lowering the bar, are we giving them a different criteri[on] to get in?"* (P6).

Viewing reform as addition vs revision impacts plausibility

Reform pace depended on alignment with programs' objectives to produce competent health professionals. Participants viewed reform as challenging because it represented significant *additional* procedure and expense:

> *That's a lot of work that has never been done by people that are already busy people"(P1); "[o]ur file reviews, our interviewing…these all are carried out and manned by faculty and students…so, it's a huge, huge commitment (P3).*

Those advocating for internal funding reallocation acknowledged the challenge: "*[w]e decided that's where we gonna put our money, because it's really really important. The conversation that we never have, is what are we gonna give up to get that*"(P6).

Society as facilitator and barrier to reform

Participants recognized systemic causes of underrepresentation, shaped by forces beyond program control (Supplemental Table 3). One participant noted the lack of control over the applicant pool, "*We're part of a continuum…those are the people that can come into [the program]…I don't have control over the applicant pool*"(P2). Another participant noted the external barriers related to financial accessibility, further emphasizing institutional limitations: "*That's an external agency…we couldn't afford to pay for everybody to do it*" (P6).

Participants also saw growing support for reform. Accreditation requirements and peer institutions increased pressure to decolonize: "*If the accreditation requirements change then schools are forced to change… the topic of EDI is on the agenda*" (P5). Internal to the university, institutional leaders such as the principal and faculty heads publicly expressed commitment to EDI, which set behavioral expectations for students and employees and led to institutional support for program initiatives: *"The principal of our university and Dean… have very openly spoken of their support… and are willing to put the resources into it"*(P2). Across programs, there was a shared interest in improving EDI that facilitated collaborative effort. Within individual programs, faculty, staff, and students facilitated change by advocating for, contributing to, and embracing change:

> *There are certainly students… who have been pushing for changes and that can be quite effective"(P5); "it's the faculty supporting it as well, you know, supporting [students with] creating, on their own initiatives, that are specifically focused on EDIIA…bringing them to be in to be a member of committees so their ideas can be spread...(P2)*

Discussion

Individuals from equity-deserving backgrounds continue to face barriers and disparities in health sciences education and the healthcare system. Leaders at the participating university expressed commitment to EDI-focused admission reform but faced challenges within an environment where a belief in the current system as meritocratic (objective and effective in selecting the "best" candidates) was deeply entrenched. Concerns about the fairness and predictive value of current admission metrics coexisted with the belief that these metrics act as proxies for "quality" in education and practice. Adopting EDI-affirming approaches within the existing system was perceived as implausible, though external pressures could be leveraged to push the university towards reform.

At the studied university, the success of admissions criteria was primarily assessed by students' academic performance within the existing curriculum. This approach presumes the curriculum itself is equitable. Unfortunately, there is extensive literature that critiques the absence of equity and

decolonization in current health professions curricula.[33–37] Yet evidence shows that traditional academic metrics have limited ability to predict long-term practice efficacy[38,39] while diversity in the workforce improves health equity.[40–46] Substantive admission reform, therefore, must occur alongside curricula and institutional structures that redefine merit and success. This includes decolonizing curricula, decreasing dependence on standardized tests as unmeasured metrics of students' professional capability, and aligning admissions with program-level competencies that value equity-promoting practice.

Participants cited inadequate resources as a major barrier, reflecting a belief that EDI requires supplemental rather than core funding.[47,48] This "add-on" perception contributed to concerns about workload, cost and hindered the plausibility of reform. To counter this, institutions should reallocate existing resources to embed EDI initiatives as essential operational priorities, rather than optional enhancements. Government, institutional, and regulatory bodies already require some equity reporting, but these accountability frameworks should track the long-term impact of admissions policies on workforce diversity and health equity outcomes. Leveraging societal and institutional momentum can help sustain reforms beyond individual programs.

Limitations

This qualitative study intends to critically explore the association between leadership perspectives and challenges to equity-focused admission reform within the context of this study. It is not designed to generalize across sites or beyond this scope. Generalizability will require replication across sites and quantitative methods.

Conclusion

Barriers to EDI-focused admission reform are both symptoms and causes of colonial and inequitable aspects of our healthcare system and health sciences curricula. Participants illustrated the interconnected struggle between perceptions of admission rigour, maintaining the status quo while engaging in EDI reform, and under-resourced societal pressures for EDI reform. For reform to be sustainable, admission criteria rooted in colonial, racial, gendered, class-based, and ableist biases need to be challenged as the core and most robust criteria for admissions. A broader perspective on admissions should be accompanied by curricula aligned with health equity and support for marginalized populations. To achieve this, institutions should be held accountable for retaining historical admission measures that have failed to address our inequitable health care system. Harnessing institutional leadership and societal momentum offers a path to dismantling entrenched inequities in admissions and, ultimately, in the health professions workforce.

.

Author information:

1- Faculty of Health Sciences, Queen's University, Ontario, Canada

Correspondence to:

Jiale Xie

email: 18jx49@queensu.ca

Published ahead of issue:

Oct 10, 2025

Conflict of Interest:

The authors have no relevant financial or non-financial interests to disclose.

Funding:

No funding was received for conducting this study or the preparation of this manuscript.

Acknowledgements:

We thank the preliminary study design and data collection advice by an admission working group at our institution. We thank our participants for sharing their insights and contributing to the revision of this manuscript.

Edited by:

Henry Moon (senior section editor); Cindy Schmidt (senior section editor); Marcel D'Eon (editor-in-chief)

References:

1. Zaidi Z, Young M, Balmer DF, Park YS. Endarkening the epistemé: critical race theory and medical education scholarship. *Acad Med.* 2021 Nov 1;96(11S):Si-Sv. https://doi.org/10.1097/ACM.0000000000004373
2. Tsai J, Lindo E, Bridges K. Seeing the window, finding the spider: applying critical race theory to medical education to make up where biomedical models and social determinants of health curricula fall short. *Front Public Health.* 2021 Jul 9;9(9):653643. https://doi.org/10.3389/fpubh.2021.653643
3. Bell BV. "We'd really love to but we're really busy": silence, precarity and resistance as structural barriers to anti-racism in nursing education. *J Adv Nurs.* 2024;80(1):214–25. https://doi.org/10.1111/jan.15795
4. Naidu T. Modern medicine is a colonial artifact: introducing decoloniality to medical education research. *Acad Med.* 2021 Nov;96(11S):S9–12. https://doi.org/10.1097/ACM.0000000000004339
5. Carbado DW. Critical what what? *Conn L Rev.* 2011 Jul 1;43(5):1593–643. Available from: https://ssrn.com/abstract=1919716 [Accessed on May 12, 2024].
6. Dixson AD, Rousseau Anderson C. Where are we? critical race theory in education 20 years later. *Peabody J Educ.* 2018 Jan 1;93(1):121–31. https://doi.org/10.1080/0161956X.2017.1403194
7. Lam J, Phillips C, Okafor I. COVID-19: An urgent opportunity to decrease financial barriers to medical school admissions. *Can Med Educ J.* 2020 Dec 7;11(6):e163–4. https://doi.org/10.36834/cmej.70219
8. Shipeolu L, Mathieu J, Mahmood F, Okafor I. Bridging the gap: improving CASPer test confidence and competency for underrepresented minorities in medicine through interactive peer-assisted learning. *Can Med Educ J.* 2021 Feb;12(1):e70–5. https://doi.org/10.36834/cmej.70616
9. De Freitas C, Buckley R, Klimo R, Daniel JM, Mountjoy M, Vanstone M. Admissions experiences of aspiring physicians from low-income backgrounds. *Med Educ.* 2021 Jul;55(7):840–9. https://doi.org/10.1111/medu.14462
10. Owen LE, Anderson SA, Dowell JS. Free text adversity statements as part of a contextualised admissions process: a qualitative analysis. *BMC*

Med Educ. 2018 Dec;18(1):58. https://doi.org/10.1186/s12909-018-1158-6
11. Hadinger MA. Underrepresented minorities in medical school admissions: a qualitative study. *Teach Learn Med.* 2017 Jan 2;29(1):31–41. https://doi.org/10.1080/10401334.2016.1220861
12. Isik U, Wouters A, Petra Verdonk, Croiset G, Kusurkar RA. "As an ethnic minority, you just have to work twice as hard." Experiences and motivation of ethnic minority students in medical education. *Perspect Med Educ.* 2021;10(5):272–8. https://doi.org/10.1007/S40037-021-00679-4
13. Joseph J, Dao D, Hwang SM, et al. Perceptions of barriers and facilitators to becoming a medical professional among underrepresented undergraduate and postbaccalaureate learners. *Mayo Clin Proc Innov Qual Outcomes.* 2021 Apr 1;5(2):347–58. https://doi.org/10.1016/j.mayocpiqo.2021.01.003
14. Clark DA, Kleiman S, Spanierman LB, Isaac P, Poolokasingham G. "Do you live in a teepee?" Aboriginal students' experiences with racial microaggressions in Canada. *J Divers High Educ.* 2014;7(2):112–25. https://doi.org/10.1037/a0036573
15. Said EW. *Orientalism.* Knopf Doubleday Publishing Group; 2014. 434 p. https://doi.org/10.4324/9780203092170-13
16. Santos B de S. *Epistemologies of the south: justice against epistemicide.* New York: Routledge; 2015. 284 p.
17. Joy TR. Strategies for enhancing Equity, Diversity, and Inclusion in medical school admissions–a Canadian medical school's journey. *Front Public Health.* 2022 Jun 24;10:879173. https://doi.org/10.3389/fpubh.2022.879173
18. Saddler N, Adams S, Robinson LA, Okafor I. Taking initiative in addressing diversity in medicine. *Can J Sci Math Technol Educ.* 2021 Jun 1;21(2):309–20. https://doi.org/10.1007/s42330-021-00154-6
19. Young ME, Thomas A, Varpio L, et al. Facilitating admissions of diverse students: a six-point, evidence-informed framework for pipeline and program development. *Perspect Med Educ.* 2017 Apr;6(2):82–90. https://doi.org/10.1007/S40037-017-0341-5
20. Foley J. Queen's increasing efforts to recruit Black and Indigenous medical students – Kingston News. Kingstonist News - 100% local, independent news in Kingston, ON. 2020 Available from: https://www.kingstonist.com/news/queens-increasing-efforts-to-recruit-black-and-indigenous-medical-students/. [Accessed on Jun 5, 2024].
21. Mercer C. Medical school reserves seats for low-income students to increase diversity. *CMAJ.* 2018 Nov 5;190(44):E1314–5. https://doi.org/10.1503/cmaj.109-5673
22. Association of American Medical Colleges. *Holistic Review.* 2023. Available from: https://www.aamc.org/services/member-capacity-building/holistic-review. [Accessed on Aug 18, 2022].
23. Ontario Medical School Application System. *OMSAS - Ontario medical school application fee waiver program.* OUAC Ontario Universities Application Centre. 2023 Available from: https://www.ouac.on.ca/guide/omsas-waiver-program/ [Accessed on Dec 12, 2023].
24. Okafor I, Phillips L. Shifting the paradigm in outreach to under-represented groups. *MedEdPublish.* 2018 Dec 1;7. https://doi.org/10.15694/mep.2018.0000286.1
25. Young ME, Shankar S, St-Onge C. An exploration of values in medical school admissions processes: the interplay between contextual factors, admissions practices, and validity. *Adv Health Sci Educ.* 2023 Dec 8. https://doi.org/10.1007/s10459-023-10307-x
26. Beagan BL, Sibbald KR, Goree TD, Pride TM. Affirmative action and employment equity in the professions: Backlash fueled by individualism and meritocracy. *Can Rev Sociol Can Sociol.* 2024;61(3):241–61. https://doi.org/10.1111/cars.12480
27. Kincheloe JL. *Critical Constructivism Primer.* Peter Lang; 2005. 196 p.
28. Critical Constructivism. *Global Social Theory.* 2018 Available from: https://globalsocialtheory.org/concepts/critical-constructivism/. [Accessed on May 3, 2023].
29. Malterud K, Siersma VD, Guassora AD. sample size in qualitative interview studies: guided by information power. *Qual Health Res.*

2016;26(13):1753–60. https://doi.org/10.1177/1049732315617444
30. Braun V, Clarke V. Toward good practice in thematic analysis: Avoiding common problems and be(com)ing a knowing researcher. *Int J Transgender Health.* 2023 Jan 25;24(1):1–6. https://doi.org/10.1080/26895269.2022.2129597
31. Lawless B, Chen YW. Developing a method of critical thematic analysis for qualitative communication inquiry. Howard J Commun. 2019 Jan 1;30(1):92–106. https://doi.org/10.1080/10646175.2018.1439423
32. Barry P. *Beginning theory: an introduction to literary and cultural theory.* 2. ed. Manchester: Manchester Univ. Press; 2008. 290 p. (Beginnings).
33. Razack S, Richardson L, Pillay SR. The violence of curriculum: dismantling systemic racism, colonisation and Indigenous erasure within medical education. *Med Educ.* 2025 Jan;59(1):114–23. https://doi.org/10.1111/medu.15470
34. Sivananthajothy P, Adel A, Afhami S, Castrogiovanni N, Osei-Tutu K, Brown A. Equity, diversity, and…exclusion? A national mixed methods study of "belonging" in Canadian undergraduate medical education. *Adv Health Sci Educ Theory Pract.* 2024 May;29(2):611–39. https://doi.org/10.1007/s10459-023-10265-4
35. Cameron R, Gregory P. The lived experiences of racism among Indigenous nursing students enrolled in a Canadian baccalaureate nursing education program. *QANE-AFI.* 2024 Oct 15;10(3). https://doi.org/10.17483/2368-6669.1438
36. Hughes N, Norville S, Chan R, Arunthavaraga R, Armena D, Hosseinpour N, et al. Exploring How Racism Structures Canadian Physical Therapy Programs: Counter-Stories From Racialized Students. *JHR.* 2021 Apr 30. Available from: https://www.jhrehab.org/2019/11/14/exploring-how-racism-structures-canadian-physical-therapy-programs-counter-stories-from-racialized-students/
37. Adler S, Boivin-Côté J, Gravel I, Ouizzane C, Bizimungu S, Bourque CJ, et al. Experienced or witnessed racism and microaggressions during medical education: an exploratory survey of medical learners at a large Canadian medical school. *CMEJ.* 2025 July 28. https://doi.org/10.36834/cmej.79882
38. Dong T, Gilliland WR, Cruess D, et al. A longitudinal study of commonly used admissions measures and disenrollment from medical school and graduate medical education probation or termination from training. *Mil Med.* 2018 Nov 1;183(11–12):e680–4. https://doi.org/10.1093/milmed/usy069
39. Kim T, Chang JY, Myung SJ, et al. Predictors of undergraduate and postgraduate clinical performance: a longitudinal cohort study. *J Surg Educ.* 2016 Jul 1;73(4):715–20. https://doi.org/10.1016/j.jsurg.2016.03.006
40. Silver JK, Bean AC, Slocum C, et al. Physician workforce disparities and patient care: a narrative review. *Health Equity.* 2019 Jul 1;3(1):360–77. https://doi.org/10.1089/heq.2019.0040
41. Marrast LM, Zallman L, Woolhandler S, Bor DH, McCormick D. Minority physicians' role in the care of underserved patients: diversifying the physician workforce may be key in addressing health disparities. *JAMA Intern Med.* 2014 Feb 1;174(2):289–91. https://doi.org/10.1001/jamainternmed.2013.12756
42. Walker KO, Moreno G, Grumbach K. The association among specialty, race, ethnicity, and practice location among california physicians in diverse specialties. *J Natl Med Assoc.* 2012;104(0):46–52. https://doi.org/10.1016/S0027-9684(15)30126-7
43. Alsan M, Garrick O, Graziani G. Does diversity matter for health? experimental evidence from Oakland. *Am Econ Rev.* 2019 Dec;109(12):4071–111. https://doi.org/10.1257/aer.20181446
44. Shen MJ, Peterson EB, Costas-Muñiz R, et al. The effects of race and racial concordance on patient-physician communication: a systematic review of the literature. *J Racial Ethn Health Disparities.* 2018 Feb;5(1):117–40. https://doi.org/10.1007/s40615-017-0350-4
45. Verbree AR, Isik U, Janssen J, Dilaver G. Inclusion and diversity within medical education: a focus group study of students' experiences. *BMC Med Educ.* 2023 Jan 25;23(1):61. https://doi.org/10.1186/s12909-023-04036-3

46. Bullen J, Roberts L, Hoffman J. What predicts health students' self-reported preparedness to work in Indigenous health settings? *Aust Educ Res.* 2017 Mar 1;44(1):71–87. https://doi.org/10.1007/s13384-017-0230-2
47. Cleland JA, Nicholson S, Kelly N, Moffat M. Taking context seriously: explaining widening access policy enactments in UK medical schools. *Med Educ.* 2015 Jan;49(1):25–35. https://doi.org/10.1111/medu.12502
48. Ko M, Henderson MC, Fancher TL, London MR, Simon M, Hardeman RR. US medical school admissions leaders' experiences with barriers to and advancements in diversity, equity, and inclusion. *JAMA Netw Open.* 2023 Feb 24;6(2):e2254928. https://doi.org/10.1001/jamanetworkopen.2022.54928