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Commentary and Opinions

Equitable assessment in medical education: confronting the hidden curriculum and systemic bias

Évaluation équitable dans l'enseignement médical : confronter le programme caché et les préjugés systémiques

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Assessments in medical education play a pivotal role in shaping not only learners' experiences but ultimately, the quality of care patients receive through the clinicians the system produces. Designed to be objective, assessments convey implicit lessons based on what they emphasize and omit, and by how they are enacted. They represent the unintended lessons and priorities about whose knowledge, communication, and professionalism standards are deemed most valuable.[1] They also highlight assumptions within the educational framework that reveal what successes and failures are presumed to be and illustrate the hidden curriculum in action.

Evaluation practices often overlook structural inequities and implicit biases within educational environments. Learners from marginalized groups receive disproportionately negative evaluations and have delayed progression, and experience disparities not explained by clinical performance alone.[2] These patterns carry lasting impacts on learners' confidence, sense of belonging, and career advancements.[3]

Diversity within the health professions improves patient outcomes and helps narrow health equity gaps.[4] Many admission and recruitment efforts now target underrepresented populations in undergraduate and postgraduate medical training. However, while diversity initiatives have expanded the demographic breadth of medical trainees, inclusive admissions mean little if learners enter learning environments unprepared to support them. The result is often negative feelings of well-being and belonging, as well as higher rates of burnout and increased attrition.[5]

When systemic issues are not appropriately addressed, exclusion and disadvantage proliferate, undermining both healthcare equity and learner rights. Although student demographics are diversifying slowly, those of faculty and postgraduate leadership remain largely homogeneous.[6] This raises concern that assessment practices, which are central to selection and career advancement, may propagate structural and interpersonal bias. Even if unfounded, perceptions of assessment inequity can burden underrepresented learners and compound the already challenging learning environments in which they are expected to perform. Ensuring fairness does not mean removing subjectivity, but requires clear criteria and accountability for how judgments are made.

Equity-informed assessments are therefore not a matter of political correctness but of educational integrity. Evaluations that ignore systemic bias and perpetuate disparities conflate access and privilege with ability. It is essential to promote fairness, reduce bias, and give all learners a genuine opportunity to demonstrate competence. EDI-informed assessments foster transparency, reinforce legitimacy, and prepare future clinicians to provide culturally competent,

patient-centered care. They uphold ethical and accreditation standards, promote the success of underrepresented learners, and help dismantle structural barriers within the medical education system. By modelling the cultural humility expected in clinical practice, equitable assessment advances the broader goal of health equity.

Despite rising institutional commitment to EDI, assessment remains one of the more resistant domains to change.[4] Faculty often report feeling ill-equipped to integrate EDI into evaluation practices, citing insufficient training, tools, or institutional support.[4] This apprehension was also echoed in our experience presenting a workshop at the University of Toronto with interdisciplinary health professions educators. Despite the limited literature, the workshop consolidated existing evidence and practical strategies. Participants consistently expressed that the *how* of incorporating EDI in assessments remains unclear. They recognized the moral and educational necessity of EDI integration but also voiced concern about preserving clinical validity and rigor. Therein lies the dilemma!

This is a clear call to action. Medical education must transform assessment practices so they are explicitly grounded in EDI principles. However, there is limited, if any, literature to guide the vision, design and development of such assessments in medical education. The question of how to implement assessments that respond to the diverse educational needs of medical learners, while ensuring their effective use in clinical development remains unclear. Educators and scholars should draw on both the broader educational literature and health professions scholarship to co-develop pragmatic, evidence-informed frameworks for equitable assessment design and implementation. These frameworks must aim to achieve both fairness and clinical validity. The most effective approach and best outcome remain unknown, prompting the need for further scholarship. All aspects considered, assessment practices should promote transparency in the process, accountability in outcomes, and inclusivity in application.

Reimagining assessment through an equity lens requires both structural and cultural reform. Only when assessment systems are transparent, fair, and inclusive can medical education claim to be meritocratic. Equity in evaluation is not ancillary to clinical training; instead, it is essential to the integrity of medical education, the profession it serves, and the students it supports.

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