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WHEN I SAY

When I say … removing barriers

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A heightened focus on justice, equity, diversity, and inclusion (JEDI)[1] has led many within health professions education (HPE) to seek ways to remove barriers to training and practice. Yet, we have observed many barrier "removal" practices that do not actually remove barriers but instead aid individuals or groups to surmount barriers that remain in place. While this distinction may initially appear pedantic, itself perhaps a barrier to action, we feel this nuance is critical to evaluate our progress towards JEDI in our programs. When barriers are left in place but addressed through individualised means, we believe too often this practice reflects inertia rather than thoughtful deliberation at the nexus of norms and values.[2]

Barrier removal is fundamentally about inclusion. Although the term *inclusion* suggests the work of bringing in marginalised Others, Graham and Slee[3] argue inclusion must operate beyond bringing people into a realm they were previously excluded from and aiding their assimilation into the existing environment. Instead, they argue inclusion requires cultural and structural change to reform what has been traditionally centred. Such inclusion must transform the conditions of entry and the assumptions upon which activities within the space occur. This formulation echoes Harding's[4] assertion that adding in people previously excluded challenges ways of knowing within a field and, thus, requires fundamental change. Inclusion, then, is not simply about fitting new people into existing environments, it is about rethinking the rules of the game within the spaces they are being included into. This way of conceptualising inclusion aligns with the spirit of diversity initiatives in medical education, which profess that increasing diversity will enrich the field with new perspectives and, in turn, better serve the public.[5] Presumably, these valuable new perspectives ought to challenge our traditional ways of doing—the centre—to invite fundamental reform.

To transform the centre, various mechanisms are advocated. The field of disability studies discusses two approaches to address barriers: accommodation and universal design. Accommodation is the most prevalent approach and is codified in many countries' disability rights legislation. This approach recognises that environments may be inaccessible and offers individual changes to policy and procedure to address barriers. By recognising individual differences and adjusting the environment for those individuals accordingly, accommodations represent an approach grounded in equity. However, in a high-performance field steeped in ableism,[6] individualised barrier removal is stigmatised and invites covering one's access requirements.[7,8] The impetus for change is individual need, which confers deficit on the individual rather than a barrier-laden environment. Furthermore, such an individualised approach must be re-negotiated by each student. Universal design offers an alternative: design that reaches for maximal inclusivity without retrofitting. This systemic approach to barrier removal problematizes the social environment rather than the individual. Through its work to systematically eliminate structural barriers to participation for all, universal design is grounded in notions of justice. The approach requires broad investigation of barriers to participation for those marginalised within current systems, and thoughtful, ongoing reconfiguration of the system to maximise participation.[9] Such an approach often requires letting go of traditional ways of working, invites introspection on core values and desired outcomes, and pushes towards creative solutions informed by perspectives of equity-denied groups. Accommodations and universal design arguably both address barriers, but with different effects on the centre: while the former troubles the centre while leaving it intact, the latter takes an unqualified approach to shift the centre. By building new ways of working that begin from the lived experiences and needs of systemically marginalised people, what is privileged (centred) shifts. In shifting the centre, the range of possible ways to do health professions education grows.

These ideas from disability studies invite us to consider the intention and mechanisms of barrier removal. Strategies such as offering targeted programs in interviewing skills, building students'

foundational knowledge in areas that admission rubrics are based upon, or offering financial support to gain experiences expected by admissions committees do not remove explicit or tacit barriers, they lift individuals over barriers. Similar strategies continue after admission: offering a food bank to supplement low budgets, a portal to request "time off" for medical appointments, yoga classes to manage stress. While well-intended, such barrier surmounting activities tacitly endorse existing pedagogic, sociocultural, and built environments to help students "play the game." The approach tinkers around the edges rather than transforming HPE environments, finding ways to assimilate divergent students into the professions. Possible transformational alternatives might include reshaping admissions decision metrics to deprioritize knowledge and experience exclusive to dominant classes or races, implementing a universal basic income for health professions students to remove the economic barrier to learning, and ensuring all learners have weekly time off during regular business hours for personal and community care without judgement of its validity.

In HPE, our approach to barriers requires further attention as part of a process to continuously examine the norms, rules, and responses that we have created, endorsed, or supported within our field. We encourage readers to critically reflect on the ways barrier removal has been claimed in their local context to consider the actions taken thus far and their effects. Do these actions maintain the status quo? How did the chosen response reckon with the tensions of quality care and academic standards? Who is centred and ultimately benefits from the resulting system? What risks remain through the chosen approach? Responses that support individuals to surmount a barrier may represent necessary immediate, interim solutions that buy us time to think deeply and orchestrate transformation. Or, the barrier may be truly necessary to safeguard the profession or public and can only be addressed through individualised efforts to support a person to achieve an existing requirement. However, these approaches ought to be clearly labelled for what they are, bridges over barriers rather than barrier removal. Therefore, when we say *removing barriers*, we mean interrogating the barrier (What creates the barrier? What assumptions suggest its necessity? Is this assumption necessary or useful in the present day? Who does it serve and who does it exclude? How might we operate otherwise?) and implementing alternative ways to operate that systemically remove the barrier, for all.

DATA AVAILABILITY STATEMENT

Data sharing is not applicable to this article as no datasets were generated or analysed during the current study.

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