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RESEARCH ARTICLE

THE CLINICAL TEACHER

Cultural diversity and inclusion in UK medical schools

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Abstract

Background: Racially minoritised groups across the globe continue to experience differential outcomes in both health and education. Medical schools can play an instrumental role in addressing both these disparities, by creating inclusive student communities and ensuring that tomorrow's doctors can care for our increasingly diverse populations.

Objectives: This collaborative, qualitative study led by three United Kingdom (UK) institutions aimed to explore the perspectives of Heads of Primary Care Teaching (HOTs) on cultural diversity and inclusion across UK medical schools.

Methods: In December 2020, five focus groups were conducted remotely with 23 HOTs, or a nominated deputy. We explored participants' opinions regarding opportunities and barriers to cultural diversity and inclusion in medical education, ways to overcome these challenges and shared examples of best practice. Data were transcribed verbatim and thematically analysed by three researchers.

Results: Investigators identified six themes from the data: lack of faculty diversity, tokenistic faculty training, institutional mindset, diversifying the formal and hidden curricula, intersectionality and student voice.

Conclusion: Medical schools worldwide face similar challenges, uncertainties and opportunities when integrating diversity and inclusion throughout the learning environment. Although the importance of the topic is increasingly acknowledged, current efforts are viewed as being passive and tokenistic, hindered by challenges at multiple levels. Partnership with students and collaboration within and between institutions nationally and internationally will enable us to move forwards with both local and global positive, sustainable change.

1 | BACKGROUND

Racially minoritised groups continue to experience differential outcomes in both health and education. In health care, this patient cohort experiences poorer outcomes and more barriers to accessing health care services.[1,2] In education, an attainment gap exists for racially minoritised medical students, which persists into their postgraduate careers.[3] Medical schools have an instrumental role in addressing both these disparities, by creating inclusive student environments and ensuring that future graduates can care for our increasingly diverse populations.[4] Primary care is well-positioned to support medical schools in this mission, having

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a unique understanding of the priorities and needs of local diverse communities.

Each UK medical school has an educational lead (Head of Primary Care Teaching [HOT]) who is responsible for overseeing delivery of the undergraduate primary care curriculum, on campus and in community settings. Despite the wealth of international literature[3–7] exploring how cultural diversity and inclusion can be integrated throughout medical school learning environments, barriers continue to be encountered at multiple levels.[5–7] Medical schools face challenges when diversifying the curriculum[7,8]; in parallel the 'hidden curriculum' risks portraying conflicting messages,[8] meaning that what students are taught may differ from what they see.[6]

Research shows there may be a discrepancy between literature recommendations and what is occurring in practice.[9,10] However, there are limited studies exploring educational leaders' perspectives, aiming to understand how they interpret and translate recommendations into practice. Cultural diversity training in medical education is viewed as fragmented, owing to the lack of a coherent educational framework, and communication between institutions has been called for as a way to combat this.[6] We are not aware of a study to date that brings together educational leads from UK medical schools to discuss opportunities and barriers to incorporating cultural diversity and inclusion training for trainees and faculty in their own context. Facilitating communication across institutions could uncover ways to overcome these challenges together.

Although we appreciate the importance of taking an intersectional approach,[11] this study specifically considers diversity through the lens of race and ethnicity. Selvarajah et al[12] highlighted the problematic nature of terms such as 'BAME' (Black, Asian and minority ethnic) and 'ethnic minority', which homogenise and flatten differences between non-White identities. We therefore use the term 'racially minoritised' to reflect the active social processes that sustain these power differentials.[12] This study aims to answer the question 'How do HOTs view cultural diversity and inclusion in UK medical schools?'. Although this piece of work sits uniquely in a UK health care context, the study question aims to explore a global issue and the findings could be equally transferable to other settings outside of the United Kingdom.

2 | METHODS

Investigators from three UK institutions (Imperial College London, The University of Dundee and The University of Glasgow) conducted this collaborative, qualitative study.[13]

A member of the research team invited HOTs from 37 UK medical schools to participate via email. Those who were unavailable could nominate a deputy to attend on their behalf. Of those approached, 23 provided written consent to participate. Moderators of the focus groups were also HOTs, or someone of similar seniority with an interest in cultural diversity and experience at moderating focus groups. The latter facilitator position was acknowledged at the commencement of the focus group to redress any perceived empower imbalances within the group.

Ethical approval was granted by the Imperial College London Medical Education Ethics Committee.

On 10 December 2020, five focus groups were conducted remotely, lasting approximately 30 minutes each. We ensured small focus groups (three to five participants per group) to encourage interaction and promote open and safe discussion. We developed the interview guide based on key themes from the current literature base (Table S1, Focus Group Interview Guide). Audio recordings of focus groups were transcribed verbatim. A member of the research team then checked the transcripts for accuracy and anonymised them.

Three research members (two medical students and one early career medical educator) thematically analysed, organised and collated data on Dedoose qualitative software (version 8.3.45). We engaged in a reflexive approach throughout the study, examining how our own beliefs, backgrounds and positions might have incidentally impacted on the research outcome. The involvement of individuals at different institutions and stages in medical training allowed for greater reflexivity, by providing perspectives from a variety of backgrounds.[14] Using the phases of analysis proposed by Braun and Clarke,[15] we identified initial codes prior to searching for, reviewing, and defining themes. We discussed discrepancies over emerging codes and themes at a series of meetings until consensus was reached. The final phase of analysis, write up of the report, was carried out with input from all researchers.

3 | FINDINGS

Six themes were identified from the data. Themes and illustrative quotes are summarised in Table 1. Findings and recommendations are summarised in Table 2.

I hope it carries on. I hope it's not just been triggered by Black Lives Matter, and it fizzles out over the next year.

It's diversity in the wider sense, is not it? It's not just about diversity within ethnic groups, it's diversity of humanity.

TABLE 1 Themes and illustrative quotes

Theme	Illustrative quote from participant
Lack of faculty diversity	'Gender is very important, because how long did it take? Women have been 50% of medical school intake at least since the 80s, I would say, in most schools. But actually to see women as 50% of senior faculty and deans of medical schools has not happened yet. So, there's a very long lag time'. FG4 P14
	'We want to start asking some of our GP teachers from BAME groups just to say are there some hidden blocks to you wanting to become GP lecturers at the university. It may just be that they do not want to become GP lecturers at the university which is fine. But again asking that question, but if anybody's got any better ideas as of how we approach that I'd love to hear'. FG3 P9
Tokenistic faculty training	'We've had three workshops, all very different. It's surprising what comes out of them. We've got to the point where people have shared their experiences and thought about them. And yesterday we decided the next step was to actually practice, do some role-plays in small groups and practice how we might be an active bystander. So it was really about people sharing experiences rather than lectures'. FG1 P2
	'Making sure that we provide equality and diversity training, particularly starting with interviewers and OSCE assessors. But everybody needs it'. FG1 P3
	'So I think we are very conscious that it's something that tutors will probably need, well, I do not think the word Training is right, but education and experience of discussing as well'. FG5 P20
	'There's the potential they could feel quite exposed or concerned that students might see them as lacking awareness or knowledge or experience in a particular area that they feel very is important, but they might be concerned they'll be seen as lacking'. FG5 P20
Institutional mindset	'I hope, I hope, I hope it carries on. I hope it's not just been triggered by Black Lives Matter, and it fizzles out over the next year'. FG1 P1
	'[We must ensure] the leadership is really comfortable with it being on the top of the agenda'. FG4 P14
	'But there were … a body of people going, we can see we got it wrong. That'll damage the reputation of our institution' FG2 P5
	'It's just getting that absolutely high-level buy-in and then having that top-down driver to say, no, you do need to prioritise these things … some of the things that certainly we have been talking about for years … suddenly are hot topics. And senior people are now going, but what are we doing about this? It's like, finally'. FG2 P5
Diversifying the formal and hidden curriculum	'We have got modules that do tend to focus very much on these issues of marginalisation and barriers to care and so on'. FG4 P16
	'We have a transgender person coming and doing transgender workshops and disability and blind and deaf … And I think it's very powerful the students hearing their voices really rather than us medics delivering something when actually we do not have that personal experience'. FG3 P10
	'If you call somebody Mrs Begum … you are signifying something … Mrs Begum's likely to be in East London, Bangladeshi, possibly poor, possibly overweight, possibly diabetic. So, the embedded assumptions within what looks like, it's becoming more inclusive actually reinforces stereotypes'. FG4 P14
	'Our students will end up working anywhere. Some of them will be overseas students anyway. But some of them will be applying for Foundation Programmes anywhere in the UK'. FG4 P14
	'The first thing we did, and I'm sure most med schools did, was just had a quick flick through all the cases that we give for every course and just make sure it's representative'. FG3 P9
Intersectionality	'There's a lot of focus, at the moment, on BAME and the injustices around that. And I feel sometimes that issues around … LGBTQ and just plain old sexism, which has never really gone away, are sometimes marginalised by the degree of, for want of a better word, trendiness that there are around black and minority ethnic issues'. FG4 P16
	'It is about inclusion and exclusion. And the basis on which people are included or excluded is secondary to that rather than the most important thing'. FG4 P16
	'We'll be concentrating on looking at diversity in one particular area … at the moment we are looking at the BMA Racism Charter. And in the past … the LGBT Charter, there's been a focus on that'. FG5 P20
	'It's diversity in the wider sense, is not it? It's not just about diversity within ethnic groups, it's diversity of humanity'. FG5 P18
Student voice	'So when students bring their stories that we encourage them to think that they are not criticising the medical school or those seniors at the medical school and we make that safe space for them'. FG3 P10
	'Even though we tell them at the beginning of every year how to lodge a concern, they keep saying that they do not know how to lodge a concern. So we clearly have not made it easy enough'. FG1 P3
	'Unless you tell them you have heard them, they do not necessarily know they are heard'. FG3 P9

(Continues)

TABLE 1 (Continued)

Theme	Illustrative quote from participant
	'Students have told us that they want is to know what happens afterwards with it, and so outcomes'. FG3 P10
	'Students are experiencing them all the time and clearly not flagging them up a lot of the time, because whether they are confident or whether they think nothing's going to change'. FG5 P22
	'Making a list of champions of senior staff champions, representatives of the different personal characteristics, that students can go to talk with'. FG1 P2
	'We have got student champions and things that can talk to us and feed it back and are not scared to talk to us because they are speaking on behalf of other students who maybe feel more scared'. FG2 P4
	'Having a way for students to anonymously report incidents, whether they are microaggressions or more serious incidents'. FG5 P20

TABLE 2 Summary of findings and recommendations

Findings	Recommendation
• There is a lack of faculty diversity, particularly in senior positions. • Faculty are concerned about the negative impact this may have upon students. • The current approach to increasing faculty diversity is considered slow and passive. • Community GP tutors are felt to be more diverse and more representative of the student body.	1. Increase faculty diversity through active recruitment and promotion of diverse tutors. 2. Communicate with other institutions to share experiences and examples of best practice.
• Current diversity training is viewed as tokenistic. • Faculty want diversity training that is authentic and meaningful. • The mindset of more senior university leadership is vital to drive change; however, some do not recognise issues around cultural diversity and inclusion.	3. Implement cultural diversity training for all staff, creating opportunities for discussion, role-play and listening to real-life stories.
• Faculty design and therefore control the curriculum. • There is an ongoing struggle to create case examples that are representative, without reinforcing negative stereotypes.	4. Raise awareness of implicit biases and negative stereotyping through faculty training, to avoid their biases being reflected across the curriculum. 5. Encourage discussions around social and structural factors that determine health outcomes, encouraging students to reflect on their own implicit biases.
• Local patient populations some medical students are exposed to are less diverse in terms of race and ethnicity. • Viewing diversity through an intersectional lens may better prepare students to work in communities beyond those where they have trained. • Most institutions do not appear to have adopted an intersectional framework.	6. Support faculty to develop and integrate an intersectional approach to cultural diversity teaching.
• Racism and other forms of discrimination continue to go underreported. • Faculty recognise barriers to student reporting, such as unclear reporting mechanisms, concerns about future careers and feeling doubtful change will occur.	7. Empower students to report discrimination, through anonymous reporting, student champions and active bystander training. 8. Feedback the outcome of reports and implemented changes to students. 9. Work collaboratively with students using their ideas as a catalyst for change.
• UK medical schools share the same overarching mission; to ensure medical graduates can care for our increasingly diverse societies. • UK medical schools face similar challenges, uncertainties, and opportunities integrating cultural diversity and inclusion. • Communication between institutions could trigger change in other institutions. • There is a willingness and eagerness to share experiences and learn from others.	10. Communicate and collaborate with other institutions, nationally and globally.

We have got student champions that can talk to us and feedback and are not scared to talk to us because they are speaking on behalf of other students.

3.1 | Lack of faculty diversity

Participants commented on the lack of faculty diversity, particularly in senior positions, and the negative impact this may have on students, primarily in terms of role modelling. Hidden barriers and biases impeding promotion were thought to be a contributing factor. Participants noted that general practitioner (GP) clinical tutors in the community are often more diverse than medical school faculty and therefore often more representative of the student body.

> We have a lot of colleagues … from black, ethnic, diverse backgrounds. But to see them in very, very senior, prominent positions, and consultant roles, has not rolled through … that has an impact on the students' learning environment … identity formation … the opportunities they get in clinical settings. FG4P14

One participant described the current approach to increasing faculty diversity as 'passive'. This sentiment was echoed across focus groups. There was concern over the length of time it will take for faculty to become representative, with some likening it to the increase in gender diversity. Participants emphasised the need for an active approach, through promotion, and active recruitment of more diverse faculty members.

However, there was a sense of uncertainty on how to tackle this, and so coordination and sharing of good practice across institutions was sought.

> I do not know if others have done this but I'd love to copy someone else … we do not really know what we are doing. FG3P9

3.2 | Tokenistic faculty training

Diversity training for faculty staff, including community GP tutors, is seen as crucial, as they may feel underequipped to discuss issues around cultural diversity. Participants viewed current training as 'tokenistic' and accused it of oversimplifying a complex issue.

> It is quite tokenistic. It's like, this is how you should behave around certain people … It would be nice if … it was a bit [broader]. FG5P18

Participants emphasised a preference for training which provides opportunity for role-play, discussion, reflection and hearing real-life stories. Some reflected on the potential for students and faculty to learn together; however, they ultimately felt this might leave faculty feeling exposed, preventing open discussion.

3.3 | Institutional mindset

Participants highlighted the importance of institutions acknowledging issues around cultural diversity and responding in a visible way to student concerns and communicating updates on implemented changes. All focus groups considered the 'mindset' of more senior university leadership as vital to drive change. Some felt the problem is still not recognised, whereas others fear raising the profile of such issues could damage institutional reputations.

> There's a culture shift required. And I think there's still a body of people certainly within big institutions that feel that this is not necessary, and perhaps still do not recognise the problem. FG2P5

The institutional response to the Black Lives Matter movement was discussed, with some speaking positively of this as a trigger for action, whereas others were concerned that the reactive response was unsustainable.

Conversations within focus groups led some to reflect on how sharing experiences and again looking to other institutions could be a way of instigating change at their own medical school.

3.4 | Diversifying the formal and hidden curriculum

Participants acknowledged that the formal curriculum is controlled by those who design it.

> It's us in the sense that we do control the curriculum. FG3P9

However, no consensus appeared on how best to integrate diversity and inclusion throughout the formal curriculum, with institutions adopting varying approaches.

Participants reflected on the local patient populations medical students work alongside. Some considered these to be often less

diverse in terms of race and ethnicity, which they reported as problematic, thus limiting student exposure and opportunities to practice cross-cultural care.

> It is possible for students to be in a practice where there is zero ethnic diversity. FG4P16

Another aspect of the hidden curriculum was the experience of microaggressions on clinical placements, potentially undermining formal cultural diversity training.

Problem-based learning cases were widely discussed, with participants highlighting the challenge of examples being representative of a population without using signifiers that reinforce stereotypes.

3.5 | Intersectionality

Participants highlighted the need for the curriculum to view diversity through an intersectional lens, encouraging an appreciation for the combined effect of factors that proliferate marginalisation.

> I think often we'll focus on particular things, but I would agree that diversity has to be seen in a much wider sense. FG5P20

There was a sense that this approach could help students develop skills required to work with diverse patient populations; however, most institutions do not appear to have implemented an intersectional framework, with the focus often remaining on individual aspects of diversity.

3.6 | Student voice

The need for a safe space for students to report incidents of racism and share experiences of discrimination was echoed across focus groups.

> To find a safe space or to find a safe person to report to without the fear of being judged, the fear of getting a supervisor or a clinician or whoever it might be into trouble. FG3P10

Participants commented that racism and other forms of discrimination, such as sexism, continue to go underreported. Recognised barriers to students' reporting include unclear reporting mechanisms, concerns about the negative impact on future careers, and feeling doubtful an allegation will result in change. Students must be assured that when sharing experiences, they will be listened to, and action will be taken.

> And the feeling has gone round that they aren't listened to, that they aren't taken seriously, even though we in the faculty think we are. FG1P2

Student champions, active bystander training and anonymous reporting were suggested as ways of ensuring the student voice is heard.

4 | DISCUSSION

Our findings show that despite continued efforts, UK medical schools face challenges to integrating diversity and inclusion throughout the learning environment, from faculty representation to cultural diversity training and diversification of the curriculum. The lack of faculty diversity leaves medical students from racially minoritised backgrounds with limited role models, with particular concern surrounding the length of time it will take for faculty to become representative. Additionally, the medical curriculum continues to be one that is viewed as being bereft of diversity and fails to view multiplicity through an intersectional lens. Faculty training is essential to address this, but we must also shift the mindset of educational leaders and institutions by listening to students, ensuring that future change is positive and sustainable. Although each medical school sits in its own unique context, our study highlights that the overarching goals of medical schools are the same, and with these shared goals comes common challenges,[16] requiring international communication and collaboration.

We know that medical students from racially minoritised backgrounds experience less positive learning environments due to a lack of role models,[17–19] and increased incidents of discrimination,[20] which can negatively impact their sense of belonging[21] and contribute to the attainment gap.[22] Our findings bring to light the ongoing difficulties faced by faculty and students when trying to address these issues. Faculty are concerned over the length of time it will take to increase representation and role-models and often struggle to know how to address this.

Students under-report incidents of discrimination, corroborated by a recent British Medical Journal investigation,[3] often due to fear that their concerns will not be dealt with constructively.[23] Medical schools must take urgent action to improve the learning environment for racially minoritised medical students, through institutional policies which facilitate the recruitment and promotion of racially minoritised colleagues.[24] Institutions should work collaboratively with students alongside guidance from the British Medical Association Race Charter to ensure that appropriate mechanisms are in place for reporting and responding to racial harassment at individual and institutional levels.[21,25] By developing active bystanders and student champions, as well as ensuring that action unleashes visible outcomes, we can also draw attention to our collective responsibility to denounce any form of discrimination. The impact of racism on medical students is not an isolated problem. Other counties, such as

the United States, recognise the detrimental impact this can have and the importance of understanding the medical school learning environment to identify exacerbating factors, allowing us to instigate meaningful change.[26,27]

We must also consider the way in which our faculty teach cultural diversity and the impact this might have upon our students. Research highlights that faculty, in the United Kingdom and beyond, may avoid discussing cultural diversity issues due to uncertainty about how to approach the topic.[16,18,27] On clinical placements, the way in which doctors communicate with and about individuals from racially minoritised backgrounds might inadvertently contribute to the 'hidden curriculum'.[28,29] It should also be considered that faculty might influence students' learning environment in other ways, for example, through their control of the formal curriculum and portrayal of patients in clinical cases, a view mirrored by Dogra and Bansal.[30] Acosta and Ackerman-Barger[27] argue that to develop a diverse and inclusive curriculum, faculty must first engage in effective training. To be successful, this training must move from being tokenistic to become authentic and meaningful,[24] encouraging critical reflection and allowing new perspectives to be heard.[27] This could be achieved through listening to real-life experiences from racially minoritised individuals and creating opportunities for role-play and discussion.

The need for medical schools to adopt an intersectional framework was evident from our data and supports research from Sears,[11] who discusses how an intersectionality-based curriculum can facilitate patient-centred care, encouraging medical students to identify areas of commonality with patients and reducing implicit biases. However, it appeared that most institutions have not yet adopted an intersectional framework. Muntinga et al[7] support this, discussing how the curriculum often lacks opportunity for students to explore the interaction between biosocial and sociocultural factors that determine health outcomes. Adopting an intersectional approach could deepen students' understanding of the complexity of human differences[7,11] ensuring tomorrow's doctors can adapt to work in global communities beyond those where they have trained. We recommend urgent further research in this area, aiming to understand how to support faculty to develop and integrate an intersectionality-based medical school curriculum.

4.1 | Limitations

The absence of student participants was a limitation. We suggest this should be an area for future research.

We did not gather information on participant demographics; therefore, cannot comment on how their sociocultural identities may have influenced perspectives.

Time constraints prevented focus groups covering all intended areas. However, each group began with a different theme, ensuring all areas were discussed (Box 1).

BOX 1 Three key recommendations for integrating cultural diversity and inclusion

1. Institutes should think beyond tokenistic faculty training, ensuring training offers opportunities for meaningful reflection and change.
2. Institutes need to consider purposeful efforts towards recruitment and promotion of diverse faculty.
3. Faculties should engage in coproduction with students, integrating key principles of diversity and inclusion in curriculum and assessment.

5 | CONCLUSION

Although medical schools around the world increasingly acknowledge the importance of cultural diversity and inclusion, progress remains slow and inadequate. Structural reform and changes at multiple levels, from the curriculum to institutional policies, are required to create truly inclusive learning environments. Our study highlights that the overarching mission of medical schools is the same, and with this shared mission comes similar challenges, uncertainties and opportunities. Ongoing communication and collaboration between global institutions will be key to us moving forwards to ensure positive, sustainable change for our future doctors and their patients.

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CONFLICT OF INTEREST

The authors have no conflict of interest to disclose.

ETHICS STATEMENT

Ethical approval was granted by the Imperial College London Medical Education Ethics Committee.

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SUPPORTING INFORMATION

Additional supporting information may be found in the online version of the article at the publisher's website.

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