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George , Riya Elizabeth ; Sidhu, Manni

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THE CLINICAL TEACHER

Promoting inclusivity in health professions education

Riya E. George[1] | **Manbinder S. Sidhu**[2]

[1]Clinical Communication Skills & Diversity Education, Institute of Health Sciences Education, Queen Mary University of London, London, UK

[2]Health Services Management Centre, University of Birmingham, Birmingham, UK

Correspondence
Riya Elizabeth George, Reader/Associate Professor, Clinical Communication Skills & Diversity Education. Institute of Health Sciences Education, Queen Mary University of London. Robin Brook Centre, St Bartholomew's Hospital, London EC1A 7BE, UK.
Email: r.george@qmul.ac.uk

1 | INTRODUCTION

Clinical educators are increasingly in contact with students from a diverse range of backgrounds, who are likely to differ in their educational abilities, learning preferences, and expectations about teaching.[1,2] The changing landscape in health professions education, marked by its growing diversity, has led to growing concerns about inclusivity. Whilst conceptualisations of inclusivity vary and continue to evolve, at its very core, inclusivity involves considering good practices to widen student participation and ensure learning is relevant, meaningful, and accessible for all.[3]

1.1 | What is inclusive learning and teaching?

Hockings[4] defines inclusive learning and teaching in higher education as 'the way in which pedagogy, curricula and assessment are designed and delivered to engage students in learning that is accessible to all'. We have utilised Hart et al.'s[5] framework of 'inclusive practice' as a pedagogical lens to consider how to promote inclusivity in health professions education; see Figure 1.

> *The way in which pedagogy, curricula and assessment are designed and delivered to engage students in learning that is accessible to all.*

At the centre of Hart et al.'s framework is 'transformability', which involves identifying and considering ways to expand the potential for individuals' capacity to learn. This is achieved through the practice of three pedagogic principles: (1) *co-agency*, which asserts that the responsibility of learning is shared between the teacher and the student; (2) *trust*, referring to educators' belief that meaning and relevance can be found through experience; and third, *everybody*, acknowledging the need to enhance the learning of all. Building on Hart et al.'s[5] interpretation of transformability, Florian and Linkalter[6] encourage educators to consider three purposes (outlined below) to transform student learning capacity and educational environments to promote inclusivity. We have used these purposes as a conceptual framework to develop a toolbox for clinical educators to consider how to promote inclusivity in their curriculum. This toolbox contains a series of experience and evidence-based recommendations to help clinical educators think through key issues when planning for, embedding and evaluating inclusivity. It also draws upon our experiences as authors in implementing some of these recommendations as well personal examples, the challenges we have experienced and some key learning lessons to help others consider how to promote inclusivity.

1. **Affective purposes:** These are designed to strengthen an individual's confidence, security, competence and control.
2. **Social purposes:** These are intended to increase an individual's sense of acceptance, belonging and community.
3. **Intellectual purposes:** These are proposed to ensure access, enhance relevance, meaning and reasoning for all learners.

2 | AFFECTIVE PURPOSES

2.1 | Explore what inclusivity means to an educator

Clinical educators must first define what inclusivity means in their own teaching context. Various definitions of inclusivity exist with

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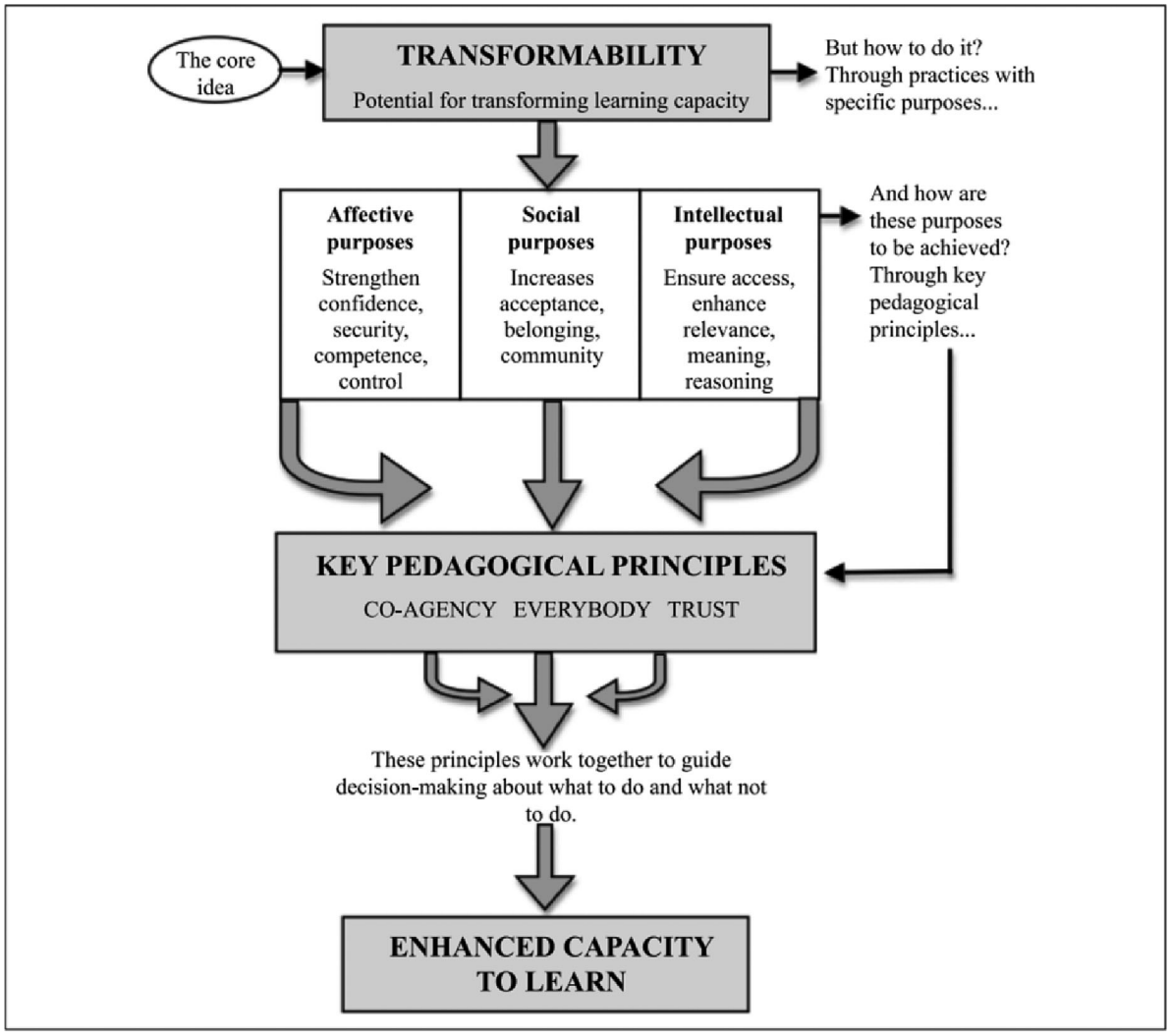

FIGURE 1 The core idea of transformability and the key pedagogical principles.

differing intentions; varying from the importance of overcoming barriers to learning, widening participation or considering ways to enhance the learning capacity of all students.[7] Within health education literature, there are various terms and concepts that align but also compete with interpretations of inclusivity such as 'diversity', 'fairness', and 'equity', to name a few. While diversity acknowledges individual differences, inclusivity moves beyond this to consider how educators *engage* with these differences. Inclusivity requires consideration of the plurality of ways diversity can impact a student's learning experience and how to meet the needs for wide ranging cohorts. The outcome of applying the principles of both diversity and inclusivity is to establish equity, meaning fairness (equal and full participation).[8] Issues of diversity and inclusivity must be recognised as two sides of the same coin: Intertwined and inseparable (see Figure 2). These terms although distinct are intrinsically linked and essential in operationalising each concept.

Diversity and inclusivity must be recognised as two sides of the same coin: Intertwined and inseparable.

A pre-requisite to fostering inclusivity requires educators to first acknowledge the plurality of their own identity, interpretations of diversity, and how differences between them and students can impact learning. A few suggested reflective questions and criteria to explore inclusivity are presented in Figures 3 and 4. Advance Higher Education programme standard, which is adapted from a self-evaluation framework on how to embed inclusivity, provides a more exhaustive list of criteria to consider.

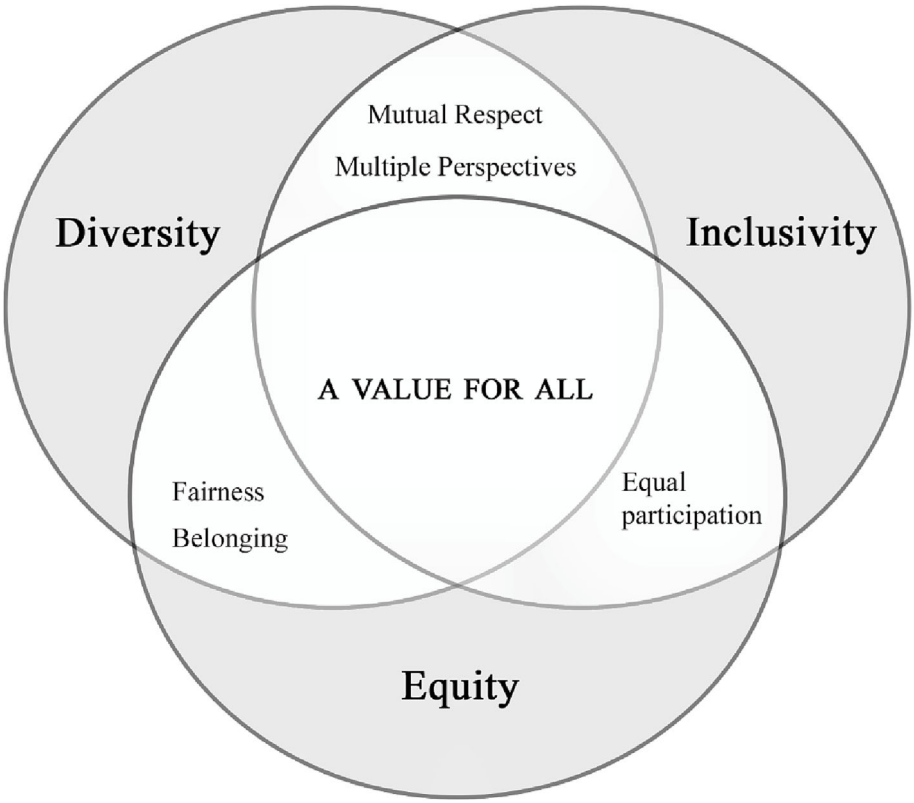

FIGURE 2 The relationships between the terms diversity, inclusivity and equity.

- How do I define inclusivity and diversity?
- What culturally diverse groups or communities do I belong to? How does my teaching and/or leadership practices reflect this?
- What theories, philosophies and understandings shape and assist my educational practice? Who is advantaged when I work in this way? Who is disadvantaged?
- How do I respond to the diversity of student learning needs and preferences?
- How can I learn more about the diversity of my student community?

FIGURE 3 Reflective questions for clinical educators.

Curriculum development is not value-free or unbiased; it is dependent on the perspectives held by educators.[9] Supporting faculty in regularly undertaking reflective exercises and attending bespoke teaching-related diversity and inclusion training may help in highlighting any assumptions or unconscious biases they may have. Such reflection does not occur in a vacuum and should be stimulated by discussions as part of a team, department, and more widely within institutions. Bhagat and Neil[10] encourage educators to conceptualise the curriculum as an 'artefact' and to contemplate factors that make the curriculum contextually and socially situated (e.g., acknowledging the increasing use of technology in health care or the implications of new roles such as physician associates). According to Bhagat and Neil,[10] auditing the curriculum for inclusivity requires educators to critically consider the following questions both as individuals and in teams:

- Whose perspectives and values does the curriculum put forward?
- Is the curriculum relevant and meaningful to a broad range of learners?
- Who does the curriculum include and who does it exclude?

Creating a more inclusive curriculum goes beyond the addition of potentially tokenistic topics on diversity; rather, it requires revisiting content and structure in ways that recognise the contestability of knowledge, wider, global perspectives, and the accommodation of students' different lived experiences.[11–13] An inclusive curriculum can be

- The **demographic characteristics** of the faculty involved in the creation of course content and programme development and how this has shaped the educational materials that have been developed/or used.
- The nature and representation of diversity shown **in images and illustrations** included in education materials and content.
- The level of **meaningful involvement** of students and patient educators in the development or re-design of curriculum.
- The extent to which case studies, figures and reference/reading lists are **reflective and representative of the diversity present** in the student body and healthcare settings (nationally and internationally).
- The level of accessibility of and flexibility in programmes of students that allow students to **meaningfully participate** in a variety of formats.
- The extent to which tangible opportunities for students to **co-create** their curriculum have been offered.
- The degree to which course content covers **multiple perspectives**, theoretical standpoints and contributions from a diverse pool of people.
- The extent to which knowledge about the student cohort has been used to **adapt curriculum delivery** to meet individual requirements and the general learning needs of the student cohort.
- The provision of learning opportunities for students to relate educational course content to their **own lived experiences**, thereby encouraging the sharing of diverse perspectives and interpretations.
- The extent to which themes of **diversity and inclusivity** have been **embedded** into learning materials and exercises.
- The inclusion of a **range of feedback and assessment** approaches that are accessible, non-discriminatory, ongoing and timely.
- The presentation of learning materials in accordance with **accessibility guidelines** which consider aspects such as the type of font, the use of subtitles, visual aids etc. (e.g., see link for an example: https://www.asme.org.uk/wp-content/uploads/2022/12/Presentations-Guide-Jun22-v3.pdf)
- The utilisation of **physical** and **virtual** learning spaces to facilitate student access to and engagement with the curriculum.
- The provision **of additional/ alternative learning** resources and technologies where required to support access to and foster engagement with the curriculum.

FIGURE 4 Suggested criteria to explore inclusivity when reviewing the curriculum.

established by introducing contentious topics, obtaining pluralistic views via case-based learning, through role-play exercises and feeding in student views within curriculum planning meetings.

2.2 | Create a safe space for learning and value student individuality

Discussing differences can be both enriching and conflicting. Creating a safe and supportive learning environment is essential for capitalising on the diversity of students' experiences and perspectives and to establish a sense of security. Safe spaces can be used by clinical educators to deconstruct student expectations and admit to uncertainty. Studies show that cultural differences exist in how learners anticipate teacher–student interactions and their expectations of classroom behaviours.[14,15] A qualitative study in Germany exploring the expectations of international medical students found that they anticipated discrimination from local patients because of their migration background and were particularly concerned about failing exams when confronted with colloquial language or dialects used in their host country.[15]

Establishing 'shared expectations' and setting 'ground rules' facilitates a safe learning environment. Educators are encouraged to discuss their expectations and concerns about different teaching sessions with students; clearly setting out their expectations of the teaching (i.e., interactive, didactic, and team-based) and encouraging

students to do the same. Setting 'ground rules' is particularly important when discussing diversity issues as these conversations may be laden with sensitivity, uncertainty and political correctness. Discussion starters and ice-breaker activities may be helpful in encouraging initial conversations on diversity; the University of Lausanne, Switzerland provides some helpful example exercises.[16] In practice, the authors found educator's expectations are prioritised over students as they may find it difficult to articulate their expectations regarding learning. Embedding quarterly reviews and feedback loops with programme leads can help combat this.

3 | SOCIAL PURPOSES

3.1 | Encourage the visibility of role models from diverse backgrounds

Positive role models in can play a fundamental role in enhancing learning and shaping students' professional identity.[17,18] Cruess et al.[19] suggest that the influence of role models is not only dependent on observation but also the degree of concordance perceived by the student. Personal characteristics are most frequently mentioned by medical students in determining who they gravitate towards, for example, race, ethnicity, and gender.[20] Increasing students' contact with a diverse range of educators has been suggested to support students from marginalised groups to build relationships with relatable positive role models.[21,22]

Various suggestions to promoting inclusivity and diversity include appointing faculty who are more representative of the study body. Some studies show that ethnic concordance between a teacher and a student can enhance rapport, sense of belonging, and support the facilitation of shared experiences.[23] However, whilst increasing visibility and representation of diversity is important, supporting faculty in recognising their individual differences and how these influence their identity as an educator is equally significant. The introduction of a reverse mentoring scheme has been implemented in both of the author's educational contexts, whereby more junior clinical educators from diverse backgrounds mentor senior clinical educators, who may be less familiar with the challenges experienced by colleagues from under-represented backgrounds. The application of reverse mentoring has been piloted at the University of Birmingham where each teaching module is being co-led by a senior and junior clinical academic.

3.2 | Promote community and public engagement

Providing students with a richer exposure to the heterogeneity present in the patient population and among their local populations through different clinical placements or community visits has shown to assist their acknowledgement and understanding of diversity.[24] It also supports students in considering how to meet the needs of different patients, thereby fostering an inclusive and person-centred approach to health care. Better engagement with members of the community and the broader public can bring wider socio-cultural, contextual knowledge, providing students with an authentic sense of the holistic nature and impact of health care.[24,25]

Engagement with members of the community can bring wider socio-cultural, contextual knowledge, providing students with an authentic sense of the holistic nature and impact of health care.

Exposing students to a variety of patient experiences helps them to consider the ways different patients can experience the same illness or condition. If practical, case studies from diverse groups should be used to introduce more heterogeneity, for example, counselling a transgender patient about breast cancer. George and Lowe[26] (first author of this paper) found that adding a series of 'what if …' questions to case studies assists students in critically reflecting upon the uncertainties of clinical practice and how to tailor their approach to the different needs of patients[26]; see Figure 5 as an example.

3.3 | Nurture support and familiarity with institutional culture

Students with protected or vulnerable characteristics (such as those protected under the UK Equality Act 2010, for example, disability, race, and sexual orientation) are more likely to struggle with integration, experience differential attainment, and are less likely to access academic support.[27,28] Each health educational institution has a unique student body with individuals whose characteristics are known or strongly suspected to alter their student experience, that is, those with English as a second language, distance learners or those who work part-time. Early identification of these students is consistent with a proactive developmental approach. Embedding practices of peer mentoring, incorporating study skills training, and setting up student support networks have been shown to increase engagement from these students.[29,30] A developmental approach also asserts that student support is a responsibility for all and advocates that anyone in contact with students should signpost support services, for example, including information on their email signatures or at open days.

Another would be more contact between personal tutors and mentees where the nature of the role moves beyond responding to issues of academic performance to facilitating self-growth. Also,

A 75-year-old woman is in Accident & Emergency after a fall. She is refusing to have her stitches taken out by a black nurse. She says she doesn't want foreigners, who don't speak her language touching her, she wants a white nurse.

- How does this make you feel?
- What does the black nurse feel?
- What do you think should happen?
- What stereotypes might be involved in this situation?

What if questions…

1. There are no 'alternative' healthcare professionals available to attend to this patient, how would you deal with this situation?
2. The black nurse reacted negatively to the patient's remark resulting in a confrontational discussion about racism. How would you intervene and resolve this issue?
3. Another black patient on the ward over-heard this patient's comment and was distressed by this remark. How would you deal with this situation

FIGURE 5 An example of adding 'what if …' questions to case scenarios.

Rachel formerly known as Richard is a transgender staff nurse. She has made you aware as a colleague that she is being bullied by several colleagues and that she is being prevented from using the female toilets. Discuss the most appropriate action you would take

A Raise the issue in a team meeting in a way that everyone can safely and openly discuss the matter and resolve together. ☐

B Explore Rachel's concerns and ask other staff for their experiences and feedback on this matter but highlight to all colleagues that bullying is not acceptable under any circumstances ☐

C Discuss with the other staff their concerns and if legitimate ask Rachel to use the unisex disabled toilets ☐

D Reassure Rachel that you would discuss the issue with the staff team leader to ensure she does have access to the female toilets ☐

FIGURE 6 An example of a situational judgement test scenario.

creating frequent opportunities within existing teaching provision to reflect upon challenging situations that may arise in the institutional culture - i.e, those that create perplexity, hesitation and doubt; or otherwise described as 'disorientating dilemmas',[31] 'inner discomforts' or 'crossroad'[32] experiences, would be valuable. The authors feel such opportunities can be achieved through discussions in problem-based learning sessions/action learning sets, reflections in clinical placements (i.e., during Schwartz rounds), delivering support workshops during times of transition and change (i.e., prior to becoming a medical student or starting clinical placements), or through exercises such as situational judgement tests (see Figure 6 as an example of a challenging situation in health care).

4 | INTELLECTUAL PURPOSES

4.1 | Reconsider pedagogical methods

A key feature for reconsidering pedagogical methods to establish inclusivity involves discussing how faculty can increase and nuance the nature of communication they have with students.[6] For example, making resources readily accessible before lectures, encouraging interaction through online forums or automated voting systems, or providing variation in the nature of clinical placements (i.e., working with third sector organisations or policy driven providers undertaking research).

Traditional pedagogic methods, such as lectures, tend to monopolise teaching in health professions education; hence, introducing a more diversified model of learning has the potential to actively accommodate the range of learning preferences and educational abilities students possess, whilst making learning more personalised rather than generic.[33] As authors, we have implemented with success some of the recommended resources and good practice examples shown in Figure 7. A more practical way to reconsider pedagogical methods we have found useful is the use of a web-based learning management system (e.g., CANVAS) in archiving different types of reading materials and the use of online platforms (e.g., Panopto) to record lectures.

4.2 | Rethink assessment

Hounsell[34] states that an inclusive approach to assessment requires faculty to 'revisit existing assessment methods and ensure that the language and format used for the assessment is accessible and explicable to all students'. Such an approach goes beyond the addition of alternative assessment methods to recognising that learning outcomes can be assessed equally using different formats. As authors, we recommend either using a range of formative and summative assessment methods over a module for all students or using different modes of assessment for a single task. Encouraging students to undertake self-assessments through online e-learning resources or supplementary assignments may create greater engagement from a wide range of students. Further, providing feedback early on through different formats such as oral, one-to-one, or group feedback, annotated exemplars, formative OSCEs, or podcasts may help clarify expectations and explain assessment criteria for students who are struggling.

5 | CONCLUSION

Rather than appreciating diversity from a distance, the practice of inclusivity involves actively engaging with difference, considering how to ensure full and equal participation and support. Establishing inclusive practices in health education professions is multidimensional; it requires a shared commitment to recognising and incorporating a diversity of perspectives, values, and experiences in teaching and learning. Clear leadership is essential in supporting faculty to actively promote inclusivity. Leadership, accountability, and responsibility should be shared and spread across a range of areas in a health educational institution for meaningful change to be made. Designating one individual this responsibility should be premised with the disclaimer that this individual is not solely accountable for promoting inclusivity; hence, diversity and inclusion is a responsibility for all. Practicing the concepts of diversity and inclusivity will support an atmosphere within

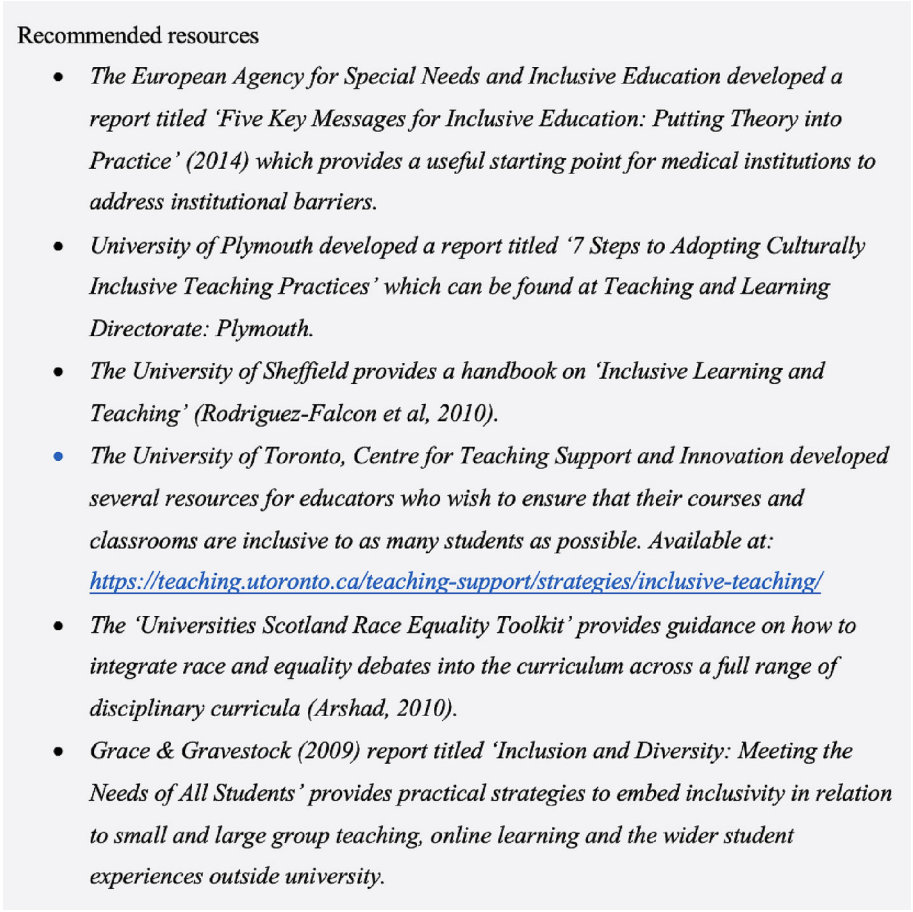

FIGURE 7 Recommended resources.

which all students can experience a supportive, tailored, and meaningful learning environment.

Rather than appreciating diversity from a distance, the practice of inclusivity involves actively engaging with difference.

AUTHOR CONTRIBUTIONS

Riya E. George: Conceptualization; resources; writing—review and editing; writing—original draft. **Manbinder S. Sidhu:** Writing—original draft; writing—review and editing; resources.

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The authors have no conflict of interest to disclose. The authors alone are responsible for the content and writing of the article.

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

ETHICAL APPROVAL

The authors have no ethical statement to declare.

ORCID

Riya E. George https://orcid.org/0000-0001-5385-8391

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