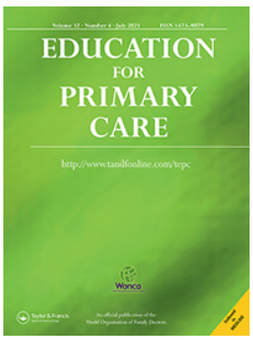

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LEADING ARTICLES

Promoting cultural diversity and inclusion in undergraduate primary care education

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ABSTRACT

In this article, we review key factors in promoting a culturally diverse and inclusive learning environment for all undergraduate medical students, and the role of primary care educators in preparing students to work with diverse teams, patients and communities. These factors include approaches to curriculum and assessment, student community, faculty development and recruitment, and wider institutional factors. By highlighting these, including areas where further research, evaluation and consensus are needed, we hope to support further discourse on how primary care educators can promote culturally diverse and inclusive undergraduate medical education.

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Introduction

Medical education has a responsibility to prepare future doctors to practise medicine in an increasingly complex and diverse world. Our medical students need skills in working in diverse teams and partnership-working with diverse patients and communities to understand and address our population's health needs. Primary care is uniquely placed to support this skills' development through being embedded within the local communities that our students will work with.

There is a need for a more diverse medical workforce, representative of the populations it serves [1]. It is essential to support medical student diversity through respectful learning environments, where all students have a sense of belonging and can be their authentic selves [2]. This is particularly important given that racially minoritised students are more likely to report higher frequency of bullying and harassment, more likely to be afraid to speak up than white counterparts [3] and more likely to experience differential attainment in medical school examinations [4–6].

There is evidence that bias and discrimination also impact health inequalities, outcomes and access for racially minoritised people [7,8]. The COVID-19 pandemic has amplified pre-existing health inequities, with a differential impact on racially minoritised communities [9].

In this article we explore the critical role of primary care educators in fostering a diverse and inclusive learning environment. We focus on undergraduate settings, but our exploration is also relevant to postgraduate contexts. We acknowledge the importance of taking an intersectional approach to diversity and recognise that identity is shaped by many factors [10]. However, to highlight specific issues, this article will focus on 'cultural diversity' as a term encompassing dimensions of ethnicity, nationality, language, religion and the social construct of 'race'. We use the term 'racially minoritised' to describe people or populations 'whose collective cultural, economic, political and social power has been eroded through the targeting of identity in active processes that sustain structures of hegemony' [11]. This term will be used throughout in preference to 'ethnic minority' or 'under-represented minority', as those who are racially minoritised may be the numerical majority but have experiences that are impacted by their race and ethnicity. We focus on key areas of curriculum and assessment, student community, faculty and institution, exploring the current evidence, strategies for change and future research directions.

Curriculum and assessment

Curriculum content

The need for medical students to be sensitive to cultural diversity has been emphasised by the General Medical Council (GMC) [12]. Healthcare professionals who work with diverse patients and recognise the impact of

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sociocultural factors on patients' health experiences may have improved patient–doctor interactions, impact positively on patient health outcomes and reduce health disparities [13–18]. There is an increasing literature on approaches to promote diversity within the medical curriculum [14,19–22]. However, there is no consensus on best practice [14,16] and barriers have been identified at student, educator [14] and institutional levels [13].

An undergraduate primary care curriculum requires a systematic and integrated approach to diversity. Research has highlighted a need to address the lack of diverse images and clinical cases [20,23] and increase contextual and cultural dimensions in curricular materials [24,25] to better reflect the diversity of patients and populations. This may reduce inadvertent stereotyping and stigmatisation. Primary care educators should ensure that case studies used are inclusive and reflective of the communities in which they are based [20] and include diverse skin images. Intersectional approaches should be adopted, exploring the complex interaction of an individual's identity, culture and health. The curriculum should include space for students to reflect on their own attitudes and biases and explore how the dimensions of cultural diversity may determine societal access to opportunities, health experiences and health outcomes through mechanisms of power, privilege and discrimination [16].

Primary care educators should work in socially accountable partnerships with wider stakeholders [1,26,27] including local community representatives to ensure that curricula reflect priority health needs, strengths and diversity of local populations. Service-learning approaches can further support students in engaging with cultural diversity [27]. Students learn through contributing to locally defined health and social issues, developing culturally sensitive communication skills in authentic contexts and increasing awareness of lived experiences of diverse communities [14]. Students could be equipped with coaching skills to hold more collaborative conversations with patients and communities [28]. Students on primary care placements could undertake quality improvement projects involving working with local community groups and GP practices [29]. Students participating in such projects should be supported to develop critical thinking and collaborative skills and advance their understanding of social responsibility.

Within primary care placements, students should be given opportunities to build meaningful relationships with diverse patients. One approach could be to assign students their own diverse, longitudinal patient caseload, enabling continuity and greater appreciation of the complex interaction of culture and healthcare in an authentic setting [30].

The cultural diversity of students themselves is a strength that brings diversity of perspectives and experience relevant to working with patients, communities and healthcare teams. Primary care should adopt inclusive, evidence-based learning strategies that take account of the needs, preferences, circumstances and strengths of diverse students [31]. Examples may include small group reflective discussions and project work that value and are enriched by diverse student perspectives, thereby benefitting all students.

Assessment

There is no consensus on how best to assess students' skills in working with culturally diverse patients [32]. A range of strategies can support the incorporation of cultural diversity as part of the assessment and promote a shift from simple factual recall to conceptual understanding and ability to relate theory to clinical practice [16,20]. Primary care assessments could include culturally diverse case scenarios and clinical presentations at OSCE stations that include assessment of a culturally sensitive person-centred approach. Workplace assessments in primary care can also enable authentic assessment of cultural diversity skills; these could include observed clinical encounters with critical reflection, and multi-source feedback including from patients. Real-world project work involving diverse patients and communities, together with reflection on learning, could be included within students' assessment portfolios.

There is strong evidence that racially minoritised medical students are awarded lower grades compared to their white counterparts. This differential attainment is observed throughout higher education systems globally [4–6] and contributing factors may include implicit bias, educational cultures and nature of assessments [4,20,33,34]. Approaches to addressing this could include diversification of examiners and implicit bias training for examiners [20].

Student experience

Over the past few decades, widening participation initiatives has increased recruitment of students from racially minoritised and low socio-economic backgrounds into the medical profession [35]. However, in the UK, there is still an under-representation of students from lower socio-economic backgrounds [36] and high rates of discontinuation persist among Black students [37]. The Wass report highlights the role of primary care in

supporting those from widening participation backgrounds to gain exposure to primary care settings pre-medical school [38] although we acknowledge that widening participation efforts should be focused across all specialities [39] .

Having a sense of belonging and safety is foundational in students' ability to learn and progress through medical school. However, racially minoritised medical students have reported less positive learning environments and increased likelihood of experiencing racial harassment and seeing their cultural identity as being a negative factor [40]. Institutions must have robust policies to enhance student belonging and address issues of discrimination. The British Medical Association (BMA) race charter provides a framework for medical schools to prevent and address racial harassment [3]. This includes recommendations on processes for reporting and handling complaints, addressing racial harassment in placements and mechanisms for embedding equality, diversity and inclusion in medical school values.

Primary care educators should create safe spaces for open dialogues on topics, such as racism and prejudice [41] and develop inclusive policies, for example, addressing dress codes, ensuring safe places for religious/cultural practices [20] and timetabling of teaching and assessments to take into account key religious events.

Faculty development and representation

Faculty development

Faculty expertise plays a vital role in training medical students to work inclusively with diverse patients, communities and each other. The way faculty members communicate with and about individuals (patients, students and colleagues) from culturally diverse backgrounds can influence student perceptions [42], and good role-modelling promotes cultural awareness among learners [43,44]. However, faculty can often be ill-equipped and unsupported when navigating this complex area [14,45] and may have differing perceptions of their own role in these conversations and in bringing about change [24,46]. This may inadvertently contribute to a 'hidden curriculum' which risks portraying diversity messages that conflict with the formal curriculum [16,47].

Many primary care educators may receive some form of unconscious bias, 'cultural competence' or active bystander training. However, there is a lack of evidence on the success of these approaches [24,48], with a risk of tokenistic participation instead of meaningful faculty engagement supporting deeper reflection on key areas relating to cultural diversity such as 'race', power, privilege, identity and social justice [48].

Primary care educators should be trained in skills to facilitate anti-racist environments, enabling better support for colleagues and students in educational and clinical contexts [20]. This could include opportunities for engaging in dialogue and critical reflection [43,48], where educators can reflect on their own perspectives on cultural diversity and explore proactive approaches to address racism and other forms of discrimination [48]. Training could be co-created and co-led with racially minoritised students who could also act as 'reverse mentors' for faculty in longitudinal training programmes.

Faculty representation

There is a lack of role models for medical students from culturally diverse backgrounds [49–51]. Addressing this should be a priority for primary care, as role models have been shown to impact on later career and speciality choice, acquisition of clinical knowledge and skills and understanding the broader nature and practice of medicine [52,53]. Racially minoritised faculty experience greater difficulty in achieving promotion to senior positions [54–56]. Institutions need transparent approaches to recruitment and promotion and should be willing to share data from monitoring of these processes and consider how to empower future diverse faculty and leaders. Changes could include: recruitment policies which ensure diverse panels, faculty declining to participate in 'non-diverse panels', being an 'active-bystander' when prejudicial comments are made [57,58] and mentoring racially minoritised faculty in promotional processes [59,60].

The locations of primary care placements should reflect local diversity. Geographic areas can be mapped to take into account key indicators including ethnicity and deprivation levels. Placing students in diverse areas will enable students to learn about health inequities and develop greater awareness of cultural diversity through working with diverse patients. It also ensures primary care funding flows equitably across a medical school's geographic primary care patch.

Institutional factors

Senior institutional support is vital to progress diversity within the primary care curriculum and beyond. Primary care educators can use their position and knowledge of local community to influence systematic institutional change. Key drivers for change include socio-demographic changes, social values and

legislative and accreditation frameworks [11,16], including those outlined by the World Health Organisation [26], GMC [12] and the Liaison Committee on Medical Education [61]. Having diversity and inclusion as a central theme within an institutional strategy, vision and mission statement enables institutional ownership and embedding within medical school educational and research activities [16]. Institutions must provide sufficient resource to integrate cultural diversity and inclusion across academic programmes and incorporate robust evaluation approaches to ensure accountability.

Future research directions

Although there is an increasing literature on strategies to promote diversity and inclusion within medical education, there is little consensus or clear recommendations on key areas, particularly in curriculum development and delivery [14] and faculty development approaches [24,48] and limited research on strategies within primary care education.

Primary care educators should seek to develop research in this area as well as explore the broader impact of primary care-led educational initiatives relating to cultural diversity [16]. Bzowyckyj et al. [62] offer a useful framework for evaluating the impact of educational interventions on patients and communities.

Conclusion

This article describes approaches that primary care educators can adopt to promote cultural diversity and inclusion within their own contexts. Multiple factors need consideration including curriculum design and development, student experience, faculty development and institutional support.

Tomorrow's doctors will be working in an increasingly diverse society with widening inequality. It is essential that primary care and medical schools urgently prioritise this collective effort, for the benefit of our students and the diverse patients and communities they will serve.

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