Active inclusion

Challenging exclusions in medical education

December 2021

msc Medical Schools Council

Equality, Diversity & Inclusion Alliance

Contents

Foreword

The pandemic has brought systematic and social issues to the fore. It's caused us to question, both as people and as leaders, what more can be done to support and champion greater inclusion and diversity for all.

Inclusive and diverse learning environments result in a better education for medical students and doctors. They can also lead to patients receiving improved and more compassionate care.

This guidance is a step towards making medical education more inclusive for all. We thank the Medical Schools Council and all the medical schools who have collaborated on this document, for their excellent work.

As changes are made, it's important to acknowledge that more must be done to address the long-standing inequalities that exist in medicine and medical education. No single organisation can solve this alone. It requires collaboration across the system to make greater and more rapid progress together.

We've seen some positive change. For example, the MSC's Equality Diversity and Inclusion Alliance will be a powerful force for good. It will bring together the entire medical school community to tackle the uncomfortable realities of inequalities in undergraduate medical education.

At the GMC, we've made a commitment to eliminate discrimination and disadvantage in training pathways, both at an undergraduate and postgraduate level. Our strategy 2021 - 2025 also sets out how we'll work with our partners across the health services to make training environments more supportive, inclusive and fair.

As this guidance is implemented, we look forward to hearing positive examples of the effect it has on medical students', doctors' and patients' lives.

Professor Colin Melville

Medical Director and Director, Education and Standards, General Medical Council

Introduction

This framework was developed at a time before and during the COVID-19 pandemic. During this time extensive systemic racial injustices had been highlighted by the murder of George Floyd in the USA, and the public health data demonstrating that racially minoritized groups were more likely to die from COVID-19 than their white peers. The Black Lives Matter movement galvanised years of anti-racist activism, and medical students wrote to medical schools demanding action across the board to address the pernicious and life-threatening inequalities they experience. They demanded change in medical education and practice.

In many ways, this moment revealed that current equality, diversity and inclusion practices were falling short of the mark in achieving their aims. The authors of this framework have therefore drawn on cutting-edge scholarship and activism in this area to inform new ways of working towards creating an equitable and just medical education for all students.

It is important to note that this work cannot and should not be driven by crises, such as the disproportionate, devastating and avoidable losses of black and brown lives outlined above. Reactionary approaches to inequality and injustice are rarely sustained or effective. In addition, it would be wrong to focus only on racial injustices as we move forward together, as undeniably important as they are. This is because a focus on one form of disadvantage will create its own exclusions. For example, if this framework had been written during the 1970s, we may have responded more strongly to the women's rights movement, which itself has been widely criticised for centring White women's experiences and obscuring racially minoritized women, disabled women, sexual minorities and so on. Thus, this framework centres an intersectional approach to all the guidance and recommendations included here.

Intersectionality was first used by American legal scholar Kimberlé Crenshaw in 1989 to describe the distinct form of discrimination Black women experienced. Since then, intersectionality has been expanded to critically interrogate the ways in which race, gender, class and other individual characteristics interconnect to produce multiple forms of exclusion and discrimination beyond sexism, homophobia, biphobia, transphobia, classism, ableism, racism, ageism and so forth. This is important because it recognises that individuals rarely fall into one simple category, instead they are complex and this means any initiatives to challenge exclusion must also have an intersectional approach.

Active inclusion: challenging exclusions in medical education is intended as a framework for supporting and guiding medical schools to make their environments and processes more inclusive and to identify and decisively address exclusions experienced by their

staff and students that arise due to social and political structures. This document provides an overview of issues of inequity and injustice and sets out key areas of practice for consideration. For each key area of practice there is a series of suggestions that medical schools can begin to investigate in relation to their own practices.

The key areas of practice included in the document are not exhaustive and the Medical Schools Council (MSC) is aware that medical schools are already beginning to address many of these areas. This document is intended to support medical schools with their processes and to help direct them to the many examples of good practice already seen across the UK.

The document will be supplemented by further pieces of more detailed work that will explore each of the key areas of practice identified here. These separate publications will provide examples of good practice and also look at UK and international research in medical education as well as any other studies that can be applied to the medical education context.

MSC has recently established the MSC Equality, Diversity and Inclusion Alliance which brings together the leads for EDI from all UK medical schools to address common challenges in implementing EDI focused change within medical schools. The EDI Alliance will support the implementation of this guidance by bringing medical schools together to share best practice.

What do ‘active inclusion’ and ‘challenging exclusion’ mean?

The phrase active inclusion has been included in the title of this guidance. This wording has been chosen because inclusion is not a passive activity; medical schools must strive to make their environments inclusive for both staff and students. This process is ongoing and requires institutions to continuously review and improve systems and ways of working.

The term ‘challenging exclusions’ has also been included in the title of this document to emphasise that traditional EDI work can fall short of its aims if it stops at recognising diversity (we are all different) and aiming for inclusion (but we can be included by someone else). At root, *Challenging exclusions* acknowledges that people are excluded, experience inequity and injustice, or unfair advantage, precisely because of who they are and where they are positioned within an unequal socio-political structure. Furthermore, these inequalities are not naturally occurring but socially designed and reproduced over time, so that they appear natural. These inequalities will not disappear by merely acknowledging that we are all different. Challenging, and ultimately, removing exclusions within our community requires explicit actions in redistribution of resources, reparation and transformation, rather than a simple adoption of the language of equality and justice.

For the purposes of this document the different types of diversity enshrined in the Equality Act 2010 should all be considered. These protected characteristics are;

- Age
- Disability
- Gender reassignment
- Marriage and civil partnership
- Pregnancy and maternity
- Race
- Religion or belief
- Sex
- Sexual orientation

While the Equality Act does not cover socio-economic background this is a characteristic also considered within this guidance. Medical schools are all committed to widening participation to students from low socio-economic backgrounds and therefore wish to ensure that once these students are studying with us, their experiences, retention, success and progression are not mired by further exclusions within medical schools.

The Public Sector Equality Duty (the PSED) requires medical schools to pay due regard to the needs to advance equality of opportunity, foster good relations between people with different characteristics, and eliminate unlawful discrimination and harassment. Fostering good relations means tackling prejudice and promoting understanding between different groups. Complying with the duty should include gathering information and engaging with people with different protected characteristics to help assess impacts of different policies and practices on them and to identify priority issues to help achieve the aims of the PSED. However, meeting these legal requirements of the Equality Act and PSED must also include embedding intersectionality within all practices and processes.

Why is active inclusion and challenging exclusions in medical education important?

In spite of substantial work addressing medicine as an elite profession with significant exclusions, there is extensive evidence to demonstrate the continued challenges faced disproportionately by students with one or more protected characteristic.

An important example is evidence to show that medical students from ethnic minorities have poorer academic outcomes on average compared to their White peers.[1] Research on this award gap makes it clear that this difference in performance is not due to any deficit in the students themselves but is instead caused by policies and learning environments within medical schools and clinical training. Therefore, addressing the hostile environment within medical schools is key to removing barriers to success for racially minoritised students. More broadly there are further examples within higher education that demonstrate barriers for the active inclusion of marginalised student groups;

- The Stonewall "LGBT In Britain – University Report" showed that 42% of LGBTQIA+ students hid their identity at university for fear of discrimination.[2]
- The National Union of Students in 2018 found one in three Muslim students experienced some form of abuse or crime at their place of study, and that female and LGBTQIA+ Muslim students were even more vulnerable.[3]
- A recent review of the experiences of disabled students in higher education concluded many students continue to feel excluded within teaching, learning and social environments, in addition to increased bureaucratic and financial pressures.[4]

---

1 Woolf K, Potts HWW, McManus IC. Ethnicity and academic performance in UK trained doctors and medical students: systematic review and meta-analysis. BMJ. 2011;342.

2 www.stonewall.org.uk/lgbt-britain-university-report

3 www.nusconnect.org.uk/resources/the-experience-of-muslim-students-in-2017-18

4 www.policyconnect.org.uk/research/arriving-thriving-learning-disabled-students-ensure-access-all

This is not an exhaustive list, but it does demonstrate that despite years for equality and diversity work there remains a clear need within higher education to challenge exclusions faced by students from marginalised communities.

In medical education, there is growing evidence that diversity provides an enriched learning environment for all medical students.[5] Research from the United States shows that students trained in an inclusive environment become better doctors that are more able to serve a diverse set of patients.[6] Challenging exclusions in medical education means better health outcomes for marginalised communities who often face the greatest health inequities. For example, if medical students are taught to diagnose signs and symptoms in all skin pigmentations, they will be better equipped to save the lives of all patients. This will combat current public health crises experienced by racially minoritised people in the UK, most recently illustrated by the data on their increased mortality in the COVID-19 pandemic.[7]

Actioning inclusion in medical education will also play a powerful part in addressing the race inequalities experienced within the NHS workforce, improving organisational culture for current and future healthcare professionals. A survey by the British Medical Association found that only 55% of doctors from ethnic minorities said there was respect for diversity and a culture of inclusion in their workplace compared to 75% of White doctors.[8] This also illustrates that the disadvantage faced by students is likely to carry on once they leave medical school and impact on their postgraduate careers.

---

5 Antonio AL, Chang MJ, et al. Effects of racial diversity on complex thinking in college students. Psychol Sci 2004; 15;507-510
Whitla DK, Orfield G, et al. Educational benefits of diversity in medical school: A survey of students. Academic Medicne 2003; 78:460-466

6 Saha S, Guiton G, et al. Student body racial and ethnic composition and diversity related outcomes in US medical schools. JAMA 2008; 300 (10): 1135-45

7 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/908434/Disparities_in_the_risk_and_outcomes_of_COVID_August_2020_update.pdf

8 NHS Staff Survey 2019, The NHS Long Term Plan, The Snowy White Peaks of the NHS

Key areas of practice for further consideration by medical schools

This section covers a number of areas that medical schools should consider as they seek to challenge exclusions within their environments and policies for students and staff. As previously mentioned, this is not an exhaustive list and these areas of practice will be expanded upon in further guidance, which will also highlight best practice from across the UK and look at the evidence base for the interventions suggested.

Many of the interventions described below require schools to involve medical students in their development. This should be sensitively handled and students from minority backgrounds should not feel obliged to solve problems on behalf of their medical school. Medical schools should be mindful that minoritised medical students and staff can experience something known as the 'minority tax' which can be defined as being asked to put in extra work to 'solve' issues around inequalities that arise from the actions of others, institutions, systems and the wider socio-political structure.[9] Medical schools should consider how they can best support students to carry out this work and whether some form of compensation or official acknowledgement of their input would be appropriate. Centring a redistributive justice or reparative approach means that there is recognition of where power, resources and support are located and seeks to collectively address the inequalities therein.

Make your school accountable for challenging exclusions

This document will outline a large number of measures that medical schools can take to make their school more diverse and inclusive. Due to the scope of work it will be important that governance arrangements for medical schools have robust oversight of the different work streams. Transparency and clear reporting processes are fundamental to accountability. The ability to collect and analyse data on medical students and staff to ensure that interventions put in place to challenge exclusions are working is fundamental to active inclusion. This section sets out what medical schools should do to ensure their data collection and analysis is effective.

---

9 Rodríguez, J.E., Campbell, K.M. & Pololi, L.H. Addressing disparities in academic medicine: what of the minority tax?. BMC Med Educ 15, 6 (2015). https://doi.org/10.1186/s12909-015-0290-9 https://bmcmededuc.biomedcentral.com/articles/10.1186/s12909-015-0290-9

Data and evaluation

- Many of the suggested actions in this guidance require medical schools, and affiliated institutions (universities, General Medical Council) to review the data on student identity they collect and use to evaluate their equality work.
- Data collection should cover the range of protected characteristics set out in equalities legislation and medical schools should follow best practice in collecting high quality data. For example many schools do not collect data on sexuality and this should be rectified. Furthermore, it is important that data on ethnicity is of granular enough detail to make analysis meaningful; the experiences of people from different ethnic minority backgrounds are not uniform and it is crucial that the collection of data does not preclude more detailed analysis of how students from different backgrounds are impacted by medical school policies.
- Analysis of data should take an intersectional approach; medical schools should seek to understand whether students who have more than one protected characteristic are particularly impacted by their policies.
- It is understood that medical schools cannot publish data that makes students identifiable. But this should be balanced with the need to carry out effective analysis and transparent reporting. It is not good practice to report against high level metrics such as the performance of White students vs those from all ethnic minorities. A better analysis would break down ethnicity to a granular level.

Increasing accountability

- Medical schools should clearly identify the importance and value of challenging exclusions within their overall faculty, college or school strategy. This should be supported by a more detailed standalone 'challenging exclusions' strategy which includes specific action points that are aligned with institutional strategy. Staff and students should feed into the development of this plan and it should be regularly reviewed.
- 'Challenging exclusions' should be included within existing governance structures by adding a standing item on meeting agendas. Medical schools should consider how improvements and interventions made to remove exclusion can be measured and reported on.
- Medical schools should consider ways to regularly evaluate and monitor improvements and interventions made to remove exclusions to ensure efficacy.
- Medical schools should consider setting up a dedicated committee and/or working group to implement a 'challenging exclusions' strategy which should include both staff, student and hospital trust representatives.

- Medical schools should have a lead for 'challenging exclusions' who is supported by senior members of staff and is appropriately resourced, including allocated FTE within their workload. This will allow effective implementation of challenging exclusions strategies and increase accountability.
- All members of staff, including senior staff, should receive meaningful training in this new approach to equality and justice, in addition to training sessions on the organisation's EDI strategy. Issues of equality and justice should be included in all PDRs (personal development reviews).
- Building staff awareness of the challenges that students from diverse groups face is also helpful. **Reverse mentoring** by students from minority backgrounds for senior staff can be a very powerful intervention.

Challenging exclusion in recruitment & selection

Recruitment and selection are both vital in making sure medical schools challenge exclusions. Good recruitment will ensure that diverse groups are encouraged to see medicine as a career for them while selection is key to ensuring student intakes are diverse.

Recruitment

- Ensure outreach and recruitment material challenges exclusions by including images and stories of students from a wide range of backgrounds. Medical schools should also consider setting out what they are doing to challenge exclusions and how all students are welcome.
- Role models are an important way of raising aspirations and encouraging students from diverse backgrounds to apply to medical school. Therefore, medical schools should consider ensuring that a diverse set of students and staff attend open days and are involved in outreach activities. This links with the recruitment of a diverse faculty (see the section on how to challenge exclusions as an employer).
- Medical schools should consider how their student demographic matches both local and national pictures and consider targeted outreach to address any missing groups.
- Potential applicants with a disability may need particular support as they are often unsure as to how their disability may impact on their ability to study medicine. Medical schools are encouraged to address these concerns in recruitment material.

Selection

- Medical schools can consider auditing their interview questions to ensure they do not stereotype different groups and that they can be answered well by students from all backgrounds.
- Medical schools should provide training in challenging exclusions, tailored to the role of a selector, for everyone involved in making selection decisions. The training should also help selectors understand the medical school's mission in terms of transforming medical education.
- Medical schools should consider collecting identity data from selectors so they can ensure a diverse set of people are making decisions about admissions.
- Medical schools should collect and analyse identity data from applicants and audit this so they can show their selection process is fair to all.

Challenging exclusions within the medical school environment

This section covers how medical schools should challenge exclusions within the medical school environment itself. Placements are considered in a subsequent section.

Support is covered in some detail within this section, to avoid potential problems arising and to support students when things do go wrong. This is essential in helping students to feel safe and secure within the medical school environment.

The following are some key points and suggestions medical schools should consider;

- Medical schools should consider reviewing the range of events that make up their welcome week and ensure that there are a range of social events available that are accessible and welcoming to all students. Alcohol free events should be considered and events should be carefully scheduled to account for the needs of students with protected characteristics including parents and those wishing to observe religious requirements. Medical schools may find it helpful to work with their medical student societies to develop inclusive welcome week activities.
- Medical schools should ensure they have robust mechanisms in place for students to report harassment and unfair treatment within the medical school environment and for these reports to be investigated and the outcome to be fed back to students.[10] The BMA Charter on Racial Harassment may be a helpful starting place

10 GMC standards *Promoting excellence* – R2.7 Organisations must have a system for raising concerns about education and training within the organisation. They must investigate and respond when such concerns are raised, and this must involve feedback to the individuals who raised the concerns.

for medical schools considering looking at their policies. However, it is important that students can report about other forms of prejudice and discrimination such as homophobia or ableism.[11]

- Medical schools should look at how they currently involve students from a range of backgrounds in the governance of their medical schools and audit whether this is effective in making students feel they are involved in the decisions impacting on their learning.

- Medical students can be involved in governance in a number of ways. Medical schools can undertake consultation with the whole student body or governance groups can include student representatives. It can be helpful to rotate the students involved in governance activities to ensure individuals are not overburdened by their representative roles.

- Medical schools should support their students in establishing EDI student societies for different groups of students which can advocate for and support students from diverse backgrounds. It may also be helpful to encourage the setting up of groups focused on the needs of students who share protected characteristics. For example, many medical schools have multiple societies in place for example, but not limited to: an LGBTQIA+ student society, a society for Muslim students and an Afro-Caribbean student society.

- Medical Schools should examine their physical environments. Public spaces tell stories about who's contributions are considered valuable and medical schools should be asking themselves if there is more they can be doing to celebrate the contribution of diverse communities in healthcare so that all students and communities will feel that they could be part of these institutions. The physical environment can also act as barrier to disabled students attempting to access the learning environments they are entitled to use. Medical schools should ensure that all buildings used for teaching are as accessible as possible, informed by the **social model of disability** (see glossary).

Support

- Medical students are often reluctant to seek help if they are in need of support. This can be due to many reasons, including the perception that to be a doctor you must be perfect and the fear that coming forward will result in Fitness to Practise action. There are also cultural differences in the way people from different communities perceive asking for help. One key thing all medical schools can do is to work hard to communicate to students that it is normal for everything not to be

11 GMC standards *Promoting excellence* - R3.3 Learners must not be subjected to, or subject others to, behaviour that undermines their professional confidence, performance or self-esteem.

okay all of the time and regularly signpost students to appropriate support services within the medical school.

- Another reason students may be reluctant to seek help from their medical school is a belief that the staff involved will not understand their experiences, specific forms of discrimination and the trauma they effect. Medical schools should ensure student support staff are adequately trained in the relationship between inequalities and mental health/wellbeing, rather than an individual **deficit model of distress**. Students may find it easier to speak to someone with direct experience of or relevant expertise in, for example, LGBTQI* or racial trauma, or gender-based violence. Medical schools should consult with their students for their views on the different levels of support provided to them by the medical school and/or university. This may help to identify areas where provision could be improved.[12]

- Medical schools should work to utilise the GMC guidance *Welcomed and valued* to ensure that the needs of disabled students are properly addressed and that decisions around reasonable adjustments are appropriately made.[13]

- Different groups may need proactive support from their medical schools. Projects within medical schools have shown that providing additional support for **widening participation** students in areas such as developing professional identity and belonging can help build student confidence and self-efficacy at vital transition points.

- Medical schools should consider providing time and safe spaces for students to discuss issues around inequality and exclusion with each other and with staff.

Making sure the curriculum challenges exclusions

Marginalised students have been campaigning for a more **diverse and decolonised curriculum** (see glossary entries for these two terms).

This section will outline how medical schools can consider diversifying their curricula, which can increase the sense of belonging while retaining uniqueness for medical students from diverse groups. It will also improve medical care in the future.

Development

- When developing curricula and learning materials medical schools should consider involving a diverse range of students as co-creators.

---

12 See GMC standards in *Promoting Excellence* - R3.2 Learners must have access to resources to support their health and wellbeing, and to educational and pastoral support.

13 GMC standards in Promoting Excellence - R3.4 Organisations must make reasonable adjustments for disabled learners, in line with the Equality Act 2010.

- Medical schools should identify a diversity lead for curriculum development as many leads for diversity have had little experience in curriculum development. This individual should have this role built into their workload planning with appropriate resourcing.

- Having a diverse membership of curricula development groups can help to ensure that that the curricula produced are inclusive. This links with the points made under challenging exclusions as an employer.

- It is helpful to embed a challenging exclusions approach throughout the curriculum rather than covering the issues in a single module as this will assist students to develop an in-depth and applied knowledge of the issues through multiple learning opportunities. Those involved in teaching basic science, external educators and supervisors may also be able to advise on inclusive content relevant to their areas of expertise.

- Medical schools should look at how they can decolonise their curricula. They can do this by recognising how the forces of colonialism have impacted all forms of discrimination including racism, sexism, heteronormativity and ableism. It is important to acknowledge how communities have been marginalised and explore an intersectional approach to address this.

Delivery

- Medical schools should audit teaching materials to ensure they cover diversity appropriately. One example of this would be implementing the teaching resources in *Mind the Gap* which covers clinical presentations in black and brown skin.

- Medical schools should also check case studies and Problem Based Learning cases to ensure they do not stereotype different groups – eg not all patients with HIV are LGBTQIA+ people. Additionally, diverse groups such as LGBTQIA+ people should appear in case studies where their sexuality or gender identity is not relevant to the condition, to challenge diagnostic overshadowing that can be secondary to harmful stereotypes. Similar approaches should be taken for other protected characteristics.

- Medical schools should reflect diversity in the patients, simulated patients and as far as possible clinical skills models involved in their teaching activities including assessments.[14]

---

14 GMC guidance Promoting excellence - R5.3 Medical school curricula must give medical students: […]

b. experience in a range of specialties, in different settings, with the diversity of patient groups that they would see when working as a doctor

Content

- Medical schools can map their learning outcomes on EDI to the GMC's *Outcomes for graduates* to ensure they are consistent with and enable medical students to meet the GMC outcomes and are embedded, identifiable and achievable.
- Medical schools should address complex intersectionalities in culture and health that can impact on health outcomes within their curricula.
- Curricula should also identify the impact that prejudice, bias, stigma and **microaggressions** have on students, staff and patients in healthcare environments and the impact this can have on the delivery of care.
- Medical schools should consider including teaching on the history of medicine that acknowledges the contributions of doctors and patients from diverse groups and problematic histories of medicine in relation to race, gender, sexuality, disability and other protected characteristics.
- Medical schools should strongly consider including bystander training, allyship training and advocacy training in professionalism curricula.

Assessment

- Medical schools should ensure EDI learning outcomes are assessed throughout the curricula. The MSC EDI Alliance will work with medical schools to identify the best ways to assess learning outcomes on EDI.
- Medical schools should audit assessment items and stations to ensure they do not stereotype different groups.
- Medical schools should seek assessors and simulated patients from a broad range of backgrounds. It is also recommended that they collect equality and diversity data from those involved in assessment so this can be audited (see the section on data for recommendations on collecting adequate data for such evaluations).
- Medical schools should provide good quality EDI training to assessors that is specific to their role in the process.
- Auditing performance data against different demographics is recommended so that any award gap based on different demographics can be quantified.

[…]

d. the opportunity to gain knowledge and understanding of the needs of patients from diverse social, cultural and ethnic backgrounds, with a range of illnesses or conditions and with protected characteristics.

- Medical schools and universities should put in place clearly communicated policies and processes to ensure reasonable adjustments to assessment processes can be accommodated as appropriate.

Challenging exclusions in clinical placements

From listening to students, it is clear that clinical placements are an area of particular difficulty in terms of witnessing and/or being the subject of discriminating behaviour. This is difficult for medical schools to regulate as they are not in full control of the learning environment.

These are some actions medical schools can consider to improve the quality of placements for students from all backgrounds;

- Medical schools must ensure that robust reporting measures are in place. One way of doing this would be to implement the BMA charter on racial harassment but expand the coverage so it is inclusive for all students who have protected characteristics.[15]

- Medical schools should seek to ensure that all staff involved in educational supervision and pastoral support within placements are trained so they understand how to respond appropriately if a student comes to them complaining of having experienced or witnessed discrimination by staff or patients.

- Medical schools can consider putting written agreements in place with placement providers setting out expectations as to the need to create inclusive and fair training environments. This agreement could also cover what will happen when a student raises concerns about discrimination at a placement provider.

- Medical schools should work with postgraduate training bodies and employers to address reports of harassment or discrimination by students – this will allow triangulation to help pick up potential issues in working environments.[16]

How medical schools can challenge exclusions as an employer

Through the Athena Swan process medical schools have made great progress in diversifying their clinical academic workforce in terms of gender. This progress now needs to be extended to other protected characteristics and be embedded within the

15 GMC standards in Promoting excellence - R1.1 Organisations must demonstrate a culture that allows learners and educators to raise concerns about patient safety, and the standard of care or of education and training, openly and safely without fear of adverse consequences.

16 GMC standards in Promoting excellence - R1.2 Organisations must investigate and take appropriate action locally to make sure concerns are properly dealt with. Concerns affecting the safety of patients or learners must be addressed immediately and effectively.

culture of medical school recruitment and employment policies, including those for teaching staff. Having role models within the medical school faculty is known to help students from diverse backgrounds.

Attraction

- Explicit mention should be made in job adverts that the medical school is committed to challenging its own specific exclusions by actively seeking applications from under-represented groups, as identified in a review of their own data.
- While positive discrimination is not lawful in the UK this does not mean that medical schools cannot take steps to increase the amount of applications from people from diverse backgrounds. For example, targeted marketing strategies and support can be put in place.
- Medical schools may also want to consider implementing mentoring and other outreach activities to support potential applicants to their schools to make high quality applications.

Selection

- Medical schools and universities should follow best practice in selection processes; this includes name blind application forms and routine EDI monitoring. This data monitoring should be high quality, granular and follow best practice as outlined in this guidance.

Promotion

- Medical schools and universities should review data pertaining to current promotion practices and success rates, identify any disadvantage and proactively research the causes of this disadvantage before addressing them. This should be done intersectionally.
- Medical schools and universities must have transparent processes in place around promotion.
- There should be proactive engagement with eligible staff prior to promotion dates to ensure they are aware of promotion opportunities.
- Medical schools should support applicants who do not achieve promotion by providing constructive feedback and identifying development activities that will allow them to be successful at a future date.

Audit

- Medical schools should audit the demographics of their staff at different levels of the organisation on a regular basis so they can assess the impact policy changes are having.
- Audits of pay and benefits given to staff from different backgrounds can also be an important step in identifying inequality within institutions.

Summary and next steps

As stated in the introduction, the Medical Schools Council is aware that this guidance is high-level and includes details of many interventions that medical schools will already be implementing. Therefore the MSC EDI Alliance will be undertaking work to build on this information with more in depth guidance on all of the areas covered in this resource. This work will include the identification of best practice examples of innovative work and the sharing of resources between medical schools.

Glossary

Reverse Mentoring - Reverse mentoring is the opposite format of traditional mentoring, where the senior leader is mentored by a younger or more junior employee. In the medical school context this normally means medical students mentoring employees of the medical school.

Social Model of Disability - This model comes from the perspective that people are disabled by barriers in society, not by their impairment or difference. Barriers can be physical, like buildings not having accessible toilets. Or they can be caused by people's attitudes to difference, like assuming disabled people can't do certain things

Deficit model of distress - According to the deficit model, psychopathology is the result of dysfunction and distress, which are attributed to some deficiency within the individual. This means the onus is on the individual to enact certain changes to reduce distress and dysfunction and consequently improve mental health.

Widening Participation (and Widening Access) - The terms widening access and widening participation are frequently used together to refer providing equality of access and opportunities to succeed in Higher Education for underrepresented students. In medical schools the main underrepresented group is those that of students from low socioeconomic backgrounds.

Decolonising the Curriculum - Decolonising the medicine curriculum promotes awareness and questions the traditional narratives and power imbalances in order to disrupt the legacy of white male patriarchal colonisation of medicine. By reassessing past medical colonial legacies, it could be possible to reframe, reorient and reform the profession.

Diversifying the Curriculum – Ensuring the curriculum equips students with the skills and knowledge to treat patients from minority groups safely, equitably and non-judgmentally.

Microagressions - Microaggression is a term used for commonplace daily verbal, behavioural or environmental slights, whether intentional or unintentional, that communicate hostile, derogatory, or negative attitudes toward stigmatised or culturally marginalised groups.