The challenges of diversity for medical education.

Transcript of podcast:

Time Code	
00:00:17	PRESENTER Welcome to our latest ASMEBITESIZE podcast. Today we're addressing the challenges of diversity for medical education with Professor Nisha Dogra. This podcast will be followed by a webinar with Nisha in discussion with Riya George our ASME Honorary Secretary and Lead for Diversity and Inclusion. Please visit www.asme.org.uk/events to register for the webinar at 11am on Wednesday 8th July. Now over to Nisha.
00:00:37	NISHA This podcast is the Challenges of Diversity for Medical Education. My name is Nisha Dogra and I'm an Emeritus Professor of Psychiatry Education and a retired consultant in child and adolescent psychiatry. Now diversity education in the UK is very variable. We did a survey in 2003 and found that the teaching was somewhat ad hoc, fragmented and very variable. A survey by Bentley and colleagues in 2008 had found that little had changed. A workshop in 2010 found that teaching staff in this area needed support to develop consensus on curriculum development, delivery and assessment. A review of the UK, US and Canada in 2009 found that the three countries had similar challenges. The challenges were the conceptual issues, curricula issues, and faculty support and development, and student issues. In all three countries there was a lack of conceptual clarity as to what diversity education might be about. What happened was that the governing and licensing bodies offered insufficient guidance on culture and diversity. And medical schools were able to determine their own pedagogical message, making it difficult to compare curricula and effectively measure change or progress. The philosophy between what actually constituted diversity or equality was barely made explicit. In terms of curricula issues governing bodies were quite clear about the inclusion of cultural diversity but there wasn't a huge amount of clarity about what it might mean. And there's also a split between what policy asks and what actually happens in practice. At different schools there was huge variability with what's taught and the methods used to teach it. And programme reviews indicated that it was happening more but it wasn't always clear on where it was happening, when it was happening and how it was happening, and whether it actually made a difference to the way that medical students were practising their clinical work. In terms of the curriculum it was also often add-on and not necessarily integrated throughout the curriculum and often unlinked to clinical practise. And there was also a tendency for students to say that what happened was when they went on the ward all of the learning that they did do in diversity was negated by the behaviours that they saw in clinical practise. There's also still a tendency to emphasise teaching about different or other cultures as though there's a them and us. Setting up probably not a very healthy way of looking at diversity and then thinking about culture. Dominant discourse is usually about students gaining expertise about other cultures and wanting certainty where it may not exist. And what we have found in surveys of teachers is that this is

	also true for teachers, that they often want certainty they want to be able to tell students exactly what they need to know and both students and staff may find it very difficult to sit with uncertainty and understand that with diversity, uncertainty is very hard to predict and often there are dangers when you start predicting it because what you do is make assumptions rather than checking out what's really important to the person that you might be dealing with. One of the issues of that faculty support and development, medical educators may not recognise how their own underlying beliefs about approaches in education and diversity itself influence the choices they make regarding course development. And I think this is very prevalent at the moment in, when people are talking about decolonising the curriculum the assumption with which curriculum are designed isn't often reflected on, people don't often think about well actually my particular world view is gearing me towards pushing the curriculum in a particular way. Even staff who are aware of these things maybe concerned about how to incorporate diversity into their teaching and I think one of the difficulties we do have particularly with social media these days, is that it's really, really difficult for people to make not acceptable mistakes but make errors when they're trying things out because there's such a risk of that getting shared and you being made to look like a complete fool. When actually we forget that some of the intent behind wanting to learn means that we are going to make mistakes and I'm not sure that we've got this quite right. One of the things that we do know is that unless these issues are addressed within faculty you're never really going to incorporate diversity into the medical curriculum design and I think it's interesting that we still have very little on medical curricula that actually shows where and how diversity and equality and inclusion are incorporated and in what way that is done. A survey of teacher needs in about 2014 looked at 1,100 teachers across 14 partner countries in Europe and significant needs were identified. And one of the things that came out of this study was that the findings are consistent with other studies that faculty development in this area is largely unaddressed. What we do have is we do have some evidence that simple training in a workshop can change the way that people understand diversity and feel more confident about incorporating it into their practise. So, the example I've used on the slide is one of a workshop we had on mentorship and one of the things that we were looking at is how culture and diversity of the teacher may influence the way that they mentor students. And as the slide shows there was some improvement post-workshop that people felt more confident. The problem of course is that whilst they may feel more confident that's not necessarily bourne out in practise and we haven't got enough good quality research to show how change is maintained and if it is maintained in practise, and whether the confidence is justified. One of the things we know is that without faculty development we're unlikely to get the buy-in needed to integrate and imbed the diversity and inclusion throughout the curriculum. And particularly the continuity between the pre-clinical and the clinical phases. One of the things we do know is that staff with lead roles in diversity often struggle to get the leverage that they want and we've often failed to demonstrate to students why diversity education matters particularly because even if you do good work in the pre-clinical years by the time they get on the clinical wards they feel a lot of it is negated. Another challenge is that a recent review into fairness and medical education found that research often looks at individual factors such as gender ethnicity and we know that people are obviously inter-sexual, people have got lots of factors that relate to them. So, looking at single factors doesn't necessarily give us a true picture. We also know that the research tends to look at a single policy so it'll look at for example selection or examination but not assistance as a whole. So, you might have a very good selection

	policy that does deal with equality and diversity very fairly and inclusion, but then you've got an examination system which may completely miss the point or vice-versa. What we found in the review was that increasing the number of minority students in itself is unlikely to create change if the organisational cultures aren't challenged and there are very few systems in place for challenging existing cultures about the way things are done, how they're done. And often individuals will be asked to raise issues and may not feel that they've got the confidence or the support to do so. One of the other things that students in the focus groups talked about was the need to educate the public about sexism, racism, disability discrimination and so on because they felt that even if their schools taught them it the public were often making an unfair request to see a particular kind of doctor. And the issue with that is that whilst public education is obviously always relevant, one of the things we need to think about is what is it like in the organisation? Have they dealt with these things before we're asking to move out to the public? Obviously, there are actions that we can take at individual and team-level such as being aware of cultural need and belief but being aware of the context that we work in, legal frameworks that we're obliged to comply with. We need to respect individuality whilst maintaining curiosity and respectfully challenge. We need to think about the impact of culture at every stage of our educational process from the planning to delivery, to evaluating an educational service, or to think about our interactions with our students and our trainees. We also need to review our systems and actively ask have we really applied the principles of EDI? And obviously being reflective as we do all of this is helpful. But, as you will have known with a lot of the publicity around Black Lives Matters currently is that people will make the symbolic gestures of taking the knee or making a statement that they, you know, don't support racism, are anti-racist, but actually one of the difficulties is that although these things are important they themselves are not enough. We need to do more. And one of the arguments I would make is that very few organisations have a clear policy with a specific strategy about EDI in ways that is transparent and the body of that organisation can agree and understand where their organisation is going. So, I think we need to address the challenges by having very, very specific strategies. We need to have a clear strategic aim and context and for example you might say, you'll collect data re: diversity factors including ethnicity and you use that to inform something like membership services or inclusion, or development of members for particular roles. Then you need to have very specific goals to meet that strategic aim so for example if you're going to collect, say that your strategic aim is to collect diversity data then you need to say what data it is that you're collecting and how you're defining it and how it's going to be used. And then you need to be very clear by saying how are those goals going to be met? So are you going to meet the goals through which process because unless you're very clear about how the goals are met, it's a goal that doesn't really have necessarily an outcome. And then you need to be clear that when you've said what the goal is how it's going to be met, how are you going to be able to demonstrate that the goal has been met? To make sure that it does happen because lots of organisations will say well, we aim to do this, where is the time frame and where is the accountability and the identification of who's responsible for the delivery. I think there are huge challenges to making EDI integral to all our roles and particularly medical education. I think one of the things that we need to be thinking about and discussing in a way that's open and transparent but may make us uncomfortable because actually we will reveal errors when we do so, is to think about how do we think about equality, diversity and inclusion for every role that we take in our educational capacity. I'd argue that actually our educational roles are related to all other aspects of our lives because

	we're influenced by all these other factors. So, we really need to think about how is it that we can address the challenges of EDI because to date what we know is that whatever our good intentions have been they've produced very little in terms of outcomes of change where we have got a system that is truly equal diverse, or inclusive. So, in summary I'd like to say that I think our perspectives are very, very much coloured by our own cultures and experiences so influences most, if not all, of what we do. So, we need to think very clearly about every interaction we have whether that's in person, or with a policy or with a document, or with a curriculum. Every interaction we have in person and in our systems to address this possibility and we need to be thinking at every stage am I being honest about addressing the factors that may mean that somebody else will perceive this being as unequal, not thinking about perspectives, a broad range of perspectives and act to be exclusive, or not inclusive.
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