

Medical Students' Perspectives on Inclusivity Within Clinical Environments: A Pilot Study

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Purpose: Limited resources including staff, technology, and space in United Kingdom National Health Service (NHS) environments present challenges for working teaching and learning. Cumulative pressures impact mental health and prompt medical students to question career choices, leave the profession, or emigrate. There is little understanding of the experience of inclusivity in clinical environments for medical students. This pilot study explores students' perspectives of these environments, the barriers to formulating change, and possible solutions.

Materials and Methods: Six diverse clinical medical students from the University of Manchester, based at a single NHS Trust, voluntarily participated in one of four recorded focus groups facilitated by a near-peer with protected characteristics. Low participation emphasised the importance of undertaking this pilot study to consider methods for future study design. Transcriptions were independently analysed by two reviewers to generate themes using NVivo.

Results: Key themes included positive experiences with resident doctors; negative interactions with patients; negative attitudes and poor role modelling from some staff; perceived lack of institutional support; and poor learning opportunities. Students suggested staff training and better support structures to improve learning environments.

Conclusion: This study highlights universal issues from the perspectives of minoritised students and emphasises their low participation in research. Authors suggest exploring clinical faculty support and training to improve learning environments, and innovations in study design for wider, more democratic and culturally sensitive participation.

Keywords: equality, diversity, inclusion, medical school, medical student, inclusivity, learning environment, student experience

Introduction

It can be challenging to learn, work, and teach in resource limited United Kingdom (UK) National Health Service (NHS) environments, with pressures on staffing, technology, and physical space. Cumulative pressures lead medical students to question career choices,¹ doctors to leave the country or profession^{1,2} and contribute to a notable deterioration in medical students' mental health.³

It is known that prioritising inclusivity within clinical environments can improve healthcare workers' sense of belonging.⁴ However, little is known about this for medical students. Subsequent knowledge may encourage them to feel valued, to thrive, and to progress their careers and contributions to practice.

Protected characteristics, such as ethnicity and gender, influence the lived experience of students within learning environments. Differences in attainment were reported in a meta-analysis exploring ethnicity and academic performance.⁵ Ethnic minority students and doctors performed on average worse than white colleagues, despite both groups having high academic ability entering medical school.⁶ It was concluded that this was not due to learner deficit, neither situating the problem with the student or doctor, nor blaming their personal or social background.⁶ Brown et al⁷ conducted qualitative interviews with female medical students who described gender bias dissuading women from surgical careers, pregnancy as a barrier, and disapproval of caring for a baby during training. Students felt physical environments were male dominated with institutional gender bias.

Alongside protected characteristics, factors related to interpersonal learning environments influence student experience. Broad et al⁸ conducted a questionnaire study of lived experiences of medical students in learning environments. They found 63.3% of students faced harassment, with 43.2% experiencing stereotyping. Only 5% had formally reported incidents and comments suggested students did not think reporting would make a difference.

Social Identity Theory⁹ suggests that healthcare professionals interpret experiences through the lens of their group identity. Apperception reinforces this, meaning harassment may be underreported if speaking out threatens stigmatisation or risks exclusion from the professional group. Other responses to identity threat may include open or hidden resistance which, discouraged by traditional views of professional identity formation, is increasingly recognised as originating from reinforcement of norms and values that disproportionately reflect the perspectives and priorities of culturally dominant groups.¹⁰ Students improved knowledge of diverse student perspectives, cultural humility, and the importance of authenticity, may enable them to become agents of change, through speaking out.

Governing bodies and medical associations have produced guidelines, reports, and pledges to highlight the importance of tackling such challenges and increase professional awareness. The British Medical Association (BMA) Anti-Sexism Pledge sets standards for clinical learning environments.¹¹ It includes ending sexual harassment in medicine, ensuring safe and known reporting processes for discrimination and harassment, nurturing a safe environment for pregnant students and doctors, and eliminating sexism from career progression. The Medical Schools Council (MSC) guidance, *Active Inclusion: Challenging Exclusions*, sets the Equality, Diversity, Inclusion (EDI) strategy for medical schools.¹² It suggests making student events inclusive and implementing robust reporting processes for harassment. The General Medical Council (GMC) supplemental section on EDI in *Selecting for Excellence*¹³ advocates: “The learning environment is safe for patients and supportive for learners and educators. The culture is caring, compassionate and provides a good standard of care and experience for patients, carers, and families”. It endorses better support and role modelling; improving equality, diversity, and inclusion (EDI) training for staff; and implementing EDI activities in the curriculum. However, whilst under-reporting remains a challenge, it is finding ways to sustainably implement these guidelines that is central to tackling the issues.

Existing literature fails to report medical students’ perspectives on how their protected characteristics affect their learning experiences. It is not known how aware students are of the available support and resources, or how to raise concerns about difficulties in their learning environments.

This study was based in a single sector that included both primary and care settings. It aimed to describe the challenges arising for diverse medical students in clinical learning environments, as well as the support available to them. It also aimed to explore medical student suggestions for improvement, to inform strategies for engagement in clinical placements and ultimately motivate individuals to continue in practice.

Materials and Methods

Study Design

A small pilot study was chosen because of known difficulties enabling representation from diverse students in medical education feedback.¹⁴

The authors concentrated on depth and relevance of data rather than quantity, in anticipation of low participation. The research questions centred on:

What are the perceived experiences of medical students with protected characteristics within their clinical learning environments? What are their perceived challenges?

Focus groups were initially deemed best suited to gain rich descriptions from the perspectives of medical students, in an environment where students might feel supported by peers to disclose sensitive information. The focus group interviews were facilitated by the local EDI student representative for the sector, a medical student with intersectional protected characteristics who received training for this role. This near-peer approach aimed to foster a psychologically safe space, minimising hierarchy and power differentials. To avoid tokenism and in line with Fischer’s participatory governance theory,¹⁵ the research included the students’ suggested ideas for improvements.

Study Participants and Recruitment

The study was set in a northern UK medical school. Participants were recruited from approximately 450 students in years 3–5 of the medical programme through online adverts on the student portal, email, and social media. Those who expressed interest and met inclusion criteria were emailed further information, including the study background, how the data would be collected and analysed, and a consent form. Medical students included in the study had experienced clinical placements and belonged to at least one of the following protected characteristics: disability, gender reassignment, pregnant, ethnic minority, minority religious group, female, and LGBTQI. Participants self-identified and did not need to disclose their protected characteristic(s). Respondents signed consent forms and were allocated to focus groups depending on availability. All participants were advised of their right to withdraw and reassured that data would be anonymised. Six students participated in total, each attending one of four focus group interview sessions. Due to small numbers, demographic data was not collected to assuage fears around confidentiality and maintain anonymity.

Data Collection

The focus group topic guide was pre-determined by the research team who were experienced educators with an EDI focus. It used prompts and questions created in line with the aims of the study and existing literature. The focus group guide was semi-structured with flexibility for the order and prominence of questions to maintain the conversation flow and allow for new areas of exploration to be followed should they arise. Focus groups each lasted one hour and were securely conducted using the online Zoom platform over a 4-week period. The discussions were audio recorded and transcribed verbatim by a university approved transcription service. The text was anonymised and reviewed by two members of the research team. The recordings were deleted, and transcriptions stored in the university secure research data repository.

Data Analysis

Using NVivo software version 11, two researchers independently analysed data using Thematic Analysis methodology proposed by Braun and Clark.¹⁶ Researchers initially read the transcripts multiple times to understand the nuances of students' experiences. Key features of initial codes reflected both positive and negative experiences, challenges, and solutions. Grouping these into broader themes highlighted supportive relationships, barriers to inclusion, institutional issues, and recommendations for change. These were checked against the data and then named before linking to the literature and producing the report.

Discrepancies between the two researchers' coding were discussed to reach consensus. The final themes were reflected upon then discussed with the collective research team.

Ethics

The University of Manchester Proportionate Ethics Committee approved the study. [Approval date: 10.04.22, Review Reference: 2022–13,955-22918] Participants' informed consent included publication of anonymised responses/direct quotes. This paper complies with the Declaration of Helsinki.

Results

The interviews explored the perceived experiences of medical students in clinical learning environments and found these were split into two broad categories. The first highlighted positive experiences with resident (formerly named "junior" doctors) particularly Clinical Educational Fellows (CEFs). The CEF position is a near peer role for early career doctors, that splits workload between teaching and clinical delivery, with responsibility to medical students, the undergraduate support team, fellow healthcare professionals, and patients. [Table 1](#) provides a description of the perceived positive and negative experiences for students, with corresponding quotes. Students described positive experiences of being provided with good learning opportunities. Conversely, negative experiences were reported in interactions with patients.

Table 1 Perceived Positive and Negative Experiences of Medical Students with Protected Characteristics in Clinical Learning Environments

Theme	Corresponding Quotes
Positive experiences with resident doctors (particularly CEFs), the undergraduate support team, healthcare professionals and patients.	<p>“And I think the ed fellows have been incredible. They have such a good understanding of the medical requirements, they are really flexible with what we do in the sessions, let us kind of lead it and, you know, I do not think there’s been a session where I have not been asked, what do you want to do”</p> <p>“Yeah, F(Y)Is have been useful. I found they’re often the most willing to teach and have the most patience and time for you to get it wrong”.</p> <p>“They [Undergraduate support team] put me in a different group when I asked them to that did not have a Friday afternoon finish. Because I also have to leave early on Friday afternoons because our Sabbath comes in. So that was really good, and I really missed very little”.</p> <p>“Some of the nurses as well were really good with just demonstrating and explaining some of the observations. They were really helpful in that, like they took time away from their own duties and stuff”.</p> <p>“I don’t think there is a bad thing, to be honest, because they’re [patients] doing their best to help us out and they’re investing their time in future doctors like us”.</p>
Positive experiences in view of good quality learning opportunities being provided	<p>“[Tutor]asked us what we need to do instead of just telling us what we needed. He [Tutor] actually asked the medical students what they need”.</p> <p>“Was offered a debrief and we had a good conversation about death and dying and end of life and how to make someone comfortable, how to keep them comfortable during the last days, which was a good learning opportunity”.</p>
Negative experiences with regards to patient interactions	<p>“You should know my notes, I [the patient] shouldn’t have to explain myself to you”. He [the patient] was like, get out of my room. It was quite intimidating”.</p> <p>“One patient has fully commented on a nurse’s breasts, and they repeatedly did that and everything so, again, I don’t think...so it’s not like specific to, I guess, medical students”.</p> <p>“One of the patients asked, where are you from? Then they say, like where are you really from? Then I said, oh, I am [heritage/nationality] and then, as we were leaving the bay, the doctor was like, just some casual [place Z] racism for you. “</p>

Table 2, provides a description of the perceived challenges faced by students, with corresponding quotes. Four challenges identified within the learning environments included perceived stigma and negative attitudes from staff, poor role models, lack of support from the institution and poor learning opportunities.

Table 3 provides a description of the students’ ideas for improvements. Suggested improvements from students included staff training, development of staff advocates for protected characteristics and having improved support structures.

Discussion

This study aimed to address two research questions: the perceived experiences of medical students with protected characteristics within their clinical learning environments and the challenges they faced. It also explored the students’ suggested ideas for improvement. It was interesting that a broad range of issues were identified, despite the small number of participants. Students expressed positive aspects of experiential learning on placement, the highlight being contact with Clinical Educational Fellows (CEFs) as near peers. This aligns with current literature. Hossain et al¹⁷ explored the impact of a structured teaching programme for final-year medical students led by Clinical Teaching Fellows (equivalent

Table 2 Perceived Challenges of Medical Students with Protected Characteristics Within Their Clinical Learning Environments

Theme	Corresponding Quotes
Stigma and negative attitudes from staff	<p>"I feel like a lot of the specialities are very bitchy about others. Or even within their own team, like you are sat in the doctor's office, and someone walks out and they are like oh, they cannot do their job properly. Or, you know, nurses moan about doctors and doctors moan about nurses, or whatever. It's just like, what do they think about me?"</p> <p>"you're from the [institution X], they don't really make you learn that well or something".</p> <p>"One of the nurses I think it was, was like who the F does she think she is thinking she can come in here and use our stuff? I guess sometimes if they don't understand the role of the medical student on placement, they can feel a bit like we're intruding".</p> <p>"I will not say harassment, but I have had some odd comments. Like, particularly male doctors – particularly male surgeons – asking what you want to do. And if you say any sort of competitive specialty [signal break] kind of question your willingness to, you know, kind of insinuating that you cannot have a family and go into a competitive specialty.</p>
Poor role modelling	<p>"Some placements I feel like our supervisors haven't really cared about who we are. There's one that comes to mind that, you know, he didn't even ask us our names. I think we saw him about four times in the four or five weeks of being there".</p> <p>"The consultant I was on a ward round with laughed at me when I got a question wrong. It's obvious that his intention was to make you feel like low, like worse.</p> <p>"I would ask them [senior doctors] the questions, obviously, but they would answer like one or two and then it was like, oh, I am busy. Yes, fair enough, you are busy. Fair enough, you are busy but it's not really teaching me a lot.</p>
Lack of institutional support	<p>"The travel bursaries [signal break] do not really cover the car, only public transport.</p> <p>"I think there's probably a lack of knowledge of being queer in terms of the support system in the medical school, I do not think there's any...if I was struggling with that. You know, I am comfortable around identity. But if I was struggling with that, I do not think I'd know who to turn to.</p> <p>"there's not really like a clear place or a safe place where you can go...you're always too scared to say something about it. 'Cause the person to talk to is mainly like our supervisor and they're the one signing us off at the end".</p>
Poor learning opportunities	<p>"I think scavenging for opportunities was a big thing for my placements. I do not think there was any placement where I did not have to really look for opportunities. It's exceptionally tiring and draining. And I know it's not meant to be easy but, you know..., I am considered a disabled student and as someone who struggles with fatigue and energy levels...I have spoken about this before with someone, the need to actively hunt things down is absolutely exhausting".</p> <p>"they are [medical students] not really learning anything on the ward rounds because there's just too much. You join in like in the middle of everything. You do not know what's going on. You have to read all the notes, everything to catch up with all the patients and the doctor's talking riddles and you have no idea what's going on. It is just mind-draining and it's just too much".</p> <p>"you'll have presented a physical examination for them and spent ten minutes talking at them and then they'll go, oh, I didn't watch you do it, actually, so I can't actually sign you off for it".</p>

to CEFs in the study). Students commented positively on the teaching being reliable, relevant and varied, and the fellows being a familiar face during their placement. This suggests it would be worthwhile to consider a similar more structured intervention for this student body.

Students encountered many challenges, with some concerning experiences, such as bullying and discrimination. Worryingly, the students did not feel able to challenge such behaviours within the hierarchy and believed any attempt to do so would be futile. Some incidents had created cognitive dissonance for students, and they welcomed more opportunities to debrief their confusing experiences of interacting with staff and patients. Incidents of sexism were challenging within learning environments, which aligns with current literature. Ibrahim et al¹⁸ conducted a qualitative study of female medical students, to explore their experiences of sexism whilst in their clinical work. There was evidence of sexual harassment, stereotyping, and microaggressions, all of which negatively impacted students' mental health and their participation on placement. They also felt multiple factors hindered reporting. Recent campaigns and reports in the literature and medical press highlight that these issues are not local to the study setting but need to be addressed at scale

Table 3 Student Suggestions for Improvement

Theme	Corresponding Quotes
Improve support structures	<p>"... there should be more support in place for students that struggle.... The counselling service, you have to ring up at like eight o'clock to get an appointment and stuff like that. When you are depressed, you are not waking up at 8am.... The counselling service at the uni do not understand the medical cause".</p> <p>"Yeah, maybe, like, increase number of days or...I do not know. Like, I know med students do not like to go in on the weekends, but I'd rather go in on a Saturday or a Sunday.... I'd rather go in then if there's a clinic or if there's a doctor there that can help me with what I missed, then having to repeat it, or do it in the summer, or like [voices overlap] Easter holidays".</p> <p>"... I think the exam support just isn't there. A lot of the exam support they offer is very short-term. So, like you can get extra time, or you can get a different room, or you can resit in two weeks"</p>
Staff training	<p>"I think maybe with disabilities and things, if maybe like the staff that we are working with were more educated on those things they could not only provide support, but I think they can help you recognise when you have one. 'Cause I think it takes a really long time for that to happen".</p> <p>"Think we are gradually becoming more aware of the importance of treating people kindly. And I think the medical students need to feel invested in, and we need to feel like consultants see us as future doctors rather than as annoyances and as nuisances who they just need to get rid of and sign off".</p> <p>"I guess maybe like implementing a new role as someone who has knowledge on these protected characteristics and knows how to support these students.</p> <p>"I think it would be nice to have...like for each group to have a dedicated clinical fellow. I guess it would take the pressure off the other clinical fellows, ...it would give them more flexibility, I think, with their workload and with helping us as well".</p>

in medical education. Interventions may include the instigation of better staff training and user-friendly reporting systems or online platforms for anonymously raising concerns.

There was a widespread feeling among students that they were unwelcome and burdensome in the clinical environment; senior staff did not understand their needs; and the NHS working environment was not a happy one. This is in keeping with previous studies. Ravalier et al¹⁹ conducted a survey and semi-structured interviews with NHS staff, exploring work stress. These mixed methods elicited issues with workload and the work environment. Their data also unearthed that half of respondents felt poorly supported by their manager. It is worrying that students are entering potentially troubled clinical work environments, and it would be helpful to address this early in preparation for practice.

Stigma and negative attitudes were challenges within clinical learning environments, particularly around racism. This had an impact on students' sense of belonging and on career hesitancy. Morrison et al²⁰ explored racial microaggressions on graduate medical students. They found this to be a regular experience with negative impact on their wellbeing, experience, and performance. To counter this, students felt that role-modelling was particularly important.

Ward rounds were not considered valuable learning opportunities by students and could be stressful. This is supported by a systematic review, which noted the negative experience of ward rounds as learning opportunities for postgraduate trainees.²¹ In Gray et al,²² a structured framework and tool was deemed to have educational value for trainees and be acceptable to preceptors for adding educational opportunities during ward rounds. This approach may address the concerns felt by students, particularly if it is deliberately and intentionally inclusive in design.

As expected, students were stressed by summative assessments. Students with health problems wished longer term support around preparation for assessments and flexibility to manage workloads. de Oliveira et al²³ explored the experience of medical students with disability. They noted multiple challenges, including educators' poor awareness of disabilities, and lack of teaching adaptations and adjustments to the physical learning space. Students with disability suggested student collective advocacy to improve access, and for faculty to determine requirements of individual students with disability throughout their time in medical school.²³

Placement signoffs caused anxiety and, paradoxically, distracted students from learning. They wanted more clarity on who was responsible for completion and on how to manage this. Al-Mously et al²⁴ highlighted the lack of supervisor engagement in feedback, with over 50% of year 5 medical students reporting they rarely received feedback on their

clinical performance. Burgess & Mellis²⁵ emphasised the risk to medical students of lack of direct observation of clinical performance, including lack of achieving clinical competence and a feeling of being lost in the clinical environment.

Staff development was considered crucial by students to help teachers understand their learning and pastoral needs. They felt that staff training on induction requirements and Equality, Diversity, and Inclusion were important. Bilal et al²⁶ conducted a meta-analysis and systematic review looking at staff development, noting that professional competence and knowledge significantly improved with different interventions. Students in the study also suggested improved IT access and stronger bespoke support structures. Weiss et al²⁷ highlighted that 17.7% medical students in their study felt that staff did not respect protected characteristics, particularly those who were from ethnic minority, female, or LGBTQ backgrounds.

Strengths and Limitations

The qualitative data was rich, varied, and informative, despite the limited responses with a modest sample size. Whilst small numbers preclude working towards data saturation, we felt that information power was more important for this seldom-heard group.²⁸ This topic is sensitive and gaining the nuanced viewpoints of even small numbers of students generated data and perspectives which are insightful and not well-described in existing literature. Self-selection by students meant hearing from those with more specific issues, but only those with the confidence to speak out. The pilot study was designed to address anxieties around confidentiality that students with protected characteristics and intersectional issues face in speaking out through using self-identification and not collecting demographic data. However, using this strategy, along with facilitation by a near peer with diverse characteristics to facilitate the focus groups, did not result in high participation. This shows the importance of such pilot studies and will result in further research to optimise future design, including mixed methods, individual interviews, reflective narratives, and arts-based research.

Suggestions for the Future

This study has highlighted the key issues facing diverse students in a clinical sector of a large medical school. The authors suggest piloting interventions to amplify the positive findings and minimise the challenging ones. Aiming to make systems more responsive and equitable through reasoned dialogue rather than rather than passive feedback could improve trust from minoritised groups.

An example would be to design, implement, and evaluate a structured supportive programme co-produced with near peer resident doctors or Clinical Educational Fellows (CEF). The authors have obtained institutional support and aim for the initiative to be led by a CEF. Staff development can improve the learning environment, particularly if EDI is incorporated into the training. The medical school has created a standardised EDI training package for clinical placement supervisors, and this could be delivered to all educators in the sector.

The authors suggest evaluation of these further interventions through a mixed methods approach, incorporating qualitative and quantitative data analysis. This pilot study illustrates that future study design to reach students from communities who lack trust in research is about more than power differentials. Campbell et al²⁹ quip “do not think that skin gets you in” and go on to describe their experiences as scholars of colour where building respectful relationships and foregrounding cultural sensitivities to improve access requires much more consideration and reflexivity.

Conclusion

This study aimed to explore how inclusive the clinical learning environment was for medical students with protected characteristics. It elicited challenges that were universal, such as bullying and discrimination, navigating unhappy environments, and feeling devalued. Positive experiences were linked to contact with Clinical Education Fellows, and students were keen for their greater involvement in undergraduate education. A key intervention stressed by students was improved staff training, particularly around EDI. The authors aim to implement change by highlighting the issues facing medical students and through being transparent about deficits. They propose development of interventions to address the barriers facing students from protected characteristics and more nuanced evaluation of their impact and effectiveness.

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