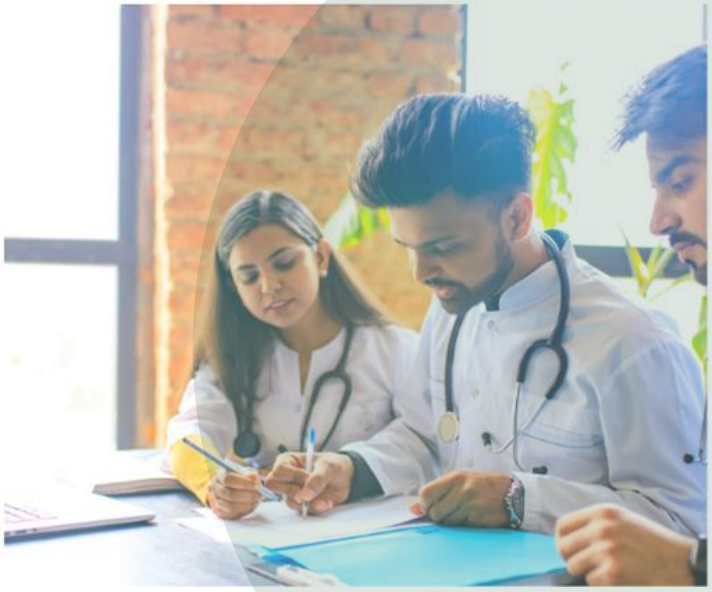

An Exploration of Inclusion Health Teaching in the Undergraduate Medical Curricula

Summary Report
June 2024

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FOREWORD – PROFESSOR SANJIV AHLUWALIA

Dear Colleague

Thank you for taking the time to read this ***summary report****. Inclusion Health is an oft discussed matter in policy and education circles, but rarely considered from the perspective of learners and those responsible for delivering curricula. Yet, and our work confirms this, amongst the challenges that citizens and patients from an inclusion health background face, access to and the ability to form therapeutic relationships with medics and other healthcare professionals is a matter of key concern.*

In this report, our team summarise the findings of two surveys – of UK medical schools on their approaches to teaching inclusion health in curricula, and of third sector organisations (predominantly people with lived experience of being a IH community member), in facilitating timely and effective care for their clients and patients. In both surveys, we see a confluence of messages – that patients from an inclusion health background struggle to access healthcare, and when they do, it is often ineffective. By contrast, medical schools report attempts to introduce inclusion health in curricula – these being limited by over-crowded (and difficult to shift) syllabi, driven by personal interests of individuals rather than a broader appreciation of the importance of access to and tailored delivery of healthcare for marginalised groups, and using educational interventions that treat the complexity of healthcare delivery of these groups at a superficial level.

The good news is that both interest and awareness of the needs of inclusion health communities is increasing, as is the need to prepare and equip the next generation of the healthcare workforce. The level of willingness to collaborate, from providers of services to inclusion health communities is strong; and medical schools themselves are planning and developing new approaches to teaching in this area. This report highlights some areas of innovation and cutting-edge teaching practice gleaned through deeper interviews with medical school colleagues.

*This emergent area is bristling with energy, enthusiasm, and new ideas. We invite you to consider its contents and perhaps champion the development of healthcare professionals in your area in this incredibly important field****.***

Please look out for the full report which is due for publication in the summer of 2024 after review and reflection with inclusion health community members and medical professionals working in the field.

INTRODUCTION

In today's diverse and complex healthcare landscape, the need for medical professionals to understand and address health inequalities faced by marginalised communities has never been more pressing. This **summary report** encapsulates the findings from our exploration into the integration of Inclusion Health (IH) education within undergraduate medical curricula in the UK.

Our report is the first to delve in to the perspectives of inclusion health communities and explore what they would like students to know about them, and how they think this should be taught. Simultaneously we investigate the views of medical school education professionals. In this pilot study, (which is part of a suite of inclusion health projects and activities emerging from Anglia Ruskin University's Faculty of Health, Medicine and Social Care) we have set out to understand what is currently being taught in medical schools around the broad area of Inclusion Health, how such learning is delivered, and the challenges encountered by medical educators when embedding IH learning into the current undergraduate medical curricula. By triangulating insights from both groups of key stakeholders, we have been able to offer a comprehensive view of the barriers and opportunities that shape IH education today.

Through surveys and interviews with medical school professionals, we highlight the existing practices, methodologies, and curriculum design approaches employed across various institutions. We identify significant challenges such as time constraints to delivery of Inclusion Health education within a crowded mandatory curriculum, resource limitations, and varying levels of confidence among educators. Despite these hurdles, there is a clear commitment among the professionals who participated in our survey and interviews to incorporate IH teaching into medical education (albeit this often occurs in an ad-hoc, opportunistic, and non-compulsory manner).

Our findings underscore the crucial role of deep-rooted community engagement and collaboration in enriching IH education for medical students. Partnerships with IH communities, NGOs, and local organisations (as well as ensuring that educators and students are aware of resources available through key organisations such as the Faculty of Homeless and Inclusion Health), are pivotal in providing students with authentic insights into the lived experiences of

marginalised groups experiencing sub-optimal health resulting from intersectional exclusion and marginalisation. Such collaborations not only enhance learning but also foster empathy and cultural competence among future healthcare providers.

In response to the identified challenges, our recommendations advocate for a longitudinal integration of IH across all medical modules, strategic funding to support community partnerships, and innovative teaching methods including developing simulation technologies to mitigate lack of IH placements and/or to build confidence in students prior to entering an IH placement. We emphasise the importance of standardised unconscious bias training early in the curriculum to prepare students for culturally sensitive healthcare practice and the encouragement of student-led bottom-up initiatives which build upon student understanding and increase their desire to engage with IH populations and community in-reach opportunities.

By implementing these recommendations, medical schools can better equip their graduates to navigate the complexities of modern healthcare, ensuring they are prepared to provide equitable and inclusive care to all patients, regardless of background or circumstance. This executive summary serves as a roadmap towards enhancing IH education and fostering a healthcare workforce that reflects and serves the diverse needs of society.

AIMS OF THE STUDY

Health inclusion for marginalised and minoritised communities remains an important but under-developed aspect of medical curricula in the UK. Despite a growing awareness which connects the gap in training and professional knowledge to meaningful engagement with communities and wider conversations about how race, possession of certain protected characteristics and intersectional social exclusion impact health morbidity and mortality, it is unknown to what extent ‘inclusion health’ is included within medical school curricula.

Accordingly, the purpose of this study was to explore to what extent inclusion health is included within medical school curricula and to seek to understand marginalised communities’ experiences of receiving inclusive and informed healthcare support from medical professionals.

As such the overarching aim of this pilot study has been to establish how fit for purpose 'inclusion health' teaching is within medical schools.

This project aimed to generate research which can be used to better equip graduates to support the healthcare needs of diverse inclusion health communities through aiding medical educators who design medical curricula to understand opportunities or barriers which exist to embed inclusion health learning and placement opportunities with inclusion health support agencies, within medical education.

RESEARCH QUESTIONS

The following research themes formed the core of this pilot study as we set out to interrogate:

1. **The extent to which inclusion health learning is incorporated in medical curricula and content/delivery methods.**
2. **The perceptions, extent of knowledge and practice of academic/medical staff in delivering inclusion health learning to U/G medical students.**
3. **The opinions of support staff and policy professionals working in civil society settings with inclusion health groups on how fit for purpose medical school training is regarding understanding the health needs and social context of working with inclusion health groups.**
4. **To identify available best practice and resources required or utilised to support delivery of inclusion health training to undergraduate medical students.**

METHODOLOGY

Ethical approval for this project was granted by Anglia Ruskin Faculty of Health, Medicine, and Social Care Ethics Committee:

Reference: **ETH2223-4334**

The study employed three primary methods: a scoping review of pertinent literature, online surveys distributed to medical educators (directed initially to Deans or Heads of Medical School for distribution to relevant staff), and civil society/NGO professionals working with inclusion health groups. These were subsequently supported, and greater depth of understanding

gained through our undertaking a combination of focus groups (n=2) and in-depth interviews (n=6) with representatives of above two groups of participants:

Participants included medical professionals and professionals from Non-Governmental Organisations serving inclusion health (IH) communities. Predominantly participants in this category (NGO respondents) were individuals with lived experience of health seeking as a member of the specific IH population.

1. **Scoping Literature Review**:
    - A thorough scoping review was conducted across major academic databases (PubMed, EBSCO, Elsevier) and limited grey literature sources to examine inclusion health teaching in undergraduate medical education. The search strategy included keywords and controlled vocabulary terms related to 'inclusion health,' encompassing specific communities such as refugees, asylum seekers, and un-housed people.
    - Inclusion criteria focused on studies addressing inclusion health teaching in undergraduate medical curricula, while exclusion criteria ruled out studies focused solely on postgraduate education or non-English publications. Data collection involved screening titles and abstracts, followed by full-text assessment and data extraction, which included recording study design, teaching methods, and outcomes. Thematic synthesis identified key themes, approaches, challenges, and gaps.
2. **Online Surveys**:
    - Surveys were distributed to all 55 medical schools in the UK (supported by the Medical Schools' Council who endorsed the research and distributed information about the study to their members). From this approach to medical educators, we received 16 responses (29% response rate)
    - 46 NGO professionals and IH community members answered the community survey (distributed to a targeted sample and snowballed to approximately 100 individuals/organisations). The medical school survey focused on the inclusion of health training in curricula, while the NGO survey assessed the adequacy of such training from the perspective of civil society professionals.

3. **Focus Groups and Interviews**:
    - Five in-depth interviews and one focus group with medical education professionals, along with a focus group with eight NGO professionals, were conducted to delve deeper into the survey findings.
    - These sessions explored educators' perceptions and recommendations for best practice as well as an exploration of barriers to teaching inclusion health. The focus group with a diverse range of representatives of IH communities focused on recommendations for curricula enhancements and assessments.

The Framework Method (Ritchie & Spencer, 2002) was used to analyse qualitative data through identifying key themes and categories. The research team manually and collaboratively coded the data, synthesising findings within and across participant groups.

LITERATURE REVIEW

The increasing recognition of the importance of understanding the domains of 'inclusion health' when delivering medical interventions and care emphasises the need to address the way in which the social determinants of health impact marginalised and underserved populations. These populations, who are typically affected by multiple adverse factors such as poverty, homelessness, discrimination, substance misuse, and mental health issues, experience significant detrimental impacts on their health outcomes resulting from unequal distribution of social determinants. While the inclusion of health inequalities in undergraduate medical curricula is acknowledged as essential (Gillam et al., 2016), the extent and methodology of inclusion health education in medical schools remain unclear. This scoping review aims to map existing literature, identifying key themes, approaches, and gaps to provide a comprehensive overview of inclusion health teaching in undergraduate medical education.

The UK's multicultural and diverse population experiences health inequalities linked to class, gender, systemic racism, and colonial legacies, with inclusion health groups facing the most severe outcomes. These groups include people experiencing homelessness, sex workers, asylum seekers, and those in prison. NHS England defines inclusion health as addressing the

health needs of socially excluded individuals, who often face multiple overlapping risk factors like poverty, violence, and trauma. Poor access to health services and negative experiences are common due to systemic barriers. The Health and Care Act 2022[1] mandates NHS services to reduce health inequalities, leading to initiatives like Core20PLUS5[2], which targets inclusion health communities. Despite these efforts, the role of medical schools is often overlooked in strategies to improve outcomes for these groups, leaving graduates feeling unprepared to support diverse and complex communities.

The literature has found that healthcare professionals play a crucial role in addressing health disparities, in turn, necessitating comprehensive education on inclusion health. In the UK, inclusion health is variably covered in undergraduate medical curricula, typically focused on sessions enhancing knowledge, skills, behaviour, and attitudes toward marginalised communities (Gillam et al., 2016; Pathway, 2023; Sharman et al., 2021). However, exposure to inclusion health groups in lectures and placements alone is insufficient to embed knowledge and understanding and can perpetuate misinformation and stigma (Gostelow et al., 2018; Dixon et al., 2021). Effective educational practices include placements with diverse organisations, debriefing opportunities, and structured curricula. Innovations often come from medical school administration leads, but student-led initiatives, such as the Student Advocates for Diversity and Inclusion (SADI) at the University of South Carolina, demonstrate the potential for bottom-up approaches which enhance diversity and inclusion in medical education (Moss et al., 2016).

Existing literature suggests that intensive early-stage curricula focusing on diversity, equity, and inclusion (DEI), such as the 2-day orientation delivered at the University of South Carolina, show promise in building foundational communication skills and promoting equity (Davis et al., 2021). Addressing racism and intersectionality and safely facilitating uncomfortable conversations about privilege and marginalisation are crucial components of such learning. Inclusion health teaching has been found to benefit not only marginalised patients, but also diverse students and staff engaged in medical education.

[1] See https://www.legislation.gov.uk/ukpga/2022/31/contents/enacted.
[2] See https://www.england.nhs.uk/about/equality/equality-hub/national-healthcare-inequalities-improvement-programme/core20plus5/

IH Communities (a summary of literature)

The LGBTQ+ population in the UK faces significant health disparities, exacerbated during the COVID-19 pandemic, including barriers to healthcare access and workplace discrimination (LGBT Foundation, 2020, 2022; Stonewall, 2018; UK Government, 2017). Despite increased socio-political discourse, undergraduate medical education on LGBTQ+ health remains inadequate, with surveys indicating limited training and confidence among students (Arthur et al., 2021; Phillips et al., 2022; Parameshwaran et al., 2017). Educational reviews underscore the patchy integration of LGBTQ+ health issues into curricula, highlighting the need for standardised, comprehensive training across medical schools (McCann and Brown, 2018).

Despite the lack of undergraduate medical education relating to LGBTQ+ issues, educating healthcare professionals (HCPs) about LGBT-related healthcare is the most effective way to improve LGBT patients' engagement in healthcare (Hughs et al., 2018). The power of the curriculum is highlighted in Bintley's research (Bintley and Winning, 2020; Bintley, 2023), which identifies the lack of LGBTQ+ content in the undergraduate medical curriculum. Participants described the curriculum as a powerful entity that reinforces norms through its language and interpretation (Bintley and Winning, 2020). Their 2023 study further explores the lived experiences of LGBTQ+ medical students, highlighting fear and structural violence within the medical curriculum as constituted, and emphasising the need for intersectionality and transdisciplinarity (Bintley, 2023). Crowe et al. (2024) stress the need for LGBTQ+ specific educational programs, as most medical students reported no training on LGBTQ+ health during undergraduate teaching (64%).

Some articles offer practical solutions. Gibson et al. (2020) developed a student-driven curriculum in the US to train medical students in LGBTQ+ health, which included diverse components and certification. Salkind et al. (2019) describe a compulsory teaching program in London, which increased students' confidence in using appropriate language and in clinical assessments of LGBTQ+ patients. However, the focus remains on the lack of LGBTQ+ led teaching, or that which took onboard students and the communities' perspectives, with little exploration into their needs (Bintley, 2023), a gap our current research aims to fill.

Refugees, asylum seekers, and undocumented migrants. At the end of 2022, UNHCR UK data reported 108.4 million forcibly

displaced people worldwide. In the UK, there were 231,597 refugees, 127,421 pending asylum cases, and 5,483 stateless persons (UNHCR, 2023). The increasing number of new arrivals placed in ‘contingency accommodation’ across the UK means medical graduates will encounter individuals from diverse migratory backgrounds across the UK.

Refugees, asylum seekers, and undocumented migrants face significant healthcare access challenges in the UK, attributed to 'hostile environment' policies initially implemented in 2012 (Webber, 2019). Healthcare ‘policing’ (monitoring of who is entitled to obtain treatment and intrusive questioning over eligibility, embedded through discriminatory policies, deter members of these groups from accessing vital healthcare, resulting in detrimental health outcomes (Asef and Kienzler, 2022). There is typically a lack of education about these populations' healthcare needs in undergraduate medical curricula, leaving future Health Care Providers (HCPs) unprepared.

Historically, healthcare providers have not received systematic training in refugee health. Recent scoping reviews in the UK and US indicate that medical students still receive little training in this area (Rashid et al., 2020; Pittala and Jacob, 2023). Efforts to address this lacuna include frameworks for integrating refugee and asylum seeker health into curricula (Gruner et al., 2022; Man Jit and Jacob, 2024). Practical measures such as placements and workshops on refugee health have been suggested as essential (Hill et al., 2009; Sharman et al., 2022), along with learning from individuals with lived experience (Silver et al., 2023).

The teaching of **Gypsy, Roma, and Traveller (GRT)** communities’ health needs in undergraduate medical education is barely explored. GRT communities face numerous healthcare access barriers and discrimination (McFadden, 2018; Siebelt et al., 2017; Smith et al., 2017). Despite community-driven projects exploring healthcare needs, and civil society produced guides for healthcare workers, little is known about what GRT communities want medical students to know. This project has sought to bridge that gap by exploring GRT (and Showmen and Boater (SB) communities' healthcare experiences and educational needs.

The health needs of **individuals who engage in sex work** are rarely included in undergraduate medical curricula. Sex workers, particularly street-based workers, face significant health disparities and stigma. A systematic review by Johnson

et al. (2022) found few studies on interventions for sex workers' health, emphasising a focus on education aimed at sex workers on their health needs, rather than enhancing medical professionals' awareness. There has been no systemic assessment of how sex workers' health is included in medical education or how informed professionals can improve health outcomes.

Unhoused individuals face significant healthcare access challenges and worse health outcomes, including greatly reduced life expectancy, and typically multiple co-morbidities (Aldridge et al., 2018; Ogbonna et al., 2023; Reilley and Williamson, 2022). Medical students' attitudes towards unhoused individuals have been shown to impact healthcare delivery (Neil and Lester, 2003; Bucks and King, 2009). Placements in homelessness settings lead to better understanding and career intentions (Walsh et al., 2019), but students often feel unprepared to work in such contexts (Feldman et al., 2020). In the US, a student-led initiative developed a Homeless Health Curriculum Framework to address these gaps (Hashmi et al., 2020).

Conclusion

The current state of inclusion health teaching in UK undergraduate medical education is fragmented, with isolated efforts targeting specific communities. Some communities, such as GRT and sex workers, receive disproportionately less attention. There is a notable absence of community input into learning materials, with curricula often not centred on their perspectives. While innovative designs from the US offer inspiration, there is a need for comprehensive assessment and proactive engagement with community members to integrate their insights into UK curricula, ensuring inclusive and empathetic medical education.

COMMUNITY ORGANISATION FINDINGS

Our comprehensive study engaged professionals working with inclusion health communities, including those with personal lived experience. We set out to explore both the barriers and opportunities in healthcare access for these groups and professionals' views on including IH teaching in undergraduate curricula and how such teaching it should be delivered. The inclusive methodology we adopted highlighted both common challenges and specific issues unique to different inclusion health communities.

Survey Respondents

- **Total Respondents:** 46 NGO professionals working with diverse inclusion health groups in the UK.
- **Average Experience with IH populations:** 10.5 years per person.
- **Frequency of Engagement with IH groups (if not themselves a community member):** 47% daily, 31% weekly.
- **Engagement with Health Professionals:** 85% engage with GPs, 47% with community nurses, 45% with health outreach workers, and 42% with hospital doctors to support the population they work with.
- **Inclusion Health Groups Supported:** People with complex mental health needs: 55%; LGBTQIA+ people: 50%; Un-housed individuals: 47%; People with physical health needs or disabilities: 42%; Drug-dependent individuals: 36%; Refugees or asylum seekers: 33%; Care leavers and care experienced individuals: 27%; Individuals with irregular migration status: 24%; Gypsy, Roma, Travellers, Showmen, and Boaters: 24%; Survivors of trafficking and modern slavery: 20%; People detained in prisons or young offenders institutes: 18%; Sex workers: 11%; 'Others' (including multiple IH categories): 9%; Individuals in immigration removal centres: 7%

Civil Society Professionals' perceptions of Barriers to Health Professionals Engaging with IH Communities

- **Cultural Awareness:** 85% identified lack of understanding as the biggest barrier.
- **Training Deficiencies:** 78% reported insufficient training for healthcare professionals.
- **Unconscious Bias:** 69% highlighted unconscious bias as a significant issue.

- **Intersectionality:** 69% noted a lack of awareness about intersectionality in healthcare provision delivered to IH populations.

A notable issue identified by a third of respondents is the significant barriers posed by stigma and fear, which profoundly impact the communities they support. One survey respondent highlighted the importance of understanding intersectionality: **"Understanding intersectionality helps healthcare providers recognise how various factors such as race, gender, socioeconomic status, and disability intersect to influence health outcomes and access to care."**

Another respondent emphasized the detrimental effects of negative experiences with primary healthcare, stating, "**Over 90% of the people I speak to each day have bad experiences with their GP practices. Their experience with primary healthcare greatly affects their mental health and wellbeing."**

Additionally, a third of respondents indicated that fear of litigation hinders adequate healthcare provision, with concerns also raised about the politicization of LGBTQ+ lives affecting healthcare.

Focus Groups

The focus group engaged with participants who worked with a wide range of communities, particularly those associated with inclusion health (IH) groups. Many of these participants had personal lived experience of being part of these IH communities, adding valuable insights to the discussions.

Main IH Community Participant Supported	Participant with lived experience
Roma	Yes
Migrants	Yes
LGBTQ+	Yes
LGBTQ+ (The Trans community)	Yes
Migrants	No
GTRSB (Boaters)	Yes

People with complex mental health needs	No
Un-housed people	No

Solutions Posed by Inclusion Health Communities

Focus group and survey participants discussed the importance of integrating inclusion health teaching into undergraduate medical education. They emphasised that community voices should be involved from the outset of curriculum development, ensuring that the curriculum addresses the needs of inclusion health communities effectively. Participants highlighted the benefits of such integration, particularly in enhancing cultural awareness and improving health outcomes.

An overwhelming majority (98%) of survey respondents believed that early-stage cultural awareness education in medical schools would improve health outcomes for the communities they support. Additionally, 100% of focus group participants supported teaching the needs of inclusion health communities to undergraduates, with one participant noting,

"This is the content in which the medical students will work, and they need to appreciate this aspect is as important as all others." Another added, "**If a medical student is culturally aware, they won't be part of compounding stigma and therefore individuals will access healthcare more and earlier, increasing positive health outcomes."**

However, concerns were raised about the inconsistent and ad-hoc incorporation of inclusion health teaching in medical curricula. Participants noted that such teaching often relies on the commitment of individual staff members rather than being a compulsory component, limiting its impact. They stressed the need for dedicated funding and institutional support to sustain and expand these programs. One LGBTQ+ advocate explained,

"**There's a commitment fee here. It doesn't come cheap... institutions should make budgetary provisions to bring people in who can add value and have experience."**

The predominant recommendation was to incorporate learning from individuals with lived experience. This included consultation on curriculum content with community members, placements in relevant NGOs for students, and comprehensive training on unconscious bias. This approach aims to equip

students with the necessary knowledge and sensitivity to engage with inclusion health communities effectively, avoiding re-traumatisation and perpetuation of stigma. An advocate for un-housed people remarked**, "It's incredibly important for them to meet those people outside of perhaps when they're in crisis... to understand what's going on outside of that."**

Participants shared positive feedback from past collaborations with educational institutions but noted that the elective nature of inclusion health teaching impedes systemic change. A GRT advocate stated**, "Maybe it should be made a little bit more... compulsory."**

Participants supported undergraduate placements in inclusion health settings but noted challenges to this approach, such as the lack of local organisations capable of supervising students and aligning placement skills with GMC learning outcomes. While 44% of survey respondents welcomed placements, others highlighted a more cautious approach and the need for prior unconscious bias/ empathy training to prevent re-stigmatisation. A migrant rights advocate emphasised**, "Healthcare is a service and there's no reason that they shouldn't have the same person-centred, compassionate client care skills that we expect from all service professionals."**

Focus group participants particularly emphasised the importance of soft skills, such as patient-centred and trauma-informed approaches, supported by robust theoretical learning embedded into the curriculum. An advocate for un-housed people noted, **"It could be quite broad cultural awareness... just to get a really good grounding of what goes on for these people [IH communities] from morning to night."**

Participants also discussed incentivising student engagement with inclusion health communities, suggesting integration of such learning into medical exams and recognition given for extracurricular activities. They argued for the inclusion of people with lived experience in the examination process, with an LGBTQ+ advocate stating, **"It's absolutely critical that there's a process of lay examination in all these professional exams... it will really make an impact in their knowledge and application in a relationship with a patient."**

MEDICAL PROFESSIONALS' FINDINGS

Survey findings (n=16) and interviews (n=6) with medical educators revealed that 90% of respondents incorporate IH modules into their curricula, underscoring a commitment to addressing health disparities amongst our (self-selected) participants.

LGBTQIA+ health emerged as the most frequently addressed topic (94% identified by of respondents), reflecting dedicated efforts by educators with personal interest in the subject area. However, teaching on other marginalised groups such as sex workers and Gypsy Roma Traveller, Showmen and Boater (GRTSB) communities remain underrepresented (only referenced by 12% of respondents), highlighting gaps in curriculum inclusivity. According to one medical school professional, **"I think it's sort of there in little bits and pieces especially when someone [a medical educator] has lived experience themself."**

The primary barriers to greater IH teaching in the curricula were identified as time constraints (71%), inadequate resources (64%), and varying levels of educator confidence (36%) in teaching about diverse IH communities. These challenges hinder comprehensive curriculum development and effective delivery. As one interviewee noted, **"Curriculums are so hacksaw ready, aren't they? You always need to, if you put extra stuff in... gotta take something out of it."**

Whilst overall only 14% of respondents reported student enthusiasm as a barrier, deeper insights revealed in focus groups and interviews unearthed a more nuanced understanding of the issue. Some students were reported to engage with IH topics primarily to enhance their CVs, rather than out of genuine interest or empathy. Such strategic behaviour underscores the need for structured IH components embedded within curricula to foster authentic engagement and long-term commitment to IH communities. According to a medical school professional**, "I think the students that I always... if I'm feeling cynical - I think they always want something to put on the CV that they did something different."**

Interviewees proposed several strategies to strengthen IH education, including student-led initiatives and strategic funding for NGOs supporting IH communities. Longitudinal integration of

IH principles across all medical specialties was also highlighted as essential to equipping future doctors with necessary skills. Reflecting on this, one educator suggested, **"It's not a niche interest that is done by just a few specialist practitioners. I think it's a topic that every doctor, no matter where they're working, needs to be equipped to deal with."**

One of the critical challenges in integrating inclusion health (IH) education into medical curricula lies in the practicalities of placements and meaningful community engagement. While medical school representatives expressed a strong desire to expose students to IH communities, logistical constraints often hinder these efforts.

Scarcity of IH-Specific Placements

A recurring issue highlighted by medical educators is the scarcity of IH-specific placements for medical students. Many medical schools struggle to secure placements that provide structured, meaningful exposure to IH communities. This shortage is exacerbated by the limited capacity of local practices and specialist services to accommodate the number of students needing placements. As one medical school professional lamented, **"We've got 300 students in each academic year, and we just can't physically get them all through an inclusion health practice locally."**

In addition to specialised placements, primary care settings that encounter a high volume of IH group patients, such as A&E departments and GP surgeries, also face challenges in hosting medical students. These settings are often stretched thin with limited resources and staff, making it difficult to prioritise educational placements alongside patient care. One educator elaborated, **"Many practices are struggling just to keep the lights on and do firefighting. Some practices simply lack the spare capacity to start or increase engagement with medical students."**

Another proposed solution involves training IH community members themselves to act as educators within medical education settings. This approach aims to create a more inclusive and authentic learning experience for students while empowering community members to share their expertise and perspectives directly. Medical educators envision community members not only sharing personal narratives but also leading teaching sessions and developing educational materials. As one interviewee suggested, **"Getting expert patients to come and**

do teaching rather than just tell their stories would be a good way of resolving some of the capacity issues."

Despite the potential benefits, engaging community members as educators requires careful planning and consideration. Concerns about safeguarding and re-traumatisation of individuals with lived experience are paramount. Medical schools must develop robust frameworks and guidelines to ensure that these engagements are safe, respectful, and mutually beneficial. As highlighted by one medical professional, **"It's risky bringing people with lived experience into lectures. It needs to be done really carefully so as not to retraumatise people."**

To mitigate some of these challenges, educators are interested in exploring the use of technology and simulation. Virtual platforms allow for safe interactions between students and IH community members, minimising logistical barriers and providing controlled learning environments. However, there is a cautious recognition that while technology can scale up education, it may also depersonalise the learning experience. As one educator noted, **"What you gain in scaling up, you perhaps lose in the personal human interaction that is so key to this subject."**

Conclusion

Addressing the challenges of placement and meaningful community engagement is essential for enhancing IH education in medical schools. By expanding placement opportunities, training community members as educators, and leveraging technology, medical schools can provide students with more comprehensive and authentic experiences in IH education. These efforts in turn not only enrich student learning but also strengthen partnerships with IH communities, ultimately improving healthcare delivery and outcomes for marginalised populations.

POLICY RECOMMENDATIONS

Triangulating findings from our two groups of participants shows a surprising level of shared understanding of how best to enhance training for medical students to increase patient experience, and ultimately their engagement with health services.

It is noteworthy that 100% of participants in both groups felt that exposing undergraduate to inclusion health teaching – suitably supported by engagement with representatives of organisations or with lived experience – would benefit both students and service users.

Accordingly, we make the following recommendations:

- Undergraduate (HEIs) and Postgraduate (Deaneries and Royal Colleges) educational bodies need to work closely with specialist organisations (e.g. Faculty of Homeless Health/Pathway) to support the development and design of core standards in Inclusion Health education across the whole learner journey.
- It is recommended that Inclusion Health education is incorporated (e.g., as longitudinal integrated clerkships) into undergraduate medical curricula.
- Mandatory unconscious bias training, with a focus on inclusion health populations, should be delivered to undergraduate students during the early stages of their course.
- Actively engaging students in co-design of learning is needed to enhance engagement in IH.
- Heads of Medical Schools and Deans should actively support engagement of civil society organisations working with inclusion health groups in their locality, so as to encourage collaborative teaching and placement opportunities.
- Involvement of IH communities (properly remunerated) in the co-production of learning materials is required, developed with local community partners to enable students to develop a nuanced understanding of local circumstances and populations.
- HEI assessment processes should actively incorporate IH competencies, with input from people with lived experience as members of IH populations.

- Preparation for students to enter placement requires mandatory pre-placement development activities for the student alongside pre-placement and on-going support for host agencies.
- New technology and simulations should be used as an adjunct to working in IH settings, be appropriately developed in collaboration with IH agencies and seen as an adjunct, not a replacement for a placement within such a setting.

FULL LIST OF LITERATURE CONSULTED

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