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Article type : When I Say

When I say diversity

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This is the author manuscript accepted for publication and has undergone full peer review but has not been through the copyediting, typesetting, pagination and proofreading process, which may lead to differences between this version and the [Version of Record](#). Please cite this article as [doi: 10.1111/MEDU.14299](https://doi.org/10.1111/MEDU.14299)

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Diversity has become an important term in medical education, impacting on curriculum design, selection policies, and school culture. For some, it may have acquired the status of a 'god term', an essential concept which influences and guides educational practice, yet may also be used as a 'rhetorical absolute',¹ as has been suggested for the term 'competence' in medical education.² This positioning recognises the significance of diversity as a concept. However, it may also do as much disservice as would resistance or scepticism, as it does not encourage the necessary 'unpacking' of the complexity and evolution of diversity as a key educational idea.

Historical and social factors influence what diversity refers to or prioritises. Not long ago, diversity would have been presumed to refer exclusively to race-based civil-rights issues. For example, President Truman's 1948 *Executive Order 9981* establishing equality of treatment and opportunity in the USA armed services for people of all races, religions, or national origins is widely considered the first diversity initiative. Discourses on diversity have since evolved to include a broad range of demographic dimensions, both sociocultural and individual. Diversity's focus has also shifted from solely visible characteristics (ethnicity, gender, age, disability) to encompassing the less visible or secondary dimensions of diversity, such as religion, sexuality, marital status, socio-economic status, and so on.³

Even though the protection of such aspects may be enshrined in universal declarations on human rights and cultural diversity, it may still be imperative to address particular diversity characteristics in one context, while in another context, addressing others may be more necessary. Such a nuanced approach to diversity is also suggested by the notion of intersectionality, which recognises the multiple and 'entangled' categories which make up a person's identity, resulting from a 'myriad of social and political influences'.⁴ It is clearly no simple matter to cite 'diversity' and expect others to fully understand its meaning or use; context is crucial.

Diversity is also much more than a charitable concession to the historically marginalised. In medical education, for example, the grounds for supporting diversity can vary: economic, arguing that diversity is necessary to compete in the global economy; competence-based, in that health systems

need the wider population to be fully represented in the health workforce for service quality and cultural access reasons; and moral, to the extent that institutions within a society have a responsibility to reflect the individuals who make up society. Diversity might even be supported on meritocratic grounds, consistent with the belief that the capacity to be a good doctor is unrelated to gender, race/ethnicity, sexuality, socioeconomic status, and so on. Even the apparently neutral notion of 'academic merit' is not immune to challenge, for as others have noted, determining the criteria for such merit still involves the exertion of hegemonic power in determining what counts as excellence.⁵

Other critiques draw attention to the inherent educational advantage usually enjoyed by the historically established and socially advantaged group. Privilege, in its simplest definition, is understood to be those rights, benefits and advantages enjoyed by a person or body of persons beyond the advantages of other individuals. Typically (but not always), it is the majority group in a society that holds the power and economic resources. What gets considered under diversity is then determined by that majority group as another manifestation of its power, along with offering 'others' (those who are different from them in a critical way) an opportunity to be represented in the majority group. This and similar manifestations of power decide how social relationships may be organised, justified and perpetuated, often through 'legitimising myths' (e.g., categorising people from widening access backgrounds as somehow different to 'traditional' students.) Valuing diversity therefore means reflecting on the significance of language, and avoiding discourses of 'them' and 'us'.⁶

Growing awareness of how privilege plays out in medicine is increasingly apparent in the medical literature.^{e.g., 7-8} However, this has not necessarily translated into material changes, and in many cases is met with varying degrees or forms of resistance, as writers such as Saleem Razack and Javeed Sukhera have insightfully explored.⁹⁻¹⁰ Yet only by challenging and potentially disrupting the accepted practices of educational systems and structures which subordinate certain groups can medical education go beyond 'vague platitudes'⁹ to achieve progress in terms of diversifying who applies for medical school, who is accepted into medical school (and who successfully completes the course), and what institutional and professional norms need to change to enable progression around diversity. Instead, diversity is frequently considered to have been 'done' by making one or more kinds of diversity characteristics a key criterion for selection, or ensuring various groups are discussed within the curriculum, or through assessing 'diversity' primarily as an individual skill important for patient outcomes.

Rather, diversity is evolving into an educational value which goes well beyond compositional or curricular criteria.¹¹ This arguably gives diversity a broader remit than related values such as equity and fairness, topics which have already been addressed in this series.¹²⁻¹³ If equity and fairness strive for a level playing field, recent ideas about diversity represent an approach which actively promotes the full expression of excellence in medical school and clinical practice.^{11,14} As many have noted, it is not enough to identify and celebrate remarkable individuals who succeed despite existing inequities; we need to create suitable clinical and educational environments that allow excellence to flourish, in all its intrinsic diversity.^{9,14} Such an approach requires manifesting values such as acceptance, inclusiveness, mutual respect and a firm belief in the inherent richness of the variety of human experience and perspective. In other words, an environment in which everyone can feel that they belong,¹⁵ or where the notion of 'we' has greater resonance than 'us' and 'them'. This is a considerable challenge, given the privileged status of the profession, and its established historical and sociocultural practices.

When we say diversity, then, we mean a noun, not a verb. Rather than 'doing diversity', we see diversity as an explicit value position which holds that excellence in medical education and practice can only truly occur once historical obstacles are recognised and addressed, and the notions of belonging, inclusion and virtue in difference are authentically embraced. Ultimately, diversity efforts must be directed at 're-calibrating' the system so that unacknowledged privilege is no longer the default setting for access and opportunity in medical education.

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Date:

2020-10

Citation:

Chiavaroli, N., Blitz, J. & Cleland, J. (2020). When I say ... diversity. MEDICAL EDUCATION, 54 (10), pp.876-877. <https://doi.org/10.1111/medu.14299>.

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