NHS RACE & HEALTH OBSERVATORY
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Structural Inequities and Student Agency in Medical Education:

A Rapid Review of Representation, Knowledge, and Reform

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Glossary

Advocacy–Resistance Dynamic: A conceptual framing in which student or clinician advocacy may simultaneously function as institutional resistance, particularly when challenging hierarchical or discriminatory systems.

Autocatalysis (in Medical Education): A metaphor describing students as agents of change whose actions accelerate further institutional reflection, reform, and cultural shift once initiated.

Cultural Competency: The ability of healthcare professionals to interact effectively with patients from diverse cultural backgrounds, encompassing knowledge, attitudes, and communication skills.

Cultural Safety: An extension of cultural competency that focuses on power imbalances, institutional structures, and the patient's experience of safety within healthcare systems.

Decolonisation of Medical Education: The process of critically examining and restructuring curricula to address Eurocentric bias, colonial legacies, and epistemic exclusion in healthcare knowledge.

Differential Attainment: Systematic differences in academic or clinical performance outcomes between student groups, often associated with ethnicity, socioeconomic background, or other structural factors.

Epistemic Inequality: Inequality in the production, validation, and inclusion of knowledge systems, leading to marginalisation of non-dominant perspectives in medical education and research.

Epistemic Pluralism: An approach that recognises multiple valid knowledge systems (including non-Western and Indigenous frameworks) in understanding health and illness.

Eurocentricity: A worldview that centres Western biomedical knowledge as universal, often marginalising alternative cultural or historical understandings of health.

Health Inequalities: Systematic and avoidable differences in health outcomes between population groups, often driven by social, economic, and structural determinants.

Medical Education Curriculum: The structured content, teaching methods, and assessment frameworks used to train medical students.

Tokenism: Minimal or symbolic inclusion of marginalised groups or perspectives, often performed to demonstrate diversity without meaningful structural change.

Structural Racism: Systemic embedding of racial inequality across institutions, policies, and practices, producing differential access, outcomes, and experiences.

Widening Participation: Initiatives aimed at increasing access to medical education for individuals from underrepresented or disadvantaged backgrounds.

SOCRATES*: The name of a widely used clinical mnemonic used by medical professionals and paramedics to evaluate a patient's pain; Site, Onset, Character, Radiation, Associations, Time Course, Eating/Relieving Factors, Severity.

Contents

1. Aim of This Rapid Review

1.1 Aim and Objectives of the Review

This review is intended for students, faculty members, stakeholders, prospective advisory board members, and personnel within the NHS Race and Health Observatory who are interested in understanding how meaningful change can be enacted by students and earlycareer professionals across different stages of their careers and within diverse organisational settings. It offers a reflective and evidence-informed exploration of equity within medical education, based not only in policy and research, but also in the lived experiences of those navigating and challenging these systems.

1.2 Students as Autocatalysts for Change

Within this review, I aim to outline the current state of representation in medical education, examine the impact of structural racism within medical education systems and evaluate how clinical students contribute to reducing health inequalities. Central to this work is the recognition of students as autocatalysts for change- individuals capable of influencing and reshaping clinical education through advocacy, leadership, and lived experience (Luman A, Lamb SM, Stevenson A, Lindsley JE, 2021).

1.3 Methodology and Participant Reflections

A key component of this work involves extracting lessons, reflections, and journeys from medical students studying across a range of medical schools based in England. Through structured interviews conducted over Microsoft Teams, participants shared personal experiences and insights developed throughout their educational and professional journeys. The review also proposes actionable strategies for embedding equity within medical education, with recommendations directed towards students, educators, and NHS organisations alike.

These hour-long conversations explored themes surrounding representation, inequity, allyship, institutional culture, and systems change, situated alongside evidence-informed research, statistics, and case studies. Their testimonies are interwoven throughout the review as real life narratives supporting the themes covered in this work.

1.4 Participant Profiles

The interviewees include:

- Dr Humaira Ahmed BMBS, BSc (Hons) is a resident doctor and founder of Skinclusive Hub (Skinclusive Hub, 2026), an award-winning digital health platform dedicated to advancing skin diversity, improving education on skin of colour, and promoting inclusive research within medicine and dentistry.
- Adan Khan is a former medical student and founder of Diversity in Medical Academia (DIMA, 2026). With interests spanning biomedical engineering, artificial intelligence, and digital health, his work focuses on developing innovative, patient-centred solutions to contemporary healthcare challenges.

- David Bahibanda is a final-year medical student and incoming resident doctor whose work and reflections are informed by his Congolese heritage (David Bahibanda, 2026), with a particular emphasis on the role of cultural understanding in delivering compassionate, person-centred healthcare.
- Georgina Shajan is an award-winning and published final-year medical student with interests in general practice, paediatrics, and medical leadership. She has held leadership positions including, a role in the Association for the Study of Medical Education Equality, Diversity and Inclusion Committee (Georgina Shajan, 2026), contributing to initiatives focused on healthcare improvement, medical education, and equity in medicine.

1.5 Structure and Scope of the Review

This review seeks to dissect the macrosphere of equity in medical education through a series of focused themes and discussion points. While it does not attempt to cover every dimension of the topic, it is intended to serve as both a trigger for continued dialogue and a catalyst for actionable change within medical education systems.

2. Structural Inequities in Medical Education

2.1 Medical Education as a Structural Determinant of Health

Racial and Ethnic health inequalities remain a persistent feature of healthcare systems in the UK (Robertson R, Williams E, Buck D and Breckwoldt J, 2021). While much attention has been paid to disparities in clinical outcomes, there must also be a shift towards the educational structures that shape future clinicians. Medical education is not a neutral system. Curricula, teaching materials, and assessment frameworks actively shape how future doctors recognise, interpret, and manage disease. As such, inequities embedded within education risk being reproduced in clinical practice (Dr Gishen F, 2020)

2.2 Social Accountability and Institutional Responsibility

Since the late twentieth century, there has been growing recognition that medical education should extend beyond scientific knowledge and technical competence to include wider social responsibilities. Momentum for socially accountable medical education increased following the 1988 declaration by the World Federation for Medical Education, which emphasised that medical schools have a responsibility to respond to the health needs of the populations they serve (Abdalla MN, Osman A, Mahmoud N, Harney SC, Abdalla ME, 2025). Despite this, surveys by the British Medical Association in 2018 found that 45% of Black, Asian and minority ethnic doctors felt there was neither respect for diversity nor a culture of inclusion within their workplace (BMA, 2026). Initiatives such as the 2020 British Medical Association racial harassment charter also highlighted the need to address racial inequities within medical education and healthcare environments (BMA, 2025).

2.3 Diversity, Representation and the Hidden Curriculum

While it has been found that the NHS workforce and UK medical school cohorts are becoming increasingly diverse, many students and healthcare professionals from racially minoritised backgrounds continue to experience exclusion within medical education and clinical practice.

2.4 Anti-Racist Frameworks and Institutional Gaps

Recommendation 20 of the Commission on Race and Ethnic Disparities, *Making of Modern Britain: teaching an inclusive curriculum*, argued that diversifying educational curricula from an early stage may help challenge societal prejudices and improve understanding of the diversity and history of the UK population (GOV.UK, 2021)

The medical curricula function as a litmus test for how seriously institutions prioritise antiracist healthcare. While frameworks exist, such as the Medical Schools Council Decolonisation Framework (MSC, 2025) and the NHS Workforce Race Equality Standard (NHS England, 2025) their implementation remains inconsistent between university institutions (and teaching hospitals)**.** This creates a gap between policy intent and educational practice. Institutional responses to inequities in curricula are therefore not merely academic decisions; but they reflect broader commitments to equity, accountability, and patient care among medical students (Bayer A, Crutchfield P. 2024)

2.5 Students as Agents of Educational Reform

Students occupy a unique position within medical education: they hold the potential of being both recipients of knowledge and active participants in shaping learning environments. The concept of students as autocatalysis, a process that accelerates itself once initiated, provides a useful framework for understanding student-led change in medical education. Their lived experience of curricula provides direct insight into where gaps, biases, and omissions exist (Heck AJ, Cross CE, Tatum VY, Chase AJ. 2023). Focusing on students also allows us to identify inequities at the point of knowledge transmission; understanding how educational exposure shapes clinical confidence.

3. Lived Experiences of Student Advocacy and Institutional Change

3.1 Cultural Competency and Communication in Clinical Education

Incoming Resident Doctor, David Bahibanda, described engaging in advocacy work aimed at improving cultural competency and communication within healthcare education and practice. His work included delivering a TEDxNHS talk exploring cultural practices (TEDxNHS, 2026), contributing to NHS England panel discussions and developing public-facing educational resources focused on culturally responsive communication. He described “showing them different ways of how to communicate” and “creating an awareness essentially around cultural competency.” Through these initiatives, David demonstrated how students can contribute to reducing health inequalities by broadening conversations surrounding communication, cultural understanding and patient-centred care. His work reflects the growing role of students not only as learners within medical education, but also as educators and advocates capable of influencing wider institutional discourse (Bertolini L, Debby Gerritsen D and Sol K, 2024)

3.2 Accessibility, Neurodiversity and Inclusive Education

Final year medical student, Georgina Shajan similarly contributed through a range of initiatives focused on accessibility, equity and inclusion within healthcare education. Her work included involvement with the Association for the Study of Medical Education Equality,

Diversity and Inclusion Committee, development of a cultural competence toolkit and research exploring the experiences of autistic medical students. She also contributed to podcasting and healthcare improvement campaigns aimed at promoting more inclusive communication and educational practices. These initiatives addressed gaps in awareness and representation for groups whose experiences may otherwise remain marginalised within healthcare education systems. Through combining advocacy, research and educational development, Georgina's work illustrates how students can influence institutional culture from within.

3.3 Research Accessibility and Representation

Former medical student turned engineer as well as Founder of DIMA, Adan Khan focused on widening participation within academic research and addressing inequities in access to research opportunities. Through mentorship schemes, networking opportunities and educational sessions, the organisation sought to reduce structural barriers disproportionately affecting underrepresented students pursuing academic medicine. Adan's work highlights how student-led organisations can redistribute opportunity within medical education and challenge exclusionary structures surrounding research participation and academic advancement.

3.4 Skin of Colour Education and Clinical Representation

Resident Doctor and Founder of Skinclusive Hub, Dr Humaira Ahmed also contributed through sustained advocacy surrounding skin of colour teaching, cultural competency and inclusive healthcare education. She emphasised the importance of collaboration between students, faculty and institutions in creating sustainable educational reform, particularly through conferences, teaching programmes and awareness campaigns. She further argued that students should be involved earlier in curriculum design and policy discussions, positioning students as active stakeholders rather than passive recipients of education. Her reflections reinforce the importance of students as co-creators of reform whose lived experiences, advocacy and educational initiatives can help shape more inclusive and clinically relevant approaches to healthcare education.

While work is being done nationally to address inequalities in student, peer, patient and professional experiences of global majority groups (Bansal N, Karlsen S, Sashidharan SP, Cohen R, Chew-Graham CA, Malpass A. 2022) representation within medical education remains limited in practice among certain regions of the UK. Despite current evidence suggesting that diversity within medicine and medical education is increasing numerically **(**Charnell AM, Dennis CA. 2025). Whether that includes cultural competency, skin representation, research participation or institutional support of student- led work, many institutions continue to struggle with embedding inclusivity meaningfully within curricula, faculty development and teaching culture (Katherine S, 2019). Addressing these issues within the review will hopefully shift beyond a tokenistic approach, towards structural change that centres diverse perspectives, lived experiences and genuine partnership with both students and patients.

4. The Medical School-to-NHS Workforce Pipeline

4.1 Students Within Systems of Change

The medical school-to-NHS workforce *(see figure 1)* pipeline provides a useful framework for understanding how students can drive meaningful change within healthcare education and clinical practice. Rather than viewing students as passive recipients of knowledge, the pipeline demonstrates how learners occupy a unique position within systems of medical education: they simultaneously experience institutional shortcomings while also possessing the capacity to challenge and reshape them (Heck AJ, Cross CE, Tatum VY, Chase AJ. 2023). By tracing the journey from entry into medical school through to leadership within the NHS, the pipeline highlights how advocacy can evolve from grassroots student action into long-term institutional reform.

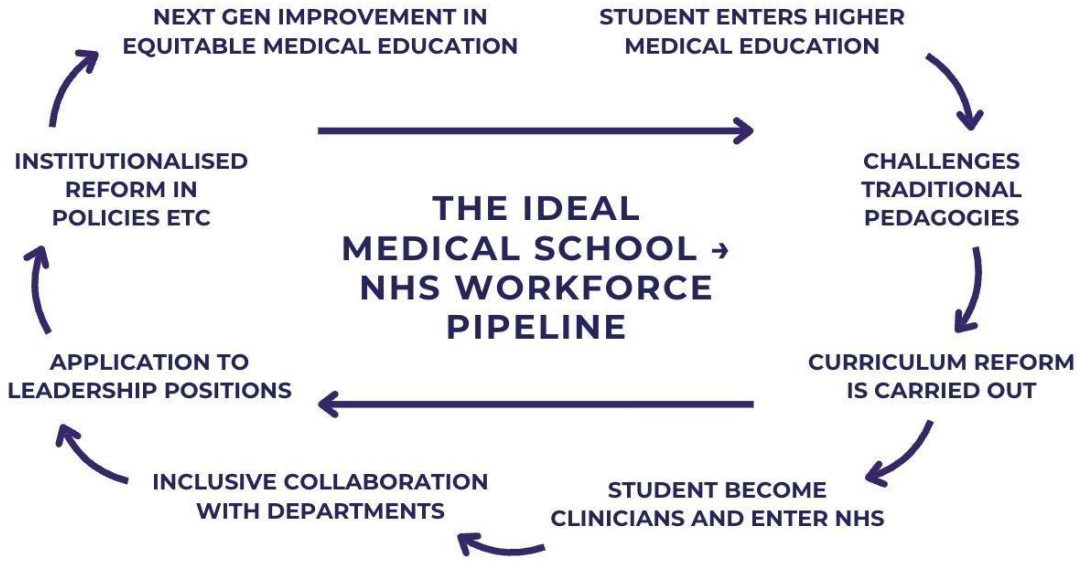

Figure 1- The medical school-to-NHS workforce (image created by Naabil Khan 22/05/26)

At the earliest stages of medical education, students are often among the first to identify gaps in representation, cultural competency, and inclusive teaching. Their lived experiences and direct engagement with curricula allow them to recognise inequities that may otherwise remain normalised within educational systems (Julian B, 2025). Exposure to traditional pedagogies, limited diversity in teaching materials, and culturally narrow approaches to communication frequently act as catalysts for advocacy.

4.2 From Grassroots Advocacy to Institutional Reform

The pipeline is particularly valuable because it demonstrates that advocacy does not occur in isolation. Student-led change often begins through feedback, research, committees, societies, audits, and grassroots educational initiatives. These activities create pressure for curriculum reform and encourage collaboration between students, educators, NHS organisations, and policymakers (Markham J, 2024). As students become increasingly involved in curriculum review, cultural competency initiatives, and anti-racist healthcare

discussions, they help transform equity from a peripheral issue into a core educational priority.

4.3 Sustainability and Leadership Development

Importantly, the pipeline also illustrates how advocacy can become sustainable over time. Students who engage in reform during medical school eventually transition into clinical practice, bringing with them a stronger awareness of health inequalities, culturally responsive communication, and structural inequities within healthcare systems. Over time, these clinicians may progress into educational, research, and leadership roles within the NHS, where they are positioned to influence policy, workforce development, and institutional priorities (Vamadevan A, Vijayan V, Jayasudha K, Varghese S, Eboh O, Karthikeyan A, Cole C, and Walker L, 2025). Their earlier experiences as student advocates therefore shape future systems of teaching and clinical care.

4.4 Embedding Equity Across Future Healthcare Systems

This cyclical model is central to understanding long-term change. Advocacy initiated at student level does not end upon graduation; rather, it becomes embedded within future leadership structures and institutional policy. As reforms become institutionalised through curriculum redesign, inclusive recruitment, accountability frameworks, and policy implementation, future generations of students enter more equitable learning environments.

The pipeline therefore demonstrates how student advocacy has the potential to create selfsustaining improvement across medical education and the NHS workforce. It reinforces the idea that improving equity within healthcare education requires not only institutional commitment, but also recognition of students as powerful contributors to reform, accountability, and the ongoing pursuit of equitable patient care.

5. The Role of Institutions and Anti-Racist Strategy

5.1 Institutional
Support and Systems Leadership

While focusing on individual change, the systemic/ institutional backing and guidance of organisations such as the Race and Health Observatory play a critical role in bridging gaps between students, healthcare professionals, as well as policy makers with evidence and practice**.**

5.2 The NHS Race and Health Observatory Framework

The RHO strategy for 2025-2027 on the principles of anti-racist care was curated to give guidance to readers on how to effectively implement inclusive care, policy and education. Interpreting this model as a directional plan for student involvement in anti-racist care can provide an initial idea of how change can be sustainable achieved *(see Figure 2).*

Figure 2- Model of the RHO strategy for 2025-2027 in a student context with examples given by the student interviewees (influenced by the RHO Anti-Racist Toolkit but image created by Naabil Khan 22/05/26)

6. Structural Racism, Epistemic Bias and Decolonising Medical Education

6.1 Structural Racism Within Medical Education

Structural racism within medical education extends beyond curriculum content. It is embedded within institutional culture, admissions processes, assessment practices, research priorities, and policy implementation. In healthcare education, systemic racism contributes to the persistence of racial health inequalities by shaping how future doctors understand disease, diagnose patients, and interpret evidence (Terrance TC, Sugarwala L, McIntosh S, Bisbee-Burrows M, Castillejo L, Evans A, Reed K, Rogers K, Cullen JP, 2022)

Consequently, medical education can unintentionally legitimise inequitable healthcare practices if structural determinants of health are not critically addressed (Baciu A, Negussie Y, Geller A, et al, 2017). Evaluations of medical education systems consistently identify structural inequities across curricula, clinical teaching, assessments, research systems, and institutional governance. Addressing structural racism therefore requires more than increasing diversity alone. It involves critically analysing and reforming academic structures such as the curricula, improving representation of physical models and clinical perspectives, embedding anti-racist teaching, and ensuring that healthcare training accurately reflects the social drivers of health inequities (Dent RB, Vichare A, Casimir J. 2021).

This need for an identification and challenge to the structural racism seen in academia was echoed by all participants. With some defining structural racism, based on their lived experiences, not necessarily through overt exclusion, but through omission, invisibility, and the normalisation of dominant perspectives within medical education. Participants highlighted how institutional systems continue to privilege particular forms of knowledge while marginalising alternative cultural understandings of health, identity, and patient experience.

6.2 Cultural Competency and the Limits of Biomedical Frameworks

Incoming Resident doctor, David Bahibanda, argued that cultural competency was frequently treated as supplementary rather than fundamental to medical training, reflecting broader institutional assumptions about what constitutes “core” medical knowledge. He identified structural issues within healthcare education through what he perceived as the prioritisation of biomedical efficiency over cultural understanding. His reflections also suggested that dominant educational frameworks continue to privilege Eurocentric biomedical perspectives while overlooking the social, cultural and historical dimensions of patient care. In doing so, healthcare education risked reinforcing inequities through the selective validation of knowledge considered legitimate or worthy of inclusion.

Reflecting on clinical communication training, he explained: “We use SOCRATES* a lot when looking for a clinical diagnosis.” While such frameworks support diagnostic reasoning, he suggested they can narrow the way students approach patient interactions and social histories. As he described, social histories often become reduced to familiar categories such as alcohol consumption or smoking, rather than broader exploration of cultural beliefs, lived experiences or healthcare practices. David acknowledged that many institutions are attempting to improve in this area, particularly through communication teaching and problem-based learning (PBL) scenarios. However, he suggested that meaningful engagement with cultural diversity often depends on students who already possess cultural awareness introducing these conversations themselves. Thus isolating and separating students based on background expertise rather than standardised competences in medical education. For

David, cultural competency continues to be treated as an “addition” to clinical teaching rather than an essential component of patient assessment and communication.

6.3 Colonial Legacies and Global Health Education

These concerns were reflected within wider critiques of global health and medical education. Scholars have increasingly argued that many global health education programmes continue to reproduce colonial ideologies and Eurocentric ways of understanding health and illness. The colonial origins of international health institutions have been identified as particularly significant in shaping these educational structures (Kenneth B, 2025). Early international health organisations often emerged directly from colonial health authorities, prioritising the health and economic interests of colonisers while imposing interventions upon colonised populations regardless of social or cultural consequences. As a result, contemporary global health education has inherited many of the assumptions and power structures established within colonial medicine (Hussain M, Sadigh M, Sadigh M, Rastegar A, Sewankambo N, 2023).

Within formerly colonised nations, medical education has therefore been described as a colonial institution that privileges European systems of knowledge while marginalising or erasing alternative epistemologies. Bhakuni and Abimbola characterise this process as the standardisation of European epistemology, whereby Western biomedical knowledge becomes positioned as universal, objective and scientifically superior, while other forms of knowledge are rendered secondary, unscientific or culturally irrelevant (Bhakuni H, and Abimbola S, 2021). David’s reflections regarding the separation of cultural understanding from “core” clinical teaching align closely with this critique, highlighting how dominant biomedical models continue to shape what students are taught to value within clinical practice.

His reflections align with previous educational initiatives exploring cross-cultural learning in medical schools. At Manchester Medical School, clinical staff, students and patients from Manchester Royal Infirmary and Rusholme Health Centre were interviewed about crosscultural dilemmas encountered in clinical practice (Ahmed M, Hart J and Wass V, 2026) These experiences were transformed into role-play scenarios and piloted within a diversity workshop involving student volunteers and simulated patients. Preliminary findings demonstrated that students wanted more training on cross-cultural issues and showed that students themselves could successfully develop teaching materials through enquiry-based learning approaches.

Faculty participants in a qualitative study conducted by researchers from Imperial College London, University of Dundee and University of Glasgow criticised existing diversity training as overly simplistic and tokenistic (Forrest D, George S, Stewart V, Nina Dutta N, McConville K, Pope L and Kumar S, 2022) Participants argued that training frequently focused on how to behave around “certain groups” without engaging with the broader structural and cultural inequalities embedded within healthcare systems. Instead, participants favoured approaches involving role-play, discussion, reflection and engagement with real-life experiences, suggesting that experiential learning may create more meaningful understanding than passive training models. Thus highlighting the value of shifting cultural competence from a tokenistic addition to the curriculum to an integral, student- patient focused learning tool for medical student cohorts.

6.4 Epistemic Pluralism and Cultural Safety

In response to these critiques, scholars have proposed several frameworks for decolonising healthcare education, including epistemic pluralism, cultural safety and critical consciousness (Wong, S. H. M., Gishen, F., & Lokugamage, A. U. 2021). Epistemic pluralism challenges the assumption that Western biomedicine represents the only legitimate framework for understanding health and illness. Historically, paternalistic attitudes within medicine dismissed non-Western healing systems and cultural understandings of illness as outdated or inferior (Davoudi N, Nayeri ND, Zokaei MS, Fazeli N, Carspecken PF, 2025). Although approaches such as patient-centred care and the biopsychosocial model have attempted to broaden clinical thinking beyond narrow biomedical frameworks (Borrell-Carrió F, Suchman AL, Epstein RM, 2004). Critics argue that medical curricula still insufficiently recognise the role of culture, history and lived experience in shaping health behaviours and perceptions of illness (Wong, S. H. M., Gishen, F., & Lokugamage, A. U. 2021).

The concept of cultural safety similarly extends beyond traditional notions of cultural competency. While cultural competency often focuses on increasing awareness of cultural "differences," cultural safety examines the historical and structural conditions that produce inequity, including racism, colonialism and institutional power imbalances. Rather than reducing culture to a checklist of behaviours or customs, cultural safety encourages healthcare professionals to critically reflect on how healthcare systems themselves may perpetuate harm or exclusion for marginalised groups (Curtis E, Jones R, Tipene-Leach D, Walker C, Loring B, Paine SJ, Reid P, 2019).

6.5 Critical Consciousness and Anti-Racist Practice

Finally, the development of critical consciousness within healthcare education emphasises the responsibility of future clinicians to recognise and challenge structural inequities within medicine (Windsor, L.C, Alexis Jemal A, Goffnett J, Smith D, Sarol Jr. J, 2022). Doctors occupy influential positions within healthcare systems and therefore play an important role in advocating for patients disadvantaged by institutional policies, social inequalities and discriminatory practices. Integrating subjects such as global health, histories of colonial medicine and critical perspectives on race into medical curricula may help students better understand how healthcare systems have been shaped historically and how inequities continue to operate within contemporary practice (Mehjabeen D, Patel K, Jindal RM. 2025)

Evidence also suggests that culturally informed teaching can improve both student learning and patient care (Arruzza E, Chau M. 2021). Educational research highlights the importance of direct feedback from faculty, patients and simulated peers when developing cultural competency skills. Since culture is influenced by factors such as religion, socioeconomic background, migration history, age and education, nearly every clinical interaction presents an opportunity for culturally responsive learning (Walkowska A, Przymuszała P, Marciniak-Stępak P, Nowosadko M, Baum E. 2023). Clinical supervisors therefore play an important role in helping students develop communication skills that explore patients' beliefs, understandings of illness and lived experiences more effectively (Keshavarzi MH, Azandehi SK, Koohestani HR, Baradaran HR, Hayat AA, Ghorbani AA. 2022).

Curricula developed without meaningful patient involvement may unintentionally reinforce traditional hierarchies within healthcare and leave graduates underprepared for the ethical, relational and cultural complexity of modern practice (Windsor, L.C, Alexis Jemal A, Goffnett J, Smith D, Sarol Jr. J, 2022). For David, this reflects a wider structural issue within medical education, where cultural understanding remains separated from "core" clinical teaching rather than embedded throughout routine medical practice.

Although he acknowledged increasing diversity within medical schools as a positive development, he maintained that representation alone is insufficient without intentional institutional change. His reflections ultimately emphasised that cultural competency is not simply about awareness of difference, but about fostering curiosity, openness and meaningful engagement with diverse patient experiences beyond narrow biomedical frameworks through role play, interactive training models and utilising diverse patient perspectives. However, cultural competence isn't the only field of medical education underrepresented. The fundamentals of how we form these teaching materials must lay its onus onto research and its exclusivity of certain populations (Rukadikar C, Mali S, Bajpai R, Rukadikar A, Singh AK, 2022).

7. Research Representation and Epistemic Inequality

7.1 Barriers to Research Participation

Discussed by another participant, former medical student turned biomedical engineer- Adan Khan, explained that this lack of inclusivity and accessibility within academic research spaces motivated his desire to create a platform to address said issues. Linking representation in research participation to healthcare outcomes, Adan argued that "if research itself isn't inclusive from the get-go, the outcomes… will not be inclusive." He added further that "the most vulnerable demographics would still be left unheard." Although Adan acknowledged signs of progress within healthcare education, he perceived research as evolving "even slower". His reflections highlight concerns that exclusion within research not only limits representation, but also shapes whose experiences, bodies and health needs become visible within scientific knowledge production (Bibbins-Domingo, K. and Helman, A, 2022).

These concerns were supported by studies examining barriers to participation in research among Global Majority communities. Commonly identified obstacles include mistrust of healthcare institutions and researchers, socioeconomic and logistical difficulties, language barriers, cultural exclusion, limited awareness of research opportunities and concerns regarding institutional bias. Together, these factors contribute to the persistent underrepresentation of marginalised groups within medical research, despite these communities often experiencing disproportionate burdens of disease and poorer healthcare outcomes (Pardhan S, Sehmbi T, Wijewickrama R, Onumajuru H, Piyasena MP. 2025).

7.2 Historical Mistrust and Institutional Betrayal

Importantly, delving into the mistrust towards medical research cannot be separated from the historical legacy of exploitation and racism within healthcare systems. Historical examples such as the Tuskegee Syphilis Study continue to shape relationships between minoritised communities and medical institutions. In this study, hundreds of Black men with syphilis were deliberately deceived and denied treatment by researchers in the United States, resulting in preventable illness, deaths and intergenerational harm (Alsan, M. and Wanamaker, M. 2017). Similarly, the case of Henrietta Lacks demonstrates how Black patients' bodies were historically used within scientific research without consent. Cells taken from Lacks during cancer treatment became one of the most influential medical research tools of the twentieth century, contributing to major scientific advances including vaccine development and cancer research, despite neither consent nor compensation being provided to her family (Nature, 2020).

Historical injustices contribute to what some scholars describe as a legacy of misplaced trust and institutional betrayal among underserved communities. Experiences of racism, marginalisation and exclusion continue to shape how healthcare systems and research institutions are perceived today. During the COVID-19 pandemic, for example, many ethnically minority communities, despite being disproportionately affected by the virus, demonstrated lower uptake of vaccination programmes, reflecting broader concerns regarding trust, communication and institutional accountability (Shearn C, Krockow EM, 2023).

7.3 Exclusion From Knowledge Production

Adan's reflections therefore point towards a wider structural issue: when certain groups remain excluded from research participation, healthcare knowledge itself risks becoming unrepresentative. Clinical evidence, diagnostic frameworks and treatment guidelines are shaped by the populations included within research studies. Consequently, the underrepresentation of racially minoritised groups may contribute to healthcare interventions that inadequately reflect the biological, cultural and social realities of diverse patient populations. Exclusion from research is therefore not simply an issue of participation, but one of epistemic inequality, where some communities remain systematically unheard within the production of medical knowledge.

7.4 Community Engagement and Inclusive Research Practice

These cases magnify how the legacy of mistrust, alongside structural biases against Global majority communities, risk isolating these groups from informative clinical spaces through a lack of representation in studies and a failure of institutions to effectively reach these communities- as highlighted by Adan. However, this does not serve as a full picture of participant representation as more organisations and campaigns are working towards a better understanding of spaces that communities utilise in order to open up dialogues about research. As well as the use of community figures and language to invite groups to share varied perspectives within the comfort and trust of their own communities. Thus, addressing this nuanced but important theme within medical education and research (Odedina FT, Wieland ML, Barbel-Johnson K, Crook JM. 2024)

8. Tokenism, Advocacy and Institutional Resistance

8.1 Tokenistic Diversity Training in Medical Education

As defined by the *Encyclopedia of Race and Racism*, tokenism refers to "the practice of making only a perfunctory or symbolic effort" (Ofori-Darko A, 2022) towards diversity, often through minimal inclusion designed to create the appearance of equality rather than meaningful structural change. This concept emerged repeatedly throughout discussions surrounding diversity training within medical education with Georgina Shajan, final year medical student.

When speaking with fellow medical students, she described concerns about the repetitive and superficial nature of institutional bystander training, noting that students felt "every single year we do a bystander training, but it's the same module that's repeated every single time." Her reflections suggest that diversity and inclusion initiatives are frequently implemented as mandatory tick-box exercises rather than meaningful educational interventions, which may undermine their sustained impact on behaviour and institutional culture.

This perception aligns with wider concerns within medical education regarding tokenistic approaches to equality and diversity training. Previous studies have found that faculty and students frequently view existing EDI themes, such as cultural competency, teaching as oversimplified, performative and disconnected from the realities of clinical practice (Shah, D., Behravan, N., Al-Jabouri, N. and Sibbald M, 2024). Rather than encouraging critical reflection or behavioural change, repeated online modules and passive training sessions may reinforce the idea that diversity education is a procedural requirement rather than an essential component of professional development (Corsino L, Fuller AT, 2021).

8.2 Experiential Learning and Bystander Intervention

One example of an institution tackling this tokenism was the development of an active bystander workshop for internal medicine residents using standardised patient (SP) methodology. This approach utilised trained actors to simulate discriminatory or challenging clinical scenarios, allowing learners to practise responding within a controlled and reflective environment. Grounded in social learning theory, SP methodology enables participants to build confidence and communication skills before applying them within higher-pressure clinical settings, moving away from generic or generalised scenarios into deeper, more stimulating prompts (Famouri ML, Hernandez S, Omlor RL, Lane-Brown M, Evans SM, McIntosh D, Denizard-Thompson N. 2023). Reflection and structured feedback were also incorporated to support long-term behavioural development and professional growth. A similar framework has the capability of implementation in medics' early careers, within medical school, this bystander training model can utilise this SP method to equip students with the tools needed to be inclusive, critically thinking and culturally competent clinicians.

Similar approaches have been implemented within UK medical education through the Bystander Intervention Training (BiT) programme developed at Norwich Medical School Designed collaboratively by staff and students, the programme aimed to empower participants to actively challenge discrimination across areas such as race, gender and sexuality. Unlike traditional lecture-based diversity training, BiT centred on immersive roleplay scenarios involving professional actors, creating opportunities for participants to practise intervention strategies within psychologically safe learning environments. The programme was informed by behaviour change theory and focused on encouraging participants to use their own privilege to act as allies when witnessing discriminatory behaviour (Tyson, L., Skinner, J., Hariharan, B., Josiah, B., Okongwu, K., & Semlyen, J. 2025) .

Importantly, these approaches move beyond passive awareness training towards experiential learning models that encourage reflection, communication and behavioural change. These studies support the shortcomings found by Georgina through her lived experience as a student and advocate within the medical education space. Research has demonstrated that role-play and simulation can be particularly effective in developing communication skills, empathy and reflective practice within healthcare education. Observing and participating in simulated scenarios allows students not only to rehearse responses to discrimination, but also to critically examine the social and cultural dynamics underpinning clinical interactions (Gorski S, Prokop-Dorner A, Pers M, Stalmach-Przygoda A, Malecki Ł, Cebula G, Bombeke K. 2022). While many institutions have introduced mandatory equality and bystander training, repetition without meaningful engagement may reduce such programmes to symbolic gestures rather than transformative educational experiences.

8.3 Advocacy, Resistance and Professional Identity

Georgina focused on the institutional barriers encountered by students attempting to advocate for change within medical education. A significant issue she identified was the fear of professional repercussions, explaining that “the first barrier is the fear of fitness to practise.” She further highlighted the stigma often attached to advocacy work, stating that “people might instantly see you as a problem maker or someone too involved in the political side of it.” Her reflections demonstrate how institutional cultures can discourage students from challenging inequities, particularly when advocacy is perceived as disruptive, confrontational or incompatible with professional behaviour.

These concerns reflect wider debates surrounding advocacy and resistance within healthcare education. Resistance is often viewed negatively within professional healthcare environments, where compliance, hierarchy and institutional stability are prioritised. However, scholars increasingly argue that many acts of resistance within healthcare emerge from altruistic motivations, particularly attempts to challenge injustice, inequity or harmful institutional practices. In this context, advocacy and resistance cannot always be understood as separate concepts. Instead, they exist as an interconnected “advocacy-resistance” dynamic, where actions aimed at improving systems may simultaneously involve forms of institutional challenge or disruption (Ellaway RH, Wyatt T, Hubinette M. 2025).

This framing is particularly relevant within medical education, where students occupy vulnerable positions within highly hierarchical structures. Advocacy undertaken by students may involve varying degrees of resistance, as seen in the prior accounts from participants. From challenging biased teaching materials, to co- producing educational resources to resisting harmful cultural norms within clinical environments- exemplifying the autocatalystic behaviour mentioned earlier in this report.

Georgina’s comments suggest that even constructive advocacy can become framed as unprofessional when it disrupts institutional comfort or challenges existing power structures. Research examining advocacy-resistance within healthcare identifies several tensions that emerge when students or practitioners attempt to advocate for change. These include uncertainty regarding professional responsibilities, balancing competing institutional priorities, navigating collective versus individual agency and managing the potential harms associated with speaking out. For trainees in particular, advocacy may strain relationships with supervisors, affect educational experiences or create anxieties regarding future career opportunities (Ellaway RH, Wyatt T, Hubinette M. 2025). Concerns surrounding negative assessments, professional repercussions or damaged reputations can therefore discourage students from engaging critically with inequities they witness.

8.4 Professionalism, Hierarchy and Fear of Repercussion

Importantly, this creates a paradox within healthcare education. Medical institutions may promote values such as social accountability, patient advocacy and equality, while simultaneously maintaining cultures that may inhibit students from openly challenging discrimination or institutional shortcomings (Abdalla MN, Osman A, Mahmoud N, Harney SC, Abdalla ME, 2025). Georgina’s reflections highlight how professionalism itself can become narrowly defined in ways that privilege compliance over critical engagement. Students may therefore internalise the belief that maintaining professional identity requires silence, neutrality or avoidance of politically sensitive discussions.

Georgina’s experiences therefore reveal how institutional resistance to advocacy can limit meaningful progress within medical education. While students are increasingly encouraged to reflect on issues of diversity, inequity and social justice, many continue to feel constrained

by hierarchical systems that discourage open critique (Fox, M. F. J., Kandiko Howson, C., & Kingsbury, M. 2023). Addressing these tensions may require institutions not only to support advocacy rhetorically, but also to create environments in which students can safely question inequities without fear of professional punishment or reputational harm.

9. Dermatology, Skin Representation and Diagnostic Equity

9.1 Representation Within Dermatology Education

Dr Humaira Ahmed, Resident doctor, has expressed her concerns that students graduate without adequate preparation to diagnose and treat diverse patient populations safely and effectively. Describing much of her work as centred on “improving representation within healthcare education, particularly around dermatology and skin of colour,” she reflected on her own medical education, she explained: “I genuinely have not had much exposure… to diverse patient groups… even in our medical education teaching that we received, I hardly saw any photos of skin of colour within lecture slides.” Her experience highlights how underrepresentation within teaching materials can shape students’ clinical confidence and preparedness.

These concerns are supported by collections of international evidence. A 2022 survey of 600 medical students and healthcare practitioners found that 74% reported teaching materials predominantly featured white skin tones. More significantly, only 5% of respondents felt confident diagnosing dermatological conditions across a range of skin tones (Buonsenso D, Liu JF, Shanmugavadivel D, Davis T, Roland D. 2022). These findings suggest substantial gaps in clinical preparation, with many students and practitioners recognising that they have not been adequately exposed to the diversity of presentations they are likely to encounter in practice. She described the absence of skin of colour teaching and diverse patient representation as systemic educational failings with direct clinical consequences. The omission of diverse clinical presentations not only marginalises racially minority communities, but also risks perpetuating poorer patient outcomes through diagnostic uncertainty and inequitable standards of care (Kapadia D, Zhang J, Salway S, Nazroo J, Booth A, Villarroel-Williams N, Bécares L & Esmail A. 2022)

9.2 Clinical Consequences of Underrepresentation

Recent evidence has highlighted the clinical consequences of racial bias and underrepresentation within dermatology education and practice. During the COVID-19 pandemic, disparities emerged in the recognition of cyanosis in Black patients, where signs such as bluish skin discoloration were more difficult to identify on darker skin tones (Chaiken I, Sathe NA, Wurfel MM, Wang LL. 2025). Similar challenges have been reported in the delayed recognition of jaundice and disparities in the utilisation of clinical tests such as the Apgar Score (Frankie Fair F, Furness A, Higginbottom G, Oddie S, and Soltani H, 2023) and the underdiagnosis of childhood rashes in both primary and secondary care settings (Dondi, A., Ranieri, A., Andreozzi, L., Leuzzi, M., D’Alanno, G., Pierantoni, L., Zama, D., Battelli, E., Calegari, R., Borghesi, A., Lanari, M., & Neri, I. 2026). One of the clearest examples is seen in skin cancer diagnosis, particularly acral lentiginous melanoma (ALM), a subtype more commonly found in darker-skinned populations. Although ALM accounts for an estimated 30–70% of melanoma cases in people with darker skin, studies show that malignant lesions in these patients are less likely to be biopsied due to diagnostic uncertainty; often delayed or inaccurate. These disparities contribute to poorer outcomes, with a 2019 study reporting a

five-year melanoma survival rate of 66% among non-Hispanic Black Americans compared with 90% among non-Hispanic White patients (Culp MB, Lunsford NB, 2023).

9.3 Educational Image Bias and Diagnostic Confidence

Quantitative content analysis further demonstrates the scale of this imbalance. An analysis of 4,146 textbook images found that 74.5% depicted light skin tones, 21% depicted medium skin tones and only 4.5% depicted dark skin tones (Louie P, Wilkes R, 2018). This distribution is disproportionately unrepresentative of both global populations and the increasingly diverse patient groups served within contemporary healthcare systems. More broadly, the imbalance reflects underlying assumptions regarding which bodies are considered medically "normal," whose presentations are prioritised within education, and whose differences are positioned as marginal or exceptional.

9.4 Student-Led Solutions and Educational Reform

Students have played an increasingly important role in challenging racial and skin tone bias within dermatology education. One approach has involved contributing to the development of more representative institutional image libraries and educational resources, including the internationally recognised Mind The Gap, co-created by Dr Malone Mukwende during his time at St Georges Medical School, or the emerging platform Skin For All, created by myself which aims drawing upon international epidemiological data and existing equity-focused initiatives. Although students are still developing their clinical expertise, their lived experiences of educational gaps provide valuable insight into how image disparities can affect diagnostic confidence, clinical decision-making and patient interactions.

Research evaluating targeted student- led skin diversity seminars and online lecture series found significant improvements in students' self-reported confidence (Suntharan V, Wilson C, Amoafo E, Dao D, Iyamah E, Taylor M. 2025) recognising dermatological conditions in darker skin tones followed these teaching sessions, examples include the UK National Dermatology Teaching run by Dr Ahmed's, Skinclusive Hub in collaboration with the British Skin Foundation.

Pairing these case studies with the lived experiences of participants helps build a broader picture of how students across the UK are contributing to efforts to address health inequities within healthcare education and clinical practice. Together, these examples demonstrate that student-led work extends beyond individual experiences and increasingly influences institutional culture, curriculum reform and wider conversations surrounding equity within medicine.

10. Student-Led Contributions to Reducing Health Inequalities

10.1 Curriculum Reform and Decolonisation

Student-led curriculum reform has emerged as an important mechanism for challenging inequities within healthcare education. At University College London, students and clinician educators collaborated on initiatives to decolonise the undergraduate medical curriculum, questioning Eurocentric teaching norms and advocating for more culturally safe educational approaches (Wong, S. H. M., Gishen, F., & Lokugamage, A. U. 2021). These initiatives demonstrated how students can influence curriculum design, institutional policy and wider discussions surrounding structural inequities within healthcare systems.

10.2 Widening Participation and Mentorship

Students have also contributed to reducing inequalities through widening participation initiatives aimed at addressing barriers to entering medicine. Foundation for Widening Participation in Medicine (FWPM), founded by medical students, supports underrepresented groups through mentorship, outreach programmes, workshops and educational opportunities. By providing guidance on applications, careers and academic development, the organisation works to address barriers linked to social mobility and unequal access to professional networks. Similarly, medical students at the University of Manchester developed widening participation workshops to support prospective applicants from underrepresented backgrounds, positioning students as mentors, educators and advocates for equitable access to medical careers.

10.3 Advocacy, Leadership and Institutional Accountability

Research exploring medical student advocacy at the University of Glasgow further demonstrated how students contribute to institutional conversations surrounding professionalism, social accountability and health inequities (Sood M, Blane DN, Williamson AE. 2023). Participants described engaging in research, campaigning, mentorship and collaborative educational initiatives to influence how advocacy was understood and taught within medical education. Involvement in advocacy was also associated with the development of leadership skills and challenged traditional assumptions regarding the role of students within academic institutions (Ross LA, Janke KK, Boyle CJ, Gianutsos G, Lindsey CC, Moczygemba LR, Whalen K, 2013)

10.4 Systems Change and Sustainable Healthcare

Students have additionally contributed to broader systems-level change within healthcare education. The SusQI initiative at Bristol Medical School integrated sustainability principles into undergraduate quality improvement teaching, positioning students as active contributors to discussions surrounding sustainable healthcare delivery and institutional responsibility. Through collaborative workshops and applied projects, students influenced how healthcare sustainability and systems change were conceptualised within the institution (Clery P, d'Arch Smith S, Marsden O, Leedham-Green K. 2021). This initiative illustrates how educational programmes can cultivate students as active participants in shaping healthcare culture and policy.

10.5 National Advocacy and Workforce Diversity

Similarly, Melanin Medics, founded by a medical student, has supported aspiring and current Black medical students and doctors through mentorship, outreach and career development initiatives. The organisation addresses disparities in representation, differential attainment and access to professional networks by providing guidance, community support and educational opportunities. Such initiatives demonstrate how student-led advocacy can extend beyond individual institutions into national conversations surrounding equity, representation and workforce diversity within medicine.

These examples demonstrate that clinical students contribute to reducing health inequalities in multiple interconnected ways, including advocacy, curriculum reform, widening participation, mentorship, research accessibility and institutional critique. Rather than functioning solely as recipients of medical education, students increasingly operate as

educators, collaborators and change agents capable of influencing healthcare culture, policy and professional practice**.**

11. Conclusion

11.1 Key Findings

This rapid review has examined how structural inequities within medical education shape representation, knowledge production, and clinical preparedness, and how students and early-career professionals actively respond to and disrupt these systems. Drawing on interviews with medical students and resident doctors alongside empirical and policy literature, the review demonstrates that medical education is not a neutral process of knowledge transmission but a structurally mediated system that reflects and reproduces broader societal inequalities.

Across multiple domains, curriculum design, clinical teaching, research participation, assessment practices, and institutional culture, inequities persist through both overt exclusion and more subtle mechanisms of omission, epistemic bias, and the normalisation of Eurocentric biomedical frameworks. These patterns contribute to differential educational experiences and, crucially, translate into downstream clinical consequences, including diagnostic uncertainty, reduced cultural responsiveness, and inequitable patient outcomes. In dermatology, research participation, and communication training, the absence of diverse representation is shown to directly affect clinical confidence, evidence validity, and patient safety.

11.2 Students as Drivers of Structural Change

However, the findings also highlight that students are not passive recipients within these systems. Rather, they function as critical agents of change, autocatalytic actors whose lived experiences of curricular gaps and institutional inequities generate advocacy, innovation, and reform (Luman A, Lamb SM, Stevenson A, Lindsley JE, 2021). Across the medical school-toNHS workforce pipeline, students engage in a wide spectrum of transformative activity, including curriculum co-design, widening participation initiatives, research equity programmes, bystander intervention training reform, and public-facing educational work. These interventions collectively demonstrate that meaningful progress often originates from those positioned closest to the point of educational delivery and clinical translation.

11.3 Persistent Barriers and Institutional Challenges

At the same time, the review identifies persistent structural barriers that constrain this potential, including tokenistic diversity initiatives, hierarchical institutional cultures, and the professional risks associated with advocacy. These factors create a paradox in which students are encouraged to embody professionalism and social accountability, yet may be discouraged from challenging the very systems that undermine these values (Ellaway RH, Wyatt T, Hubinette M. 2025).

11.4 Towards Equitable Medical Education

The evidence suggests that addressing inequities in medical education requires more than incremental reform or isolated diversity interventions. It demands a fundamental

reconfiguration of what is considered core medical knowledge, whose experiences are valued in knowledge production, and how institutional power is distributed across educational and clinical systems. Central to this transformation is the recognition that students are not peripheral stakeholders but essential partners in shaping equitable healthcare education.

11.5 Final Reflections

Ultimately, this review positions equity in medical education as both an educational and structural imperative. By embedding student agency within formal governance, strengthening inclusive curriculum design, and aligning institutional practice with anti-racist and culturally safe principles, medical education systems can move towards training clinicians who are not only clinically competent, but also critically aware, socially responsive, and equipped to deliver equitable care across diverse populations.

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Appendix:

Written Interview with Dr. Olamide Oguntimehin- Founder & Chief Executive Melanin Medics

Can you tell us a bit about yourself and the work you're involved in around anti-racist or inclusive healthcare?

- Melanin Medics is a student-founded, community-led registered charity established in 2017 by Dr Olamide Oguntimehin, a Black medical student who recognised the need for greater representation and visibility of Black medical students and doctors in the UK
- Our mission is to promote racial equity in medical education and training, for the benefit of the workforce and patients
- We do this through educational programmes, mentoring, career development, social empowerment and the dissemination of culturally relevant resources
- We are the largest intergenerational network for medical students and doctors of Black heritage in the United Kingdom
- Over nine years, we have delivered 20 cohorts across 7 bespoke programmes, reaching 558 participants, and our Allyship and Advocacy CPD-accredited workshops have been delivered to over 2,000 participants across higher education, the NHS and the private sector

What first motivated or inspired you to pursue anti-racist care and more inclusive medicine?

- Melanin Medics was born out of lived experience, our founder navigated significant systemic barriers to medical school entry, coming from an underrepresented and lower socioeconomic background
- When she started medical school and encountered the experiences of her Black peers, she recognised that the barriers she had faced, difficulty accessing medicine, differential treatment, and a persistent sense of not belonging, were not individual failings but well-documented patterns of structural exclusion
- The absence of visible role models, mentors who shared similar backgrounds, and resources that reflected the realities of Black students made it clear that something needed to be built
- Melanin Medics emerged not from an institutional initiative, but from the lived experience of navigating a system that was not designed for Black students, and the conviction that this needed to change

From your perspective as a student advocate, how well does current healthcare teaching address racism, health inequalities, and representation?

- Teaching on racism, health inequalities and representation at an undergraduate level has evolved since Melanin Medics was established in 2017, and its presence within healthcare curricula has grown

- However, there remain significant opportunities to integrate these themes more meaningfully throughout the duration of courses, revisiting key concepts and practical applications rather than treating them as one-off modules
- Much of the early progress in this area was driven by students from affected groups who gathered resources and presented them to faculty themselves; a pattern that reflects both the passion of those students and the gap in institutional responsibility
- Teaching remains largely didactic and episodic; there is a need for greater innovation, genuine co-creation with community groups, and sustained engagement with those most affected by the inequities being taught about

Have there been any experiences during your training that highlighted gaps or challenges in current medical education?

- When Melanin Medics was founded in 2017, decolonising the medical curriculum was rarely discussed, with institutional focus placed almost exclusively on widening participation in terms of socioeconomic access
- We quickly recognised that a more diverse student population does not automatically equate to equity of experience; Black students and other racially minoritised groups were experiencing racism in medical school and on placement, feeling a lack of belonging, and encountering curricula that did not reflect their communities or histories
- Differential attainment, the persistent gap in academic outcomes between racially minoritised students and their white counterparts, was well documented but poorly addressed
- This presented a clear opportunity to advocate not just for widening access to medical school, but for ensuring equity of experience throughout medical education and training
- We recognised and capitalised on opportunities to influence the medical education environment, ensuring individuals had a fairer chance not only of getting in, but of excelling once there and working with institutions to tackle racism

What kinds of changes or initiatives have you personally been involved in to promote anti-racist or equitable healthcare education?

- Collaborated with the British Medical Association on the development of the Racial Harassment Charter for Medical Schools
- Served as a case study for the General Medical Council in initiatives tackling differential attainment in medical education and training
- Deliver CPD-accredited Allyship and Advocacy workshops on equality, diversity and inclusion to medical students, resident doctors, nursing students, paramedic students, physiotherapy students, physician associate students, senior leaders, hospital management and allied healthcare professionals across universities, medical schools, NHS trusts and healthcare organisations
- Consult with UK medical schools on anti-racist practices and policies

- Work with student societies, including African Caribbean Medical Societies, to support them in promoting anti-racism within their institutions
- Developed 7 bespoke educational programmes supporting the progression of Black medical students and doctors from application stage through to specialty training

What impact do you think students and early-career healthcare professionals can have in driving change within healthcare systems and education?

- The founding of Melanin Medics itself demonstrates that student-led action, when rooted in genuine community need and structural critique, can scale into meaningful systemic change
- Students and early-career professionals bring proximity to the problem; they are experiencing the inequities in real time, which gives them insight that researchers and policymakers working from the outside cannot replicate
- Community knowledge is a form of expertise, and when it is valued and resourced appropriately, it produces more relevant, credible and impactful interventions than those designed without it
- Students can influence change at multiple levels simultaneously; through peer support and mentoring, through advocacy with faculty and institutions, and through policy engagement at a national level
- However, this potential is only fully realised when students are given the structures, resources and institutional support to sustain their advocacy; rather than being expected to drive change on goodwill and personal time alone

What barriers do students often face when trying to advocate for anti-racist care or institutional change?

- Not knowing who to speak to or which levers to use to achieve change within complex institutional structures
- Continuity; the expectation that once involved in a project, students will maintain the same level of contribution even as their capacity changes as they progress through training
- The emotional burden of proximity, advocating for change in areas where you are personally affected by the inequity takes a significant and often unacknowledged toll
- The lack of remuneration for time and contributions, with students expected to undertake this work alongside the demands of their education
- Lack of buy-in from senior faculty who could otherwise serve as sponsors and amplify student voices within institutional decision-making
- The risk that student advocacy is celebrated rhetorically but not embedded into institutional structures, meaning progress stalls when individual champions move on

In your view, what more could medical schools, universities, or NHS organisations do to better support inclusive and anti-racist healthcare training?

- Move beyond awareness days and one-off workshops towards sustained, resourced and accountable commitments to anti-racist practice embedded in curricula, clinical training and governance
- Form long-term, non-extractive partnerships with community-led organisations; providing genuine investment of resources, governance representation and shared accountability rather than drawing on community credibility without reciprocal commitment
- Ensure that community organisations and students most affected by inequity are involved in the co-design and governance of interventions, not consulted after decisions have already been made
- Fund independent evaluation of community-led programmes, rather than placing that burden on volunteer-led organisations with limited resources

What recommendations would you give to organisations such as the NHS Race and Health Observatory when working with healthcare students and future professionals?

- Recognise and resource student and community expertise; the knowledge generated through lived experience is irreplaceable and should be compensated and valued
- Avoid drawing on the credibility and reach of student and community organisations without genuine investment of resources and long-term commitment
- Support the development of robust evaluation frameworks for community-led programmes, funding independent research that builds the evidence base for what works
- Ensure that student voices are represented in governance and decision-making structures, not only in advisory or consultative roles

Looking ahead, what changes would you hope to see in healthcare education and patient care over the next 5–10 years?

- Structural change embedded within medical education, not just in curriculum content, but in assessment design, hiring practices, governance structures and institutional culture
- A shift from widening access to genuine equity of experience, ensuring that students from racially minoritised and underrepresented backgrounds have a fair chance not only of entering medicine but of excelling throughout their careers
- Longitudinal, intersectional evaluation of interventions addressing anti-racism and health inequalities in healthcare education, building a robust evidence base that moves beyond pilot programmes and short-term projects
- Community-led organisations recognised and resourced as essential partners in health professions education, rather than operating at its margins
- A healthcare workforce that reflects the diversity of the patients it serves, and a culture in which every professional, regardless of background, feels they belong and can thrive

Is there anything else you would like to add or any message you would like to share with students, educators, or healthcare leaders?

- To students: your lived experience is not a liability, it is expertise. The barriers you have navigated have given you knowledge that the system needs. You do not have to fix what was broken before you arrived, but you have every right to demand better, and there are communities ready to support you in doing so
- To educators: the evidence is clear that the current system is not working equitably for all students. Acknowledging that is not an attack, it is the starting point for meaningful change. We encourage you to look inward at your own practices, engage genuinely with community partners, and be willing to sit with the discomfort that structural change requires
- To healthcare leaders: symbolic commitments are no longer sufficient. The communities most affected by inequity have been patient, generous and solutions-focused for long enough. What is needed now is sustained investment, shared governance and genuine accountability, not just in what you say, but in what you fund, what you measure and what you change