EDITORIAL

Not just a question of numbers: Moving from respectful inclusion and diversity to promoting belonging

Diversity and inclusion are felt to be vital for the growth of health professional education and essential for tackling health inequities, but are diversity and inclusion enough? It is important to first understand what is meant by diversity and inclusion. *Shorter Oxford English Dictionary* (2002) defines diversity as "the condition or quality of being diverse, different or varied; difference, unlikeness" and inclusion as "the action or an act of including; the fact or condition of being included; an instance of". Calls for diversity and inclusion in healthcare are often broad and include many underrepresented groups based on gender, ethnicity, culture, disability, sexuality, socioeconomic status, age, rural origin and background, all of which have an impact on health professional education, engagement and achievement.

However, a diversity and inclusion agenda can be tokenistic and narrow in its vision. Initiatives that seek to increase representation of people from traditionally underrepresented backgrounds to meet targets can be disrespectful when not accompanied by genuine efforts to create spaces for *belonging.* We need to shift our measures of success from solely quantitative targets of minority representation to qualitative measures of belonging that pay attention to the experiences of those newly included in the system. Inclusion cannot be predicated on assimilation or assumptions that those who are being invited into the system will be uncritical of the system as it currently operates. A major critique of health professional education is that it operates as a colonising system, built on a Western worldview and built by privileged, able-bodied, straight, white men for privileged, able-bodied, straight, white men. Diversity and inclusion should not mean that while minority groups are represented and their views are heard, the voice of the dominant group is the loudest, deferred to and controls the system and its outcomes. Ideally, we need to move beyond simply speaking of diversity and inclusion to engaging in meaningful discourse that changes the face of health professional education to reflect all those engaging in it. Within all health professional education, we endorse the aim of engendering belonging, which in turn provides a representative health workforce, reduces health inequities and more accurately represents a "mirror on society" (Crampton et al., 2018; Roberts, 2020). Belonging results in the views, beliefs and values of all individuals being respected and *influential*; belonging means the system changes to incorporate the voices of all, rather than trying to change the individual to "fit in" to a rigid and inflexible system.

There is much research that needs to be done to unpack the issues of equity, diversity, inclusion and belonging. Lang et al. (2022) addressed equality, diversity and inclusion in IS (information systems) education in their editorial of the same name, and many of

the challenges they identified as needing further research resonate with those of health professional education. We have considered their questions and adapted them to the health professional education setting:

- What are the barriers to and enablers of diversity and inclusion in health professional education? What are the structural barriers and how are we reinforcing these in our practice—as clinicians and researchers?
- How can health professional educators address the challenges of globalisation and internationalisation? How can we examine our current practice, including the current systems of exclusion, such as heteronormativity and ethnocentricity?
- How is performance and attainment in health professional education impacted by gender, ethnicity, disability, sexuality, socioeconomic status, etc? What can we do to level the playing field and remove these inequities?
- How do we deal with issues of unconscious bias in health professional education selection, teaching and assessment? Focus currently is on bringing diversity into the program, but should we focus more on diversity within the system (academics who may be variously included or excluded based on their own backgrounds)? Are we paying attention to who makes the decisions and holds the power to include, exclude and shape the diversity and inclusion of students entering the health system?
- How can we ensure that selection, teaching and assessment approaches are inclusive and value the diversity of all students and staff? Are we promoting belonging as part of this system?
- What is best practice for development of inclusive health professional education learning spaces and environments that promote respectful inclusion, diversity and belonging?

There are many areas for us to explore as health professional education researchers and ways in which we can all work to make our environments places for belonging. An editorial by Eaton (2022) exploring equity, diversity, inclusion, decolonisation and Indigenisation for academic integrity offers 10 recommendations of actions that demonstrate a commitment to equity, which are equally applicable to health professional education:

- Educate yourself
- Become an ally and activist
- Work to dismantle systemic barriers to success
- Elevate and amplify the work of underrepresented individuals
- Create meaningful opportunities for underrepresented groups
- Invite those from underrepresented groups to the table
- Avoid norms that perpetuate colonialism (citing, referencing, writing styles, silencing of oral histories)

- Resist taking ownership
- Revise policy and practice documents with an equity focus
- Make equity, diversity, inclusion, decolonisation and Indigenisation an imperative

FoHPE is pleased to announce a special horizontal theme—"Respectful Inclusion, Diversity and Belonging"—running across all issues for 2023. We are calling for original research articles, innovative teaching reports, short reports and discussion or conceptual papers that focus on diversity, inclusion and belonging. More details about the call for papers for this special section are available on the *FoHPE* website.

In this issue

The six research articles published in this issue variously explore strategies to communicate with students, the impact of our students in clinical practice, how students' attitudes shift (or not) over the course of a program and how students' characteristics might differ between health professions. Attention is also paid to the evaluation of a cultural safety program, and our invited methodology paper discusses the impact of the researcher's voice on qualitative research.

Humphrey's paper considers how the use of comics (graphic medicine) as part of an internship orientation can enhance preparation for practice of interns and help with their professional identity formation. Walker, Forbes, Osborn, Lewis, Cottrell, Peek and Argus evaluate both the student and client experience with a student-led interprofessional telehealth clinic developed in response to the COVID-19 pandemic, while Pigott, Patterson, Birch, Oakley and Doig investigate the impact of occupational therapy students on cost, throughput and patient outcomes in a health service. Change in students' patient-centredness from first to final year of a medical program is quantitatively measured by Harding, Seal, Vlok, Doyle, Dean and McGirr. This study also looked for associations between outcomes and characteristics, such as student backgrounds and area of speciality interest. A study by Stormon, Seysan, Ford and Eley also uses a survey to compare personality traits between medical and dental students, discussing key characteristics to cope with high academic workload. Finally, the article by Rissell, Wilson, Richard, Ryder and Bower reports on a process evaluation of a Central Australia Aboriginal cultural awareness training program, providing data collected over 6 years. The importance of designing First Nation informed and workplace relevant cultural safety training is discussed. The invited methodology paper written by Ajjawi problematises "voice" in qualitative research, drawing attention to the need to acknowledge the "multi-voicedness" of research that includes the often loud (but not always explicitly acknowledged) voice of the researcher in shaping and reshaping the voices of participants and the curated outcomes of qualitative research.

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Associate editors

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