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An inclusive Faculty of Medicine

OPINIONS

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An inclusive learning environment requires trust, not polarisation. Racism and discrimination in medical education must be counteracted through equitable dialogue, nuanced debate, and tolerance for different opinions.

Medical students Mohammed Almashhadani and Amanda Hylland Spjeldnæs have written an important opinion article on racism in medical education (1). As an ethnically Norwegian, middle-aged man, professor, teacher and head of department at the Faculty of Medicine at the University of Oslo (UiO), I represent a primary audience for this article. I belong to the privileged elite both globally and at the university, and even though I may at times feel small and insignificant, I am aware of the roles and stereotypes I represent. Who we are, where we come from, or even our names affect how we are perceived in ways that are beyond our personal control. We are interpreted in light of our ethnic and social backgrounds, and issues relating to cultural diversity, inclusion, and racism are always personal and emotionally charged.

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On this note, I would like to emphasise that I fully support the initiative to create a more diverse, inclusive, open, and safe learning and working environment at the Faculty of Medicine. I know that students experience both

conscious and unconscious discrimination, and it is high time we took the issue seriously (2). The question is how, in practice, we address this difficult challenge.

An inclusive learning environment

As Almashhadani and Spjeldnæs point out, the student community in the medical programme at UiO, like many other study programmes, is marked by segregation, particularly along ethnic lines. They are also correct in stating that Fadderuka (Welcome Week) exacerbates this problem. It can be positive for many, but evaluations show that the majority do not participate, and many express that alcohol plays too large a role. Therefore, our students' first encounter with the university is not the inclusive and safe learning environment we wish to offer (3,4).

For this reason, starting in spring 2020 and with strong support from the faculty leadership, I am leading a new programme to welcome the students (5). The goal of the TEAM programme is to facilitate an inclusive start for every new cohort. All students are invited to a two-day seminar with an overnight stay, and based on their fixed teaching groups for the first academic year, we work to build trust and promote cooperation across social divides. Each student group receives systematic training and practice in teamwork, with tasks that go beyond medical knowledge.

Our multicultural student environment is a unique arena for developing interpersonal skills. Medical students should learn to treat all types of people, and the first step is to get to know and trust each other.

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The TEAM programme has been well received by the students, and each semester we assess how we can improve and further develop the learning environment. This semester, we introduced a new initiative in collaboration with the medical students' organisation for mental health awareness (MMO). This involves an evening seminar that serves as a 'restart' when students change groups in their second year. The main goal is, as always, to build trust – this time with a particular emphasis on coping with exam stress and life in general (6).

I am not writing this to pat myself or the Faculty of Medicine on the back and say that everything is perfectly fine. On the contrary, I want to emphasise that this is challenging, and the TEAM programme is just a small contribution in the larger context. Building trust is a painstaking and long-term effort that requires resources and commitment at many levels. This is especially challenging when dealing with issues related to religion and ethnicity. Let me give a small but illustrative example:

At the introductory TEAM seminar, students stay in double rooms, and we assign them randomly to give them the opportunity to get to know each other across social divides. This is meant to be the same for everyone. During the last seminar, however, two Muslim students expressed a strong desire to share a room because they intended to pray together. We then faced a dilemma: Should we say no and risk appearing unsympathetic, or perhaps even anti-Muslim? Or say yes and set aside the principles of equal treatment? We chose the latter, hoping that a welcoming attitude would help build trust and openness in the long run. At the same time, we see that expectations of special treatment on ethnic or religious grounds can potentially undermine efforts to counteract social divisions in the student community.

Language skills and clinical communication

Almashhadani and Spjeldnæs also highlight the teaching of clinical communication as an arena where ethnic discrimination occurs (1). I do not doubt the students' descriptions, but as a lecturer and head of the Department of Behavioural Medicine, which is responsible for this teaching, I see a need to nuance the presentation of this issue.

The authors claim that medical students with immigrant backgrounds do not have language challenges, as they 'have been admitted to one of the study programmes with the highest entry requirements in the country.' In recent years, however, it has become evident that a number of students are accepted into higher education, especially in healthcare programmes, without sufficient Norwegian language competency (7). The number of students in this category in the medical programme at UiO has not been determined, but as an instructor in clinical communication, I can confirm that each semester there are several students who have significant difficulties in effectively communicating with patients.

This is not the fault of the students. Adequate Norwegian language skills should have been ensured before the start of the programme or guaranteed through language instruction provided by the university. However, the expectation in higher education is that students will acquire the necessary language skills through participation in regular teaching, and as instructors in clinical communication, it is our responsibility to oversee this process.

Handling this challenge in just a few group sessions per semester is a difficult dilemma. As Almashhadani and Spjeldnæs indicate, this involves complex teaching situations where we need to consider the interests of both patients and students (8). It is easy to say something wrong or be misunderstood, and as one of the instructors, I will be the first to admit that I do not always express myself perfectly. Sometimes I bite my tongue before trying to explain what I actually meant to say. But even that requires experience and confidence. Everyone can improve, but there must be room for instructors to be new or maladroit in their role.

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How can we address a student's language challenges without it being stigmatising or, in the worst case, perceived as racism? How do we handle situations where a student does not want to shake hands with patients due to religious beliefs? And how do we approach issues related to clothing and religious symbols—whether it's revealing workout attire, hijabs, or a cross worn around the neck? These are questions that we, as instructors, discuss at seminars and during lunch breaks, and the solutions largely revolve around building trust. Together with the students, we must create a learning environment where it feels safe and natural to talk openly and honestly about differences, disagreements, and stereotypes. As head of department, I therefore invite open dialogue on how the teaching of clinical communication can be further developed in a diverse and multicultural society.

Building trust together

Finally, I would like to make an appeal to all those engaged in the anti-racism movement at the Faculty of Medicine. My concern is that the fight against racism could develop into a culture war between those defined as the majority and those belonging to various minorities. I am also worried that this could become a conflict along political lines. This kind of development has been extremely destructive for many universities in the United States. It reflects an international trend, and with the presidential election fresh in mind, there is reason to fear increased polarisation and extreme counter-reactions also in Norway.

Let me share another example to illustrate a fundamental issue: I was one of the few attending professors at the seminar 'An Anti-Racist Faculty of Medicine?'" on 6 February (9). I looked forward to an open debate on difficult topics but became concerned when the seminar started with drumming and a blessing from a Sami shaman and self-proclaimed healer. I understood that this was the Sami National Day, but in my secular mind, I thought: What would the reactions have been if we had invited a minister from the Church of Norway to bless one of our academic meetings? Are actions that are perceived as exclusive or offensive when performed by the 'majority' considered inclusive and noble when representing a minority?

Racism in medicine and health is generally related to discrimination against immigrants (10). But trust and tolerance go both ways. There is also racism and intolerance among minorities, and the stereotypical 'majority' is not a homogeneous group. It consists of individuals who can also experience exclusion, underappreciation and harassment.

Many of the problems we are discussing are not about hostility or ill-will, and I am glad that Almashhadani and Spjeldnæs 'by no means accuse educators, students and clinical instructors in the field of medical education in Oslo of being racists.' For this very reason, it is important that we do not present these complex issues as accusations against particular groups or individuals. Being subjected to racism is serious, but being accused of racism is also serious. If we are aiming for openness and inclusion, we must avoid alienating well-intentioned people in our own organisation.

The vision of 'a 100 % anti-racist Faculty of Medicine' (9) can easily be perceived as a political ideology with strong normative implications for what is acceptable to say and do. Many are reluctant to participate in this discussion for fear of saying something wrong and being labelled as intolerant. I therefore propose that we direct our efforts toward creating 'an inclusive faculty' – a place where we build trust through open and honest dialogue, where there is room to be different, to disagree and to make mistakes, while we strive to understand each other as best we can.

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Creating such an inclusive culture requires positive engagement from many. There are no simple solutions at the 'systemic level.' Awareness of laws, regulation and reporting procedures is important, but trust is not something that can be decreed or demanded. Politicians and university leaders must facilitate and lead by example, but the actual work of inclusion is something we must do ourselves. It is about how each of us chooses to meet others. I am therefore grateful that Almashhadani and Spjeldnæs have initiated this important debate on behalf of the students. Let us work together to include everyone in the discussion about how we build trust among students and staff at the Faculty of Medicine.

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