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“*I sound different, I look different, I am different*”: Protecting and promoting the sense of authenticity of ethnically minoritised medical students

Abstract

Background: Being authentic can improve students’ wellbeing, enhance the medical student-patient communication and patient safety. However, the underrepresentation of ethnically minoritised students in medical education can result in identity suppression, interfering with students’ ability to succeed academically and professionally.

Methods: We conducted interviews with 20 ethnically minoritised medical students, which were analysed thematically, to explore:

i) What facilitates and prevents students from being their authentic self during medical school?

ii) What learning and teaching strategies can enable students to be, or become their authentic self?

Findings: Experiences of discrimination, microaggressions and/or racism were the main barriers to authenticity, leading to fear of being discriminated again if students expressed their true self. Lack of diversity, cultural awareness and staff representation were also fundamental barriers. Being authentic was often perceived as contradictory to being professional, and a risk that could damage students’ reputation. However, when students could express their true self, they felt happier, safer, and developed a stronger sense of belonging.

Discussion: To enhance authenticity, students need to see better staff representation, role models they can relate and aspire to, such as Black Professors. EDIB (Equity/Diversity/Inclusion/Belonging) training needs to become embedded throughout the curriculum and be delivered by facilitators with lived experiences. Other strategies to promote students’ authenticity included mentoring, better signposting to complaints procedure and wellbeing resources, and implementation of ‘zero tolerance’ policies. To our knowledge, this is one of the first studies on the concept of authenticity in medical education, and the first study focusing on ethnically minoritised students.

1. Introduction

In medical education, discrimination and institutional marginalisation are considered the primary barriers to learning (Roberts et al., 2010), leading to lack of belonging (Wong et al., 2021; Russell et al., 2012; Beagan, 2005). The historical exclusion and underrepresentation of ethnically minoritised medical students (Wyatt et al., 2021) can result in identity suppression and interfere with students' ability to succeed academically and professionally (Russell et al., 2012). Furthermore, students' ability to express their true self might be disproportionately affected by societal, structural, and institutional factors, such as racism, discrimination, and socioeconomic inequalities (Mokhachane et al., 2023). We therefore argue that efforts to promote Equality, Diversity, Inclusion and Belonging (EDIB) need to consider students' sense of authenticity. Such efforts are also needed to minimise the potential risk of psychological harm when students deny or suppress their identity (Russell et al., 2012; Baams et al., 2015; Meyer et al., 2008); or equally, the negative implications of being authentic, different, and potentially standing out (Reay et al., 2010).

Authenticity is a concept commonly studied in existential psychiatry and philosophy, referring to the degree to which an individual's actions are congruent with their beliefs and desires, despite external pressures (Jacob, 1995). In medical education, external pressures include the expectation to adopt a certain personality (e.g., goal-oriented, competitive, high-achiever), or mode of living (e.g., expensive social outings). However, authenticity is about developing self-awareness and encountering external forces (Wood et al., 2008). When students fail to recognise and/or accept their true intuitions, they can make important decisions influenced by what they think that will please others (Joseph, 2016). In contrast, being authentic has been associated with inner growth and maturity (Merril, 1995), emotional intelligence, mindfulness, and self-deceptive enhancement (Tohme & Joseph, 2020). In medical education, authenticity can improve the medical student-patient communication and care, with resultant impacts on patient safety and health outcomes (Dyrbye et al., 2007; Hardeman et al., 2016).

This study explores the experiences of ethnically minoritised medical undergraduate students regarding their sense of authenticity within the medical school, and strategies that can promote their authenticity. The overarching research questions were:

- What facilitates and prevents students from being their authentic self during medical school?

- What learning and teaching strategies can enable students to be, or become their authentic self?

To our knowledge, this is one of the first studies to investigate the concept of authenticity in medical students (Fredholm et al., 2019; Roper et al., 2016; Yardley et al., 2012), and the first study focusing on ethnically minoritised medical students.

2. Methods

We adopted a constructivist methodological position considering that our knowledge and understanding was constructed with and through the students. We specifically adopted the lenses of social constructionism as we were interested in the processes in which medical students from ethnically minoritised communities 'describe and explain the world in which they live or how they see it' (Gergen 1985, p.3). Social constructionism has been used widely for the analysis of prejudice and impressions of one's self (Gerstenmaier & Mandl, 2001), which link closely with the conceptual framework of authenticity.

This study was co-designed alongside three medical students from ethnically minoritised communities, who were part of the research team throughout the decision-making process regarding the study design, data collection, analysis, and synthesis. Students were also involved in the design of the interview schedule, which is presented in the Supplementary Materials. We also piloted the interview questions with these students, to ensure that interviews could be completed in-depth within an hour, the questions were relevant and interesting, and to assess whether we have missed any important questions.

The recruitment was advertised through more than 50 students' societies at Imperial College London, such as the Afro-Caribbean, Indian, Bangladeshi, Pakistani, Afghan and Arabic student societies. Medical students who were interested to participate were signposted to the participant information form and the expression of interest form. Twenty students were purposefully selected to maximise representation across different ethnic groups. Ten of the students identified as 'female', nine as 'male', and one as 'non-binary', all aged between 18-24. Students self-identified as Black African (n=3), Nigerian (n=3), African Caribbean (n=1), Black British (n=1), Pakistani (n=3), Bangladeshi (n=3), Arab (n=2), Chinese (n=2) and Mixed (n=2).

The interviews aimed to explore (i) how students perceived their sense of authenticity; (ii) how able they felt to be authentic in the medical school; (iii) barriers and facilitators in the process of achieving self-authenticity; and (iv) strategies that medical schools can take towards promoting students' authenticity. The interviews were conducted by the lead research and lead author (ZM), who was the EDI Lead of the Medical Education Innovation and Research Centre (MEdIC). ZM had an independent position towards the students, and post-interview reflexivity sessions were scheduled with her supervisor (SK), who identifies as ethnically minoritised.

Interviews were analysed through reflexive thematic analysis following the six-step process: familiarisation; coding; generating themes; reviewing themes; defining themes; writing-up (Braun & Clarke, 2006). This process was undertaken by the lead researcher (ZM), her supervisor (SK), an external expert academic (AZ), and the three medical students who were involved throughout the study. Thematic analysis allowed us to reflect on how our thematic conceptualisation was evolving, growing, and deepening alongside increased understanding of students' experiences and perspectives. Tentative findings were also shared with the participants to ensure that we have not misinterpreted their experiences/we have not missed significant insights and to explore the credibility of our findings.

This study gained ethical approval by the Education Ethics Review Panel at Imperial College London (reference number: EERP2021-008a).

3. Findings

The findings are divided into three sections:

a) barriers to students' sense of authenticity, including:
   - previous experiences of racism, discrimination or microaggressions
   - lack of diversity and representation
   - culture in medicine
   - authenticity and year of study
b) psychological and emotional impact of authenticity
c) strategies that enable students to be, or become, their authentic self (Figure 1), including:
   - EDIB embedded throughout the curriculum

- mentoring and personal tutoring
- zero tolerance policies
- signposting to complaints procedure
- culture of transparency
- representation and role modelling

3.1 Barriers to students' sense of authenticity

3.1.1 Previous experiences of racism, discrimination or microaggressions

Previous experiences of racism and/or discrimination were the primary barrier that prevented students from expressing their true self. Even in circumstances where students had never experienced discrimination themselves, the fear of discrimination often had the same impact.

> *"We see patients who have immigrated to the UK and don't speak English. You can see the disparity and inequality of care, staff members saying they're more 'difficult'. That scares me slightly from saying, 'you're talking about this patient, but this could be my father'. So that hinders me from sharing that aspect [of being a refugee]." (3rd year Arab student)*

> *"When you feel discriminated against, you feel like you have to ignore it, or laugh it off, but you can't react because the next thing is, 'you reacted like every other angry Black male'." (4th year Nigerian student)*

Microaggressions, which are often more indirect, subtle, or unintentional, led to students being reluctant to express their authentic self, such as wearing clothes that represent them:

> *"We were coming back wearing our do-rags and the security guy stopped us and asked for our ID, the only time that has ever happened. We didn't speak about it for ages until a year later and it's funny we both remembered it, which means that we're not imagining these things, they're actually happening." (4th year Black African student)*

Discrimination was often experienced during placements, particularly by patients who made harmful comments about students:

> *"I was with my partners when this man went 'Ugh, there's more of them', referring to the fact that we're a bunch of brown people, it's really hurtful." (4th year Pakistani student)*

Such experiences led to fear of being discriminated again if students expressed their true self:

> *"I'm applying for jobs thinking, would they assume I didn't study in England because I don't sound like my British counterparts? Would they think I'm less clinically adequate? I sound different, I look different, I am different. There's a lot of risk when you're authentic, people might not accept you. Whereas if I'm in my code, switched personality, people accept it. But I know deep down, that's not me." (6th year Nigerian student)*

3.1.2 Lack of diversity and representation

Students expressed their disappointment when EDIB sessions were not delivered by people from diverse or underrepresented communities, and/or with lived experiences:

"We had a lecture on racism given by a white lecturer who said she checked it over with a Black colleague. If we only have one lecture on racism, they should be able to get a lecturer of colour." (1st year mixed-ethnicity student)

Better representation was expected across the whole curriculum, not only in EDIB sessions:

"It's not OK to only have black people in EDI roles. If I don't see myself as a professor I'm not going into academia. How am I expected to know that I am allowed to be a professor?" (5th year Black African student)

Students also noticed the wider lack of representation, such as in the interior building design:

"Even the portraits remind me this place was never built for a person like me." (3rd year Pakistani student)

In contrast, when students experienced representation, this triggered their motivation and inspiration:

"I went to a tutorial and the person leading it was Black. I was so engaged sitting and listening to someone that looks like me. I realized, all of a sudden, this is what my white counterparts feel like every single day." (6th year Nigerian student)

3.1.3 Culture in medicine

Within the medical culture, authenticity was often perceived as opposite to professionalism:

"There's no space to be authentic, you're expected to be professional… dress in a certain way, take off jewellery, don't have tattoos…" (4th year Pakistani student)

Due to the strong hierarchical structure, students argued that only people in positions of power have the privilege to be authentic:

"You go from medical student to junior doctor, then up the ladder until you're consultant. I'm at the bottom of the hierarchy. I'd imagine, as I become more senior, I'd be more comfortable sharing who I am." (3rd year Arab student)

Authenticity was also hindered by the competitive nature of medicine:

"Everyone is doing everything all the time and accelerating… I don't understand how well you can do all these things? It's like you're never enough because everyone got a massive CV, in their LinkedIn profiles are completely different people". (4th year Arab student)

3.1.4 Authenticity and year of study

Authenticity was experienced differently based on students' year of study. First year students were less likely to feel authentic, which was attributed to the transitional phase from high school to higher education and the pressure to develop friendships quickly (e.g., Fresher's week). In contrast, students after their third year appeared more confident in being authentic. This was attributed to their academic progress and development of safer relationships:

"Everyone goes 'first year is the easiest, first year you can chill'. I was like, no, I constantly feel too dumb for this university. But now I'm 100% part of this, I made it, people recognise my name..." (3rd year Pakistani medical student)

Hence, authenticity was perceived as a '*privilege that comes a bit later" (5th year Chinese student):*

"With time, I might find the perfect balance between being authentic and professional, but that's a long, long way from now." (2nd year mixed-ethnicity student)

3.2 Psychological and emotional impact of authenticity

Students linked authenticity with feelings of happiness, positivity, freedom, and comfort. Some also mentioned feeling 'acknowledged', 'valued', 'appreciated', 'fortunate', and 'special'.

"I'm a lot happier and positive, even when I'm completely vulnerable about my identity. You create stronger relationships which is a never-ending cycle. All of a sudden, they know you in a deeper way and you feel safer to present that [vulnerable] side of yourself." (4th year Nigerian student)

In contrast, lack of authenticity was associated with feelings of shame, anxiety, depression, frustration, anger, withdrawal, sadness, helplessness, and exhaustion. As a student said:

"I look back and regret not being myself. I was ashamed I didn't embrace my Pakistani roots, or my Muslim roots. I was ashamed for not being myself." (4th year Pakistani student)

Sense of belonging was another psychological impact closely linked with authenticity. Students were better able to express themselves in spaces where they felt that they belong, which in turn led to higher self-confidence, self-esteem, and professional fulfilment. This relationship appeared to be dynamic; the greater the sense of belonging, the more students felt able to express their authentic self:

"I am at my happiest when I belong, and it comes from feeling authentic. It's not ecstasy kind of happy, it's more peaceful, kind of laid-back happiness." (2nd year mixed-ethnicity student)

3.3 Strategies to promote authenticity

3.3.1 EDIB embedded throughout the curriculum

Students argued against one-off EDIB sessions, which may not result in drastic changes. They suggested that EDIB principles should be compulsory and embedded throughout the curriculum:

"When I signed up to 'Health Equity', I thought, everyone here doesn't need this, they signed up because they are interested in medical equity. But people who aren't interested are never going to learn about this." (1st year, mixed-ethnicity student)

For example, students wanted to be informed about clinical cases that represent the wider society, instead of being taught about how conditions/symptoms appear only on Caucasian people:

"We had a lecture on appendicitis, and I asked about the pain from appendicitis being experienced differently for people with a certain ethnicity. They were going through the questions, and they just skipped mine, got completely ignored. It could have been a mistake, but these instances pile up and then you see a pattern." (2nd year mixed-ethnicity student)

Students would also prefer EDIB sessions to be delivered by people with lived experience who had to navigate challenges around expressing their true self and values:

"If a surgery is long, you can't leave to pray. You want to hear what they did when they were in your shoes." (6th year Bangladeshi student)

3.3.2 Mentoring and personal tutoring

Mentors and personal tutors played a significant role in students' ability to express their authentic self and navigate the resultant challenges, especially when they were also coming from ethnically minoritised backgrounds:

> *"I don't know how she [tutor] picked up that I wasn't feeling well. She's the first person I ever told about domestic violence. She encouraged me to go counselling and that was a catalyst to become more accepting of who I am and explore why I am who I am. It helped me not wanting to ignore those parts of my life and bury them." (2nd year Bangladeshi student).*

Having the same mentors or tutors throughout medical school was especially important to build long-term, trusting relationships:

> *"I can be more authentic because it's a one-to-one connection that has been built up over years." (3rd year Chinese student)*

3.3.3 Zero tolerance policies

Students mentioned how often they hear about zero tolerance policies, yet how rarely the injustices that happen are being addressed. In future policies, students expect recognition that racism and discrimination exist, and explicit information about what actions are taken to address them:

> *"Knowing that someone will not only look into it but will take you seriously when you report something. Knowing that something will be done, and it won't be swept under the rug. You want to know that someone's acting on your behalf." (5th year Black British student)*

3.3.4 Signposting to complaints procedure

Students expected better signposting to the complaints and reporting procedure, as they expressed that it is unlikely to express their true self in environments where they feel inadequately protected. For example, most students did not know what to do when they were either observers or recipients of discrimination:

> *"It's really hard to find the complaints procedure. I don't know if this procedure actually protects me as a Jewish student, does it go under ethnic complaints or under religious complaints? Where does it go under?" (1st year mixed-ethnicity student)*

> *"I'm not sure where to get help, and that's something everyone should know. We have welfare representatives, but it's a very sensitive topic and not everyone wants to go explain what they've just gone through." (2nd year Black African student)*

3.3.5 Culture of transparency

Students highlighted that a culture of transparency needs to be cultivated, where they feel able to have authentic and honest conversations about uncomfortable, challenging, or sensitive issues. For example, failure to acknowledge and discuss important issues around injustices, not only prevented students from being authentic, but they could also cause harm:

> *"A lecturer had a derogatory picture of a black person on the screen. One of my friends was really hurt and emailed him to remove it, and he said, 'I'm leaving next year, it doesn't matter'.*

It was quite dismissive and not acknowledging that he did something wrong or hurtful." (3rd year Pakistani student)

In contrast, when these issues were acknowledged and discussed had the opposite outcome:

"We had this scandal about some guys being sexist, and when it came out, the head of medical school came to talk to us and reassured us that the medical school does recognise these sorts of things." (2nd year Bangladeshi student)

Students mentioned how important it is for the medical school to provide training on how to navigate difficult conversations, either with other students, staff, clinicians or their patients:

"There is a way to raise concerns, but there isn't advice on how to gently bring things up." (1st year mixed-ethnicity student)

Students argued that training on having authentic conversations could also lead to better student-patient relationship and patient care:

"Your patient should know who you are, your beliefs. If you're getting to know someone well, they have the right to know you too. Normally the attitude is to remove the individual, you're just the doctor. Whereas it's way better when you have a personal connection and create a partnership, rather than just a duty." (2nd year mixed-ethnicity student)

3.3.6 Representation and role modelling

Finally, students discussed the importance of representation and role modelling. For example, a student fondly remembered praying with their personal tutor who was also Muslim, which made them feel '*visible*'. Another student mentioned that:

"I would love to have role models of doctors who are openly trans or queer or religious, because it's hard to see what that path looks like." (1st year mixed-ethnicity student)

Representation was especially important for Black students, who highlighted that seeing Black doctors or teaching staff is empowering, motivating, and inspiring:

"If I was in placement with a Black doctor, for reasons I can't explain, I can be myself. Representation makes people feel welcome, more at home and psychologically safe. Seeing people who look like you, speak like you, understand you, would go a long way to making you feel more authentic." (4th year Black African student)

"I went to a tutorial and the person leading it was Black. I was so engaged sitting and listening to someone that looks like me. I realized, all of a sudden, this is what my white counterparts feel like every single day." (6th year Nigerian student)

4. Discussion

This study aimed to explore the experiences of ethnically minoritised medical undergraduate students regarding their sense of authenticity within the medical school. Our findings discuss the psychological and emotional impact of being (or not being) authentic, the barriers to being authentic, and the pedagogical strategies that medical schools can implement to promote students' authenticity. These findings are also presented visually in Figure 1.

Previous experiences of racism, discrimination and microaggressions were the primary barrier to students' authenticity. Such experiences led to fear of being discriminated again, preventing students from expressing their true self. Most examples came from students' clinical placements with patients who made discriminatory comments about their race or ethnicity. The lack of diversity and representation in leadership positions also hindered students' sense of authenticity and belonging. Furthermore, authenticity was often perceived as opposite to professionalism; as such, students had to conform to a specific professional identity, findings consistent with previous research (Frost & Regehr, 2013; Fergus et al., 2018; Cruess et al., 2014, 2015; Wyatt et al. 2021). For example, they often had to change their accent or external appearance to fit in. This should be taken into consideration in critical medical education concepts, such as professional identity formation and socialization (Cruess et al., 2015).

This study focuses on six student-led strategies that medical schools can implement to promote authenticity. Strategy one suggests that EDIB sessions should be delivered by facilitators with lived experience to support students navigate and understand challenging experiences around expressing their authentic self. EDIB principles should also be spiralled throughout the curriculum to reflect the EDI framework, which highlights that diversity must be at the core and not at the periphery of medical education (Nivet et al., 2016).

Students found the zero tolerance policies were insufficiently implemented, and they expected medical school leaders to take stronger action against racism/discrimination. Crucially, students needed better signposting to the complaints procedure and wellbeing services from the beginning of their academic journey. Most students were not aware how to report instances of racism/discrimination and how to access wellbeing support. This is a problem commonly reported in studies showing that medical schools are poor at recording students' complaints of racial harassment (Kmietowicz, 2020). Yet, evidence shows that students who do not disclose experiences of racism/discrimination are more likely to develop psychological distress, mood and anxiety disorders due to suppression, and therefore needs to be taken seriously (McLaughlin et al., 2010; Williams et al., 2003). The role of mentors and personal tutors may be invaluable in signposting students to the reporting procedures and wellbeing services, and in guiding them to navigate the impact on their personal and professional identity. The benefits appeared to be higher when students remained with the same mentor/tutor throughout the medical school, and when they had shared experiences or similar backgrounds (e.g., working-class background, ethnically minoritised).

Students suggested that medical school should provide student training on how to navigate difficult conversations. This echoes studies which found that education does not teach students how to deal with challenging situations, such as discrimination (Roberts et al., 2010). This training would be particularly important for dealing with microaggressions, such as 'jokes' or derogatory language. As microaggressions is one of the main ways that racism is reproduced, students should be trained in how to recognise and address them, whether they are the target or not. Students' desire for honest conversations also links to 'relational authenticity' (Kernis & Goldman, 2006), which places the value of openness and honesty in interpersonal interactions at the core of authenticity (Wilt et al., 2019).

The last strategy focused on the importance of representation and role modelling. Prince et al. (2005) argues that the underrepresentation of ethnic minorities in academic medicine is partially because students lack role models they can identify with. Considering that role models can motivate, inspire, and instil professional behaviours (Passi et al., 2013), role models in positions of power can significantly affect students' ability to be authentic. This has been explained by theories of racial

similarity and shared experience of oppression (Sanchez et al., 2015), which makes students more likely to be authentic around staff with perceived shared experiences.

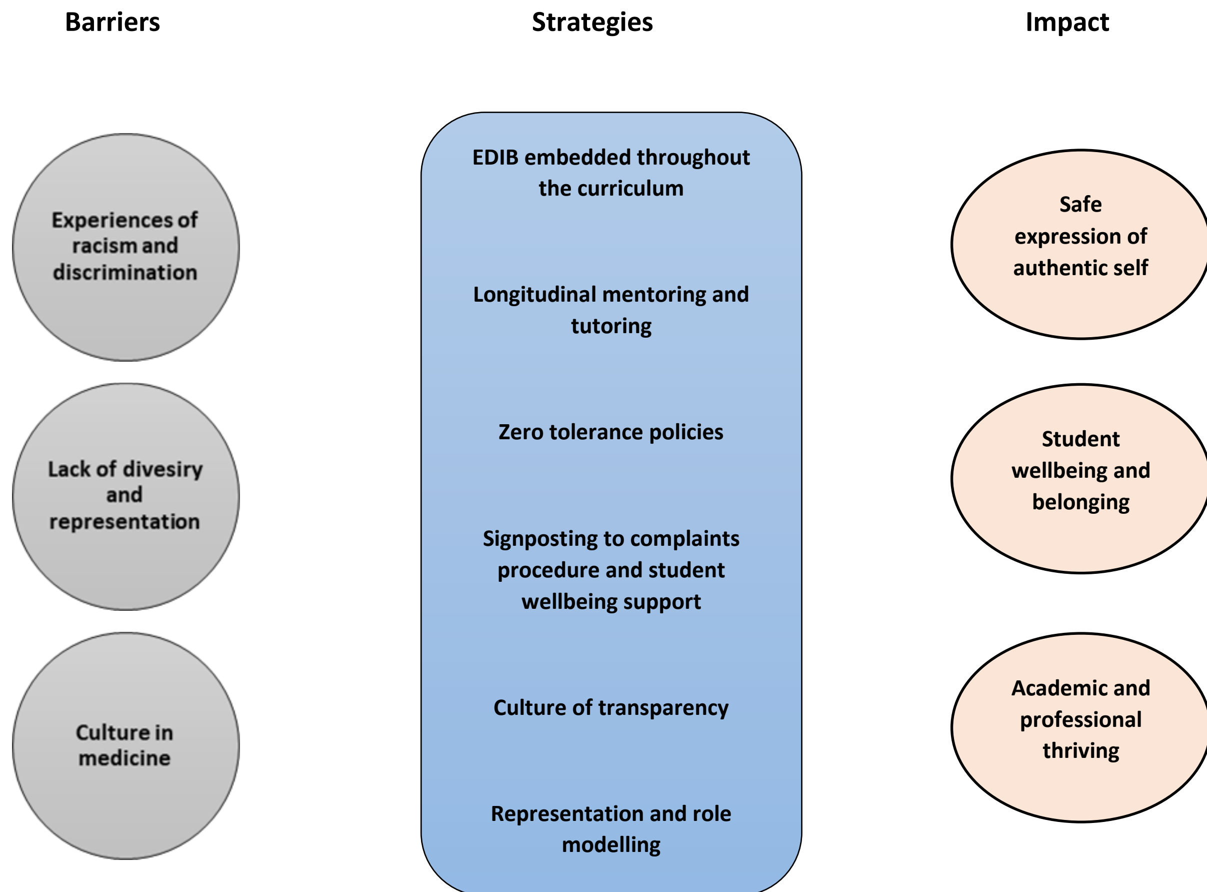
In terms of the psychological and emotional impact of authenticity, our findings echo literature associating authenticity with higher self-awareness, optimism, wellbeing, and belonging (Joseph, 2016). Because of the dynamic relationship between authenticity and belonging, students experienced higher sense of belonging in environments where they could be authentic; and vice versa, greater sense of belonging enabled students to be more authentic. From the perspective of internationally recognised psychologists, such as Yalom, Rogers and Winnicott, authenticity is not only an aspect of wellbeing, but '*the very essence of wellbeing and healthy functioning*' (Wood et al., 2008, p.386). Therefore, we argue that medical schools need to create the conditions and safe environments where students feel comfortable to express their authentic self, rather than reproducing oppression and identity suppression. This means integrating authenticity as important element in pedagogical strategies and spending more time on discussing issues of authenticity in class.

This is one of the first studies to investigate the concept of authenticity in medical students and to our knowledge, the first study with a clear focus on medical students from ethnically minoritised communities. Considering the wide use of the term 'authenticity', however, it is possible that relevant studies exist in other fields. While previous studies on authenticity focussed on 'feeling like a doctor' (Fredholm et al., 2019), professional identity (Roper et al., 2016), and student metis (Yardley et al., 2012), our study shows the specific barriers to being authentic faced by ethnically minoritised medical students and suggestions on how to mitigate these barriers coming from students themselves. However, one of the limitations of this study is that it was conducted with a relatively small number of students in a specific higher education institution; therefore the generalisability of the findings is limited. Future studies could focus on other students' backgrounds, or on staff from ethnically minoritised communities to see if experiences are mirrored. Future studies could also benefit from a larger perspective, by including student groups from other universities and countries. Finally, future research could investigate how the implementation of the above student-led strategies in medical schools may create safer and more inclusive learning environments where students can feel that they belong, reach their academic potential, and where their authenticity can be shared celebrated.

5. Conclusion

This is one of the first studies to investigate the concept of authenticity in medical students, particularly from ethnically minoritised communities. Interestingly, being authentic was often perceived as contradictory to being professional, and a risk that could damage students' reputation. Our findings discuss the psychological and emotional impact of being (or not being) authentic, the barriers to being authentic, and the pedagogical strategies that medical schools can implement to promote students' authenticity. We conclude that, to enhance authenticity, students need to see better staff representation, such as Black Professors, and EDIB principles spiralled throughout the curriculum. These changes should go hand in hand with other supporting mechanisms, such as mentoring, effective signposting to complaints procedure and wellbeing resources, and implementation of 'zero tolerance' policies.

Figure 1: Students' sense of authenticity: barriers, strategies, and impact



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