Active Inclusion, Challenging Exclusions:

Decolonising medical & dental curricula

January 2025

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Dental Schools Council

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Foreword

Three years ago, the MSC EDI Alliance decided that the third instalment in the 'Active Inclusion, Challenging Exclusions' series would focus on the topic of Decolonising the Curriculum. Along with colleagues from the Dental Schools Council (DSC), a writing group was formed, consisting of 13 medical and dental schools who met regularly to discuss the aim and the contents of this guidance document. We were keen to ensure that the document will be helpful to support medical and dental schools across the UK at different stages in the decolonisation process. The recent incidences of rioting, racism, Islamophobia and Antisemitism in some cities in the UK, have been deeply concerning. However, we were heartened to see the strong statements that have been made standing against this by universities across the UK. However, these recent events further emphasises the need for universities to actively engage in the decolonisation process, to understand, raise awareness and implement relevant actions.

This guidance document is a dynamic and live one that needs to be reviewed and updated as knowledge and literature continue to become more widely available. We encourage that this document is read and discussed further among your leadership teams to develop an action plan in implementing the suggestions and recommendations to decolonise medical and dental curricula. We have pushed for bold changes but ones that we are equipped to work towards within our own schools and in collaboration with other medical and dental schools.

During meetings, the members of the drafting group had robust discussions on whether the decolonisation of the medical and dental curricula should be focused primarily on race given that colonisation has primarily oppressed people of colour or if the focus should be intersectional with all protected characteristics given equal weightage. There were strong suggestions also on centring the document around race/racism and highlighting how other protected characteristics interplay with race, adding layers of exclusion and social discrimination. The opinions of the writing group members were diverse, a microcosmic reflection of opinions on decolonisation across HE in the UK, which was pivotal in shaping this document. It has enabled colleagues in the writing group to respect differing viewpoints while challenging one another.

We have collectively acknowledged that maintaining race/racism as the foundation of the document is critical while bringing in other intersectional characteristics/social identities that make up an individual. Sibanda (2018) states that 'Historically, decolonisation has been a racialised issue due to colonised spaces being made up of oppressed people of colour, with whiteness and Eurocentrism dominating (Noxolo, 2017). Therefore, issues of race and decolonisation are difficult to separate. Furthermore, colonisation operates through and is informed by multiple forms of oppression which begin with racism but intersect with sexism, heterosexism, classism, ableism, Islamophobia etc. Colonialism operates and is enforced through these forms of oppression while built on the foundation of racism.

For these reasons, an intersectionality approach is important. The term 'intersectionality' was coined by Kimberlé Crenshaw (1989) to describe the double discrimination of sexism and racism experienced by Black women. In particular, she challenged American legal cases where women had to choose between making a claim on the grounds of either sexism or racism

as the combined effects of both was not recognised. Since then, the term has expanded to recognise "that people's lives are shaped by their identities, relationships and social factors. These combine to create intersecting forms of privilege and oppression depending on a person's context and existing power structures such as patriarchy, ableism, colonialism, imperialism, homophobia and racism[1]"

Upon completion of the drafts, they were reviewed by the working group. We also consulted with student leaders nominated by medical and dental schools in the EDI alliance. The document you will read is a culmination of robust discussions, debates and consultations and we are really proud of what has been produced. Different institutions have shared some examples of how they are attempting to decolonise their medical and dental curriculum, which we hope you find inspiring to use where relevant.

We are excited to be working with medical and dental schools across the UK to collaborate, share best practices and implement the suggestions made in this guidance document.

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1 UN Women Australia, https://unwomen.org.au/our-work/focus-area/intersectionality-explained/

Contents

1. Introduction

This document provides guidance on things you may want to consider in the process of decolonising the curriculum at your medical or dental school. This guidance is not an exhaustive piece, but rather provides a starting point. It is acknowledged that every medical and dental school will be starting from a different point and working within different circumstances, and, as such one size will not fit all.

There will be examples of good practice provided throughout and a resource bank can be found at the end of the document.

Who is this document for?

This document is for those working in UK medical and dental schools to assist them in working towards decolonising their curricula.

The aim of this document is for it to be accessible to everyone working in the sector regardless of where you and your school are in your decolonisation journey; no prior understanding of the topic is expected nor required. It is hoped that this document will provide you with a better understanding of the concepts that surround decolonisation of education, as well as inspiration and guidance to move forward.

What does 'decolonising the curriculum' mean?

The term 'decolonising' has taken on various definitions across a range of post-colonial movements. There are a variety of viewpoints and interpretations of and approaches to the field. In the context of higher education, decolonisation largely can be seen as the consideration of how "forces of colonialism, empire and racism have shaped the world we live in today[2]" and "the

2 Decolonising the Medical Curriculum, UCL (2021) https://decolonisingthemedicalcurriculum.wordpress.com/ adapted from: *Bhambra, G.K., Gebrial, D. and Nişancıoğlu, K., (2018). Decolonising the University. London: Pluto Press, p. 2*

presentation of alternative modes of thought from the perspective of populations which have historically been oppressed and marginalised by these forces[3].” This is not just limited to racial oppression, but also the oppression of LGBTQIA+ people, disabled people, minority genders, and the working classes.

As Finn et al. note, “decolonisation cannot be reduced to a single act. It must rather be viewed as a continuous, long-term process and commitment to change.”[4]

This guidance takes decolonisation to refer to “the aim to overturn power imbalances rooted in historic and institutional biases along axes of race, ethnicity, nationality, class, gender, sexual orientation and disability.”[5] This is the intersectional definition used on the Decolonising the Medical Curriculum website created by staff and students from UCL Medical School Clinical and Professional Practice, UCL Culture and visiting contributors, which was initially based upon the work of Bhambra et al (2018).

3 Decolonising the Medical Curriculum, UCL (2021) https://decolonisingthemedicalcurriculum.wordpress.com/ adapted from: Bhambra, G.K., Gebrial, D. and Nişancıoğlu, K., (2018). Decolonising the University. London: Pluto Press, p. 2

4 Finn, G. M., Danquah, A. and Matthan, J. (2022). Colonization, cadavers, and color: Considering decolonization of anatomy curricula. Anatomical record (Hoboken, N.J. : 2007), 305 (4), pp.938–951.

5 Decolonisng the Medical Curriculum, UCL (2021) https://decolonisingthemedicalcurriculum.wordpress.com/ *adapted from: Bhambra, G.K., Gebrial, D. and Nişancıoğlu, K., (2018). Decolonising the University. London: Pluto Press, p. 2*

2. Curriculum development

2.1 Developing content

Education institutions and curricula are shaped by those who design them. It is, therefore, important that a wide range of voices and perspectives are involved in the process of curriculum development.

When developing your medical or dental curriculum, co-creation is important. Try to ensure that as many colleagues from as many different professional and personal backgrounds as possible are involved, not just those from positions of seniority. Whilst lived experience should inform the development of the decolonised curriculum, the burden of its creation should not fall solely upon those with these lived experiences but rather involve all stakeholders.

Everyone will have insights and perspectives which are worth hearing and taking on board, not just academic staff. Library staff, for example, will be able to support with ensuring access to a diversity of literature, pastoral and administrative staff may have unique insights into how curriculum changes may affect student wellbeing and experience, whilst estates and facilities staff may be able to support with the development of inclusive environments. Providing staff with protected time to do this work may encourage as many staff as possible to take up the opportunity to be involved. The medical school at Queen Mary University of London, for example, developed specific work groups made up of professional and academic staff to answer the question of if they had a blank slate, what would they like to do with the curriculum? These groups meet monthly, and it is intended that they will also eventually include students. Similarly, the Faculty of Medicine and Health Sciences at University of Nottingham formed a task and finish group made up of over forty staff and students to design an inclusive curriculum toolkit.

A diverse range of students should also be consulted and involved with the development of the decolonised curriculum. Whilst the needs and insights of students will be different, the value of their contributions should be considered on a par with that of staff.

Allocating space in the academic timetable for this work can help facilitate and encourage this active co-creation.

It is important that the work both staff and students put into developing a decolonised curriculum does not go unrecognised and that they receive compensation for their contributions. In the case of staff, this could be done through allocating protected time within staff's paid hours or credit could be provided for this work in performance development reviews. Student recognition could be through remuneration (some schools have found funding for this through central university equity, diversity, and inclusion (EDI) funding) or academic credit. Leicester University Medical School, for example, offer the chance to complete this work as a Student Selected Component, whilst it is offered as an elective at St George's University of London, and the University of Southampton Faculty of Medicine pays students who contribute substantially toward decolonising the curriculum through the Faculty EDI budget.

2.2 Training

All staff and students should understand the concept of decolonisation and the importance of the principles of equity, diversity, and inclusion.

Some themes medical and dental schools have run training for staff on have included:

- Encompassing historical considerations in the curricula
- Cultural relevance and representation

- Use of inclusive language
- Stereotypes and bias in the curriculum
- Developing inclusive assessments
- Managing dynamics in multicultural teams/classroom settings
- Unconscious bias
- Exploring microaggressions and active bystander training
- Exploring health inequities in the clinical placement contexts.

There is a wealth of EDI training options now available to schools. Training should be fit for purpose and ideally role specific. If choosing an external provider, ask if the training is customisable to allow you to signpost your own medical school policies, NHS trust and university Report and Support options, and provide medical education-specific case studies and examples. Contact other schools who have used the provider for their feedback. Many schools have reported higher engagement with EDI training when it is delivered face to face, although this may not always be possible due to external factors.

Whether inhouse or externally run, it is vital an open, supportive, and non-judgmental environment is provided to allow frank and honest discussions of difficult topics, where questions can be raised and answered.

The Newcastle University School of Medicine ran a series of bespoke EDI training sessions for school staff. The titles of the sessions were:

- EDI framework
- White privilege
- Anti-racism and allyship
- Be an active bystander

Melanin Medics, a national charity promoting racial diversity in

medicine, widening aspirations and aiding career progression, runs workshops on Allyship and Advocacy, which are designed to equip medical students, doctors, allied healthcare students and professionals with the knowledge and skills necessary to promote diversity and inclusion within their professional environments. Topics covered in the sessions include inequality in medicine, allyship and supporting colleagues, advocating for patients, and actionable strategies to support and practice allyship and advocacy.

The student body can be a vital source of information and listening to them can play a key role in decolonising the curriculum. As such, Southampton Medical School introduced reverse mentoring, enabling students to mentor senior members of the medical faculty to help them understand the perspectives and experiences of students from minoritised backgrounds. Students who take part in the scheme are financially compensated for their time. A study of the project found "a positive change in staff characterisation of the students and an acceptance of institutional responsibility for challenges faced."[6]

These outcomes led to the creation of Southampton Medical School Student-Staff Collaborative Decolonisation Project.

6 Curtis, S. et al. (2021). Challenging the deficit discourse in medical schools through reverse mentoring—using discourse analysis to explore staff perceptions of under-represented medical students. BMJ Open 2021;11:e054890.

3. Content

3.1 Why question the content?

There are two key reasons to question the content of your curriculum through a decolonial lens:

1. To ensure that your students are receiving the most rounded and complete education possible.
2. To ensure that the future patient population is receiving the most effective and appropriate care for them.

A key aim of medical and dental education is to produce the next generation of clinically competent doctors and dentists to serve diverse communities. This is not possible if content does not reflect the increasingly diverse patient population. For example, how will a doctor be able to identify measles if they have only ever seen it presented on white skin? How will a dentist be able to identify periodontal disease in all of their patients if they have never seen it presented on a person of colour? Simply put, more inclusive and effective education leads to better patient care.

3.2 Whose voices are we hearing?

Historically, the white male voice has been predominant in health education, whilst the achievements of those who are oppressed within society have tended to be less heard. A UCL study, for example, found that 70% of the authors of science papers included in two university reading lists were male, and 90% were from European, North American or Australasian universities[7]. If this is the case in your curriculum, it is more than likely that a wealth of knowledge, expertise and incredibly valuable perspectives are being neglected.

7 Schucan Bird, K; Pitman, L; (2019) How diverse is your reading list? Exploring issues of representation and decolonisation in the UK

A simple first step to this can be reviewing your reading list and looking to provide a wider range of voices and perspectives. Library staff at the University of Exeter created a useful resource on decolonising your reading list, which can be found here.

Do not take texts as authoritative just because they have always been seen that way; look for alternatives to accompany them from hidden or oppressed figures. This can be particularly pertinent in the teaching of history and developments in medicine and dentistry, where western histories typically dominate. Expanding beyond this to include a truly global history, for example including teaching on displaced indigenous healing systems[8], or the contribution of the Windrush generation in building the NHS, will allow for a more complete picture to be taught to your students.

It can in some instances be challenging to include voices that are suppressed, as this information is not always widely available or easy to find. Consulting library staff, liaising with staff and student networks and fostering active partnerships with patients and members of the public can be particularly useful to help unearth this information. Through working with the communities that these voices represent, there is a higher likelihood of success.

In their Medical Humanities module, Brunel Medical School explores the relationship of human storytelling to health and medicine, looking at how the stories of people, patients and their doctors from a range of backgrounds has influenced the changing landscape of medicine. It also looks at the evolution and meaning of change, and how this relates to our students

8 Lokugamage, U; Ahillan, T; Pathberiya, S. D. C; (2020) Decolonising ideas of healing in medical education Journal of Medical Ethics 2020;46:, pp265-272.

and their future experiences now and as doctors. There is a focus on history, in how the past affects the present and how this can inform people's viewpoints and decision-making.

3.3 Research and data

Data are not neutral. Research is often conducted in a manner which does not allow for fair representation of marginalised groups such as global majority communities or women. A recent Ipsos survey found that whilst 6 in 10 (58%) adults in the UK reported that they would be willing to participate in a clinical trial, only 4 in 10 (41%) of ethnic minority adults would be willing to[9]. It may mean that the teaching of certain conditions does not prepare students to competently treat them in many populations. Data and their findings need to be set within appropriate context and show the importance of inclusion in future research. For example, when learning about heart disease, Southampton medical students explore how gender and racial bias in research on heart disease has created gaps in our knowledge and contributed to inequities in cardiovascular outcomes and care. The importance of adopting an intersectional approach is also highlighted.

Just as students are taught the importance of discussing sample size and the type of study when assessing papers, they should too be encouraged to consider who ran and participated in the study.

Participation rates in research can be affected by peripheral trauma as a result of historical unethical practices which have taken place in research, for example, the work of

9 West, R. Diversity and clinical trials in the UK (2024), Ipsos, Available at https://www.ipsos.com/en-uk/bridging-ethnicity-gap-clinical-trial-participation-education-and-tailored-communications-needed#:~:text=The%20number%20of%20adults%20who,to%20take%20part%20in%20one. Accessed 5th September 2024)

J. Marion. Simms and the Tuskegee experiment.

"A nascent body of research suggests exposure to racially or ethnically targeted events predicts adverse physical and mental health outcomes among minority groups, even among members not directly targeted, a phenomenon known as peripheral trauma. In cases where the medical profession is the perpetrator of such actions, health effects may be even more pronounced as targeted groups experience both the stress of targeting and heightened mistrust of the medical profession."[10]

Not only can this peripheral trauma affect participation in research, studies also suggest that individuals from these groups may be more inclined to avoid healthcare,[11] resulting in health inequalities. It is important that students are educated on this matter so that future medics and dentists can work with an awareness of this important context in their future practice. With this in mind, the medical school at St George's, University of London set up internal training of healthcare science courses specifically on research inequalities which includes historical issues alongside a vision to addressing this in current and future practice.

3.4 Evaluating current content

Decolonising your curriculum does not have to mean rebuilding from scratch. A good starting point can be evaluating the current content in order to see what is currently there and what is missing. Once you have identified this, you can begin to think about replacing or removing problematic areas and filling in the gaps.

10 Alsan, M., Wanamaker, M. and Hardeman, R. R. (2020). The Tuskegee Study of Untreated Syphilis: A Case Study in Peripheral Trauma with Implications for Health Professionals. Journal of general internal medicine : JGIM, 35 (1), pp.322–325.

11 Ibid

Some key questions to ask when reviewing the content could include*:

- Who are the texts you are presenting to your students written by?

- Are they predominantly white authors or is expertise from the global majority also present?

- Have you explored, identified and recommended resources or research from diverse authors and regions to enable knowledge outside Eurocentric or West-centric perspectives?

- Are you highlighting when developments came about as a result of unethical practices?

- Is the historical context of the research provided?

- Is teaching on history and developments in medicine/ dentistry truly global or is it dominated by western histories (i.e. the Renaissance/Graeco-Roman period)?

- Is the historical context of how knowledge was created included?

- Where is your data from?

- Who were the researchers?

- What was the aim?

- What was the makeup of the research population?

- Do you teach about who decides health research agendas?

- Have you included the biopsychosocial and demographic models of diseases? E.g. the impact of housing inequalities and unequal access to healthcare on infection and mortality rates.

- Have you included health inequalities and inequities?

*Please note that this list is not exhaustive.

3.5 Developing new content

The medical and dental curricula should reflect changes within society, scientific knowledge, medical/dental practice, and regulatory requirements. When developing new content, similar questions should be asked as when evaluating the current content.

As is the case with curriculum design, co-creation is integral for effectively developing new content.

3.6 Case-based learning

Research has suggested that scenarios used in case-based learning may not sufficiently represent the diversity of the patient population.[12] At the same time, there is a danger that when diversity is represented, it is done in a stereotypical manner which simply replicates, for example, racist, sexist and homophobic assumptions. It has been suggested, for example, that varied social identities are only mentioned if that knowledge is considered a 'relevant risk factor' to the diagnosis being presented in the case,[13] for example, gay men only appear in scenarios relating to HIV or individuals born in Africa being used in scenarios relating to sickle cell disease. Clearly, this does not accurately present the situations student will encounter in clinical practice. By ensuring that patients used in case studies are from a diverse range of backgrounds feature across all scenarios, students will be better prepared to work clinically in the future. It is also important to keep intersectionality in mind when developing scenarios and

12 Bowden, S. et al. (2021). Evaluating and implementing an opportunity for diversity and inclusion in case-based learning. Canadian medical education journal, 12 (4), pp.146–148.

13 Mosley, M. P. et al. (2021). Thinking with two brains: Student perspectives on the presentation of race in pre-clinical medical education. Medical education, 55 (5), pp.595–603.

include a diverse range of names in such learning, along with how to correctly pronounce the name in the case description.

These principles should be carried over when using scenarios in Project and Team-based learning.

3.7 'EDI content'

It is important that inclusive content is not solely included in tokenistic lectures or communication skills teaching but embedded in all modules throughout the curriculum. When preparing your teaching, ask yourself what you are doing to challenge colonial narratives, to ensure that the diverse population of the UK is represented and that students are being made aware of health inequities. For example, when teaching maternal health, are your students being informed that maternal mortality for Black women is significantly higher than for White women? When discussing immunisation, are conversations around vaccination inequities included?

Some schools, for example the University of Aberdeen medical school, have found that preparing a staff toolkit can help to ensure that diversity and inclusion are embedded in the foundations of the content. Similarly, the University of Nottingham Medical School developed self-assessment questions, examples and resources to support staff in decolonising and diversifying their medical curriculum.

Including education on cultural competency and cultural humility within the curriculum can also reduce the risk of future doctors and dentists bringing harmful stereotypes into their practice.

Cultural competency: "a set of aligned and transparent skills, attitudes and principles that acknowledge, respect and work

together as a system towards optimal interactions between individuals and the various cultural and ethnic groups within a community"[14].

Cultural humility: "the ability to maintain an interpersonal stance that is other-oriented (or open to the other) in relation to aspects of cultural identity that are most important to the [person]"[15].

Lekas and colleagues argue that seeking cultural competence can "contribute to the reproduction of social stereotypes and imbalance of power between patients and providers"[16] whilst cultural humility "refers to an intrapersonal and interpersonal approach that cultivates person-centred care. Cultural humility training encourages providers to reflect on their own beliefs, values, and biases—explicit and implicit—through introspection thus, revealing their own culture's impact on patients."[17]

Look to include culture humility training as part of your curriculum. NHS Education for Scotland has an existing e-learning package which can be accessed with a Turas account. A similar e-Learning package created in collaboration with the Royal College of Midwives, can be found on eLearning for Healthcare.

Culture Humility teaching can also be embedded within other modules. The Centre for Medical Education at Queen's University

14 NHS North Kensington Health and Wellbeing (2023) https://www.grenfell.nhs.uk/cultural-competence/what-cultural-competency (Accessed 5th September 2024)

15 Hook, J. N. et al. (2013). Cultural Humility: Measuring Openness to Culturally Diverse Clients. Journal of counseling psychology, 60 (3), pp.353–366. [Online]. Available at: doi:10.1037/a0032595.

16 Lekas, H.-M., Pahl, K. and Fuller Lewis, C. (2020). Rethinking Cultural Competence: Shifting to Cultural Humility. Health services insights, 13, pp.1178632920970580–1178632920970580. [Online]. Available at: doi:10.1177/1178632920970580.

17 ibid

Belfast introduced an initiative for introducing cultural humility in family attachment teaching. This included a narrated video to help explain what Cultural Humility is and how it aligns to the Family Attachment scheme, aimed not only at first year students, but also at GP tutors to help them build the topic into in tutorials. Online interactive workshops were also run. In these sessions, students submitted answers anonymously and simultaneously to “have you ever” prompts which allowed them to think about their culture in the broadest sense. Examples of prompts included “Have you ever attended a pride event?” and “have you ever had to miss an outing as you had to care for a family member?”. The answers were displayed ‘live’ allowing the students to appreciate the breadth of replies, and thus cultural experiences, simply within their year group.

4. Delivery

4.1 Teaching aids

When preparing to deliver your content, it is important to question the diversity of your teaching aids.

A 2018 study of over 4,000 images from anatomy textbooks found that there was significant overrepresentation of light skin tones and an underrepresentation of dark skin tones.[18] Other studies, for example Parker et al 2017,[19] have found inequality also perpetuated in other protected characteristics, such as gender. In other words, the white male body is seemingly taken as the 'standard' universal model, with other demographics included as an afterthought if at all.

When preparing to deliver your content, it is therefore important to question who is being depicted. If the answer is 'only white men', there are various ways you can ensure greater diversity. Darker skinned and gender diverse mannequins are readily available for purchase. Should you not be able to purchase new mannequins, skins in varying skin tones are available to cover limbs, but this should only be seen as an interim solution. Suture pads and phlebotomy training arms are also available in a variety of skin tones.

Accessing a diverse range of clinical images has been a long-standing topic of discussion in both medical and dental education. In 2020, Malone Mukwende, a medical student from St George's University, London, developed the Mind the Gap project, a platform devised to showcase clinical signs of diseases on black and brown skin. Inspired by this work, Sheffield Dental School developed the 'Bridging

18 Louie, P., & Wilkes, R. (2018) Representations of race and skin tone in medical textbook imagery. Social Science & Medicine, 202, pp38–42.

19 Parker, R., Larkin, T. and Cockburn, J. (2017). A visual analysis of gender bias in contemporary anatomy textbooks. Social science & medicine (1982), 180, pp.106–113.

the Gap' project; a site to provide a diverse repository of images for teaching in UK Dental Schools. It is essential that these diverse images are embedded throughout the curriculum and not simply added in at the end or buried away in further reading sections.

Anatomy is a topic which may require particular consideration when it comes to decolonising the curriculum, due to the underrepresentation of certain bodies,[20] partially as a result of lack of donations. With this in mind, look to ensure that other teaching aids, such as using imagery, technology, and models are more diverse. An example of diversifying prosection can be seen in Brighton and Sussex Medical School's creation of a 3D female anatomy model, which is used in their teaching.

4.2 Use of actors & external speakers

When using actors in either teaching or assessment, it is important that a range of ethnicities, gender identities and disabilities is represented. Some schools have found paying recruiters to find actors from varying backgrounds a good way to achieve this diversity, whilst others have found approaching local community groups useful.

Also consider providing training for these actors to ensure that their feedback is inclusive and culturally aware. This could include unconscious bias training, for example.

Medical and dental schools may often invite external speakers to present on their areas of expertise. If this is the case in your school, question whether these speakers are from diverse backgrounds.

20 Finn, G. M., Danquah, A. and Matthan, J. (2022). Colonization, cadavers, and color: Considering decolonization of anatomy curricula. Anatomical record (Hoboken, N.J. : 2007), 305 (4), pp.938–951.

It is important to avoid stereotyping these actors and speakers. Be mindful to treat them as individuals and listen to their experiences, as opposed to solely seeing them as representative of a particular demographic group.

4.3 Accessibility

It is important to ensure that your learning environments themselves are accessible to all students. A great deal of information on how to do this is readily available online, with several universities centrally having produced guidance. UCL, for example, has an online resource on creating inclusive environments for neurodivergent students. Ultimately, it is important that you acknowledge that different students will have different needs and try to be responsive to these wherever possible.

Some key questions to ask about the accessibility of your teaching spaces can be seen in section 6.5 of this document.

It is also important to review the accessibility of your delivery. For example, when using digital resources, ensure that they are in a format that is accessible to screen readers and that images include image descriptions. More information on producing accessible resources can be found here.

As different styles suit different students, medical and dental schools should not assume that 'one size fits all' in terms of the 'best' way of delivering their content. Where possible, look to use a variety of session lengths (where sessions are longer than an hour, look to add in a break), group sizes, and pedagogical approaches. Some examples within medical and dental schools include using case-based learning, pedagogical talking circles and involving students in teaching design.

4.4 Delivery of content specifically relating to Equity, Diversity, and Inclusion

It is important to have content within your curriculum which specifically relates to EDI. Whilst it may be tempting to put in specific 'EDI lectures', and indeed there could be some benefit to this, this should not be your sole reference to inclusion; EDI should be considered and embedded within all modules (not just communication and clinical skills). Methods of delivery can assist with this, especially giving students a chance to discuss ideas with each other, will allow for a greater diversity of perspectives to be shared.

4.5 Language

It goes without saying that the language is important. Whilst the vast majority of individuals want to use language that is respectful, the everchanging nature of language can mean that many are left worrying about using inappropriate terminology. In response to this Khuri et al. produced an inclusive practice guide, which can be found here.[21] St George's Medical School created an appropriate language guide for lecturers, which was co-created by staff and students. Should medical and dental schools decide to produce similar documents, they should be reviewed regularly to account for the fact that language rapidly changes.

People should be encouraged to ask questions about language provided that this is done in a respectful manner.

It is also important to ensure that staff and student names are being correctly pronounced. Clarify with all students what name they would like to go by, in order to ensure

21 Khuri S, Patel S, Baker K, Mutili F, Griffiths M, Puri N, and Kilner T. (2024) Inclusive Practice Glossary

that they are being properly and respectfully addressed. Should you not be sure of the pronunciation, do not be afraid to ask again, rather than shortening someone else's name without their consent or avoiding addressing them directly, which can lead to feelings of exclusion and inequity of opportunity for the student in the learning environment.

4.6 Timetabling

The academic timetable is generally built around the Christian calendar and a westernised workday. It should, however, be acknowledged that this will not suit everyone. It is important to take consideration of significant dates for all cultures and religions when timetabling highs-stakes parts of the degree. More detail on this topic can be found in MSC's Supporting students of different faiths guidance.

4.7 Placements

Medical and dental students spend a large amount of time outside of the university environment on placement. Medical and dental schools therefore need to work with placement providers to ensure that the important work they have done to make their courses inclusive happens equally in a clinical setting. Schools which have reported successfully engaging with clinical providers on these issues recommend being pro-active rather than reactive. Creating guidance on specific issues to share with providers in advance of placements can be particularly useful. University of Exeter Medical School, for example, created Guidelines for clinical placement providers to support students who wish to wear a hijab or head covering or head scarf. Communicating in advance and agreeing what the trust can and cannot accommodate also allows realistic expectations to be

set for students in advance of their attendance.

It is vital that not only clear and transparent pathways for students to raise concerns about discrimination on placement are available, but also that sufficient mechanisms are in place to support students through the process. These pathways and mechanisms should be explicitly included in teaching materials and resources so that students are aware of their existence.

Schools could look appoint staff to act as advocates who will be the central point of reporting. Exeter Medical School, for example, has a Race Equality Resource Officer who is directly responsible for providing support to students who experience racism or microaggressions. Meanwhile, similar to the NHS England scheme, the University of Leeds Schools of Dentistry and Medicine has its own 'Freedom to Speak Up Guardians' who can be contacted by students regarding all issues around discrimination. Where roles such as these are present, ensure that they are highlighted to students when they enter medical/dental school and annually after that so that they are clear whom to contact should they need to do so. Different students will prefer to communicate via different media. Try to ensure that there are numerous methods available to students. At the University of Aberdeen Medical School students can fill in a webform to "Report a concern" which can be made entirely anonymously.

Some schools have added a question to their end of block feedback forms which asks if students have experienced discrimination or harassment on placement. This allows schools to be aware of problems and follow them up with placement providers.

When a student reports discrimination, schools should ensure that they are aware of all the available support mechanisms in the school and wider university. A ‘Report and Support’ page on your website or intranet with all this information collated may make it easier for the student to make informed decisions about what is right for them.

5. Assessment

5.1 Assessment content

Assessment should be aligned to the decolonised curriculum content. Just as images and other materials used in teaching should show a diversity of skin colours, this should also be the case in both formative and summative assessments.

Ensure that EDI considerations are included in question-writing training.

5.2 Scenario-based assessment

Medicine and dentistry as fields are based on pattern recognition and it is easy for stereotypes to slip into scenario-based assessment, even when this is not intended. In teaching and assessment based on pattern recognition, it should always be highlighted that patterns do not always apply, and that students should consider this.

Do not assume that students will have the same levels of cultural awareness. International students, for example, may not be aware of stereotypes and assumptions which are linked to UK culture, and should not be penalised for this.

When preparing OSCEs, try to look at the stations all together and ensure that a diversity of patients with a range of characteristics is being represented throughout. Try to include scenarios where patients from marginalised groups are represented, but the stereotype which is typically presented alongside them is not, for example, including LGBTQ+ in stations which are not related to stereotyped diseases, such as HIV.

It is important to use a diverse range of actors in OSCEs. This can, however, be more difficult to put in place in some areas than others. Nevertheless, regardless of the location of your school this should be discussed with external providers as in many instances, they will most likely be able to

assist. If this is not the case, Schools may need to be more creative in sourcing actors, for example, approaching local theatre groups or putting out direct advertisements. Remote stations for things such as history taking could also help increase diversity for schools where finding a wide range of actors in their locality is difficult. It can also be useful to draw upon the knowledge and experience of actors in advance of the assessments. Co-creation of stations with actors can prove beneficial in ensuring that they do not feel stereotyping is taking place in the scenarios.

5.3 Assessors

It is vital that those assessing students have an awareness of the principles discussed in this document. Just as it is recommended that staff have EDI training, including training on cultural humility, this too could be delivered to external assessors. Look to create meaningful sessions targeted specifically towards their role as an assessor.

Briefings are a further opportunity to remind assessors to be aware of cultural differences and that they should avoid biases towards certain communication styles into their marking. Reading students' facial expressions for empathy, for example, may be highly subjective. Students should not be penalised for using expressions which do not conform to neurotypical practitioners in the UK.

Diversity in the pool of assessors can also help facilitate more inclusive assessment. Encourage colleagues to sign up to this as an excellent opportunity for their development and the diversification of the pool for other schools.

The assessors themselves will be in possession of information that could be useful for diversifying the assessment process. Consider bringing together a group to focus

on providing specific EDI advice to colleagues.

5.4 Assessing EDI

Factors such as cultural humility and awareness should not just be included in curriculum content but also in assessment. Indeed, the GMC Outcomes for Graduates states that students must be able to "Recognise the potential impact of their attitudes, values, beliefs, perceptions and personal biases (which may be unconscious) on individuals and groups and identify personal strategies to address this" (outcome 2.J.) and act appropriately, with an inclusive approach, towards patients and colleagues (outcome 2.M.). These outcomes should not just be assessed in OSCEs, but also in essays, workplace-based assessment, short answer questions, and reflection pieces. It is important that these elements are not just assessed at finals but built into assessment throughout the course. Students at The Centre for Medical Education at Queen's University Belfast, for example, are asked to reflect on what they have learned using the Cultural Humility lens on their Personal Learning Blogs which are assessed in their early clinical contact module in year one. To bring their learning on Cultural Humility together, students in years three to five are also asked specifically to incorporate Cultural Humility into Reflective Practice Portfolios.

Schools should also look to include EDI factors in the mark schemes and provide students with clear guidance in advance of what assessors will be looking for.

5.5 Inclusion & reasonable adjustments

Alongside ensuring the content of assessments is decolonised, it is also important to ensure that the delivery of examinations is inclusive. Nobody understands their

own access needs more than the individual themselves. Look to work with students when developing inclusive assessment policies to see which areas need to be addressed.

Detail about religious inclusion in assessment can be found in MSC's Active Inclusions, Challenging Exclusions - Supporting students of different faiths guidance (May 2023).

It is a legal requirement for medical and dental schools to provide reasonable adjustments for disabled students, in line with equality legislation. Reasonable adjustments are changes to the way things are done in order to remove the barriers which individuals face because of their disability. More information on reasonable adjustments can be found in the GMC's Welcome and Valued guidance.

6. The Hidden Curriculum

6.1 What is the hidden curriculum?

The hidden curriculum can be defined as "the set of influences that function at the level of organisational structure and culture including, for example, implicit rules to survive the institution such as customs, rituals, and taken for granted aspects."[22] In short, it is everything that the student learns which is not explicit or formalised within the curriculum. Whilst some of this learning may be positive, it may also conflict with that which is formally taught and reinforce biases and harmful behaviour. Directly discussing the hidden curriculum with students can increase their awareness and understanding, allowing them to mitigate negative impacts and stimulate debate on important issues of power, professionalism, and inclusivity.[23] This is turn can evoke change over time.

22 Lempp, H. and Seale, C. (2004). The hidden curriculum in undergraduate medical education: qualitative study of medical students' perceptions of teaching. BMJ, 329 (7469), pp.770–773. [Online]. Available at: doi:10.1136/bmj.329.7469.770.

6.2 Behaviours of senior colleagues & teaching staff

The hidden curriculum is often implicitly learned through role models . The behaviour of senior colleagues, therefore, plays a key part in this learning. The culture and behaviours modelled should uphold principles of inclusivity.

Staff who are working with students should be made aware of the impact their conduct has upon the development of students' professional identities, and, as result, be conscious of treating all colleagues and patients with respect and preserve professional boundaries and trust. Ensuring that

22 Neve, H. and Collett, T. (2018). Empowering students with the hidden curriculum. The clinical teacher, 15 (6), pp.494–499. [Online]. Available at: doi:10.1111/tct.12736. 22

23 Ibid

everyone who works with students has received adequate EDI training, including training on cultural humility, and is regularly reminded of the importance of civility in medicine and dentistry can help mitigate this.

There will be circumstances where students encounter behaviours from senior colleagues and qualified health professionals which is contrary to the standards expected. Providing space for students to reflect on this and discuss with peers and teaching staff can be greatly beneficial to ensure that this behaviour does not transfer to their own practice in the future. It is vital that clear report and support systems are in place for cases of harassment or discrimination.

6.3 Professionalism

The concept of 'professionalism' is well-established within medical and dental curricula, however, the student population is changing, and awareness of diversity is improving. There is a greater recognition of neurodiversity and the effects this may have on communication styles, for example. This should be borne in mind when developing curricula on professionalism. The various stakeholders involved in medical and dental education, including regulatory bodies and the NHS should come together to discuss what professionalism means within contemporary educational and professional healthcare settings.

6.4 Dress and appearance

Dress codes and expectations around appearance are a further part of the hidden curriculum which can easily be addressed. Ensure that there is valid reasoning behind any restrictions placed upon students, for example in relation to hygiene. For example, there may be no need for strict dress codes in lectures, however, in clinical settings, PPE and 'bare below the elbows' policy may need to be adhered

to. When these restrictions are necessary, ensure that alternatives such as disposable oversleeves and respirator hoods or powered respirators (as per the NHS uniform and workwear guidance) are available for students who may not be able to adhere due for faith or health reasons. More specific examples on this topic can be found in in MSC's Supporting Students of Different Faiths guidance.

6.5 Physical spaces

The physical spaces students and staff spend time in will have an impact upon them.

Question who is represented in your statues and portraiture, and after whom rooms and buildings are named. Older institutions may have their history reflected in the pictures and place names around their campuses, but schools should look for opportunities to include and celebrate the diversity seen in their current cohorts of staff and students. An example of this can be seen in the University of Oxford's 'Diversifying Portraiture' project. Schools should also be aware that some of the individuals recognised with a portrait or building name will have behaved in a way that is now seen as morally reprehensible. Be prepared to listen to the concerns of students and act appropriately. This may be by providing contextual information to a picture or removing it entirely.

Spaces should be available to suit the needs of students from a diverse range of backgrounds. This could include providing quiet spaces for spiritual practices. Information on prayer rooms can be found in MSC's Supporting Students of Different Faiths guidance.

Discussions around physical spaces cannot take place without considering disability access. Many university buildings were not built with accessibility in mind. Consider ways your spaces can be

made more accessible. Some initial questions to ask yourself when reviewing the accessibility of spaces could be:

Is parking designated for disabled people available on site? Is it clearly signposted?

- Does the path to reception have smooth surfaces?
- Is there step-free access to the building?
- Once in the building, is there step-free access to individual rooms?
- If there are steps, how many are there and is there a handrail?
- Is the reception desk at a height suitable for people in wheelchairs?
- Are there accessible toilets and changing facilities?
- Are gender neutral toilets and changing facilities available?
- Is there an induction loop?
- Is lighting adjustable?
- Are there procedures in place for evacuating disabled people, including wheelchair users, in an emergency? Are all staff aware of this protocol?
- Are there fire alarms that are audible/visible to all?

It is critical that access information is available regarding your spaces, or external spaces being used for school events, prior to the event taking place, so that those using them know what to expect and whether any adaptations will be required.

Additionally, people running events should ensure that those invited have been contacted about their accessibility and dietary requirements in order that they might participate fully in the event.

Please note that the above is not an exhaustive list of considerations,

and that further guidance should be sought.

6.6 Organisational structures & policies

When working towards decolonising the curriculum, question your organisational rules and policies and how they are represented. Could some of these policies disadvantage certain groups? Do policies specifically mention issues of equity, diversity and inclusion to help close the gap, or do they reinforce the marginalization of specific groups?

As role models are an important part of any learning environment, the hierarchical structures within your school should be reviewed. Medical and dental Schools should have diverse voices involved in leadership positions and decision making processes. Questions whose voices are represented in your committees, at what level and who is missing. Is your faculty diverse, or are those at the highest levels all from a similar background? If it is the latter, look at ways this can be addressed, for example through actively mentoring a diverse workforce and considering this in succession planning.

6.7 Events

Social events serve an important function for building community at medical and dental school. Encourage your colleagues and students to organise more inclusive events by ensuring the space used is accessible, providing alcohol free options (including events which do not involve alcohol at all), and keeping costs affordable for all. Liaising with student societies and advocates who represent underrepresented groups when organising events can help to ensure greater inclusivity.

7. Resource bank

Decolonising the Curriculum Toolkits

Decolonising the Medical Curriculum – A UCL Medical School initiative towards a historically, culturally and critically conscious curriculum (wordpress.com)

Decolonising the Curriculum | About | The University of Aberdeen (abdn.ac.uk)

https://le.ac.uk/cls/cls-equality/medrace/medrace-projects/learning-environment/inclusive-curriculum-toolkit

https://www.nottingham.ac.uk/medicine/documents/edi/appendix-2-decolonising-and-diversifying-the-medical-curriculum.pdf

Inclusive teaching materials and aids

Black & brown skin (blackandbrownskin.co.uk)

Bridging the gap

Cultural Humility & Cultural Competency

Cultural Humility Digital Resource | NHS Scotland Academy

Cultural Competence and Cultural Safety - elearning for healthcare (e-lfh.org.uk)

Accessibility

Supporting neurodiversity in education | Teaching & Learning - UCL – University College London

Creating accessible teaching materials - Digital standards - University of St Andrews (st-andrews.ac.uk)

Reading lists

Decolonising your reading list - Decolonising your reading list - LibGuides at University of Exeter

For students

Melanin Medics | For current & future black medical students and doctors in the UK

Language

Inclusive_Practice_Glossary_for_Facilitators-March2024.pdf (collaborativecapacities.com)

Glossary of terms (sgul.ac.uk)

Uniform

Coronavirus » Uniforms and workwear: guidance for NHS employers (england.nhs.uk)

Decolonising Spaces

Diversifying Portraiture | Equality and Diversity Unit (ox.ac.uk)

Further MSC Guidance

https://www.medschools.ac.uk/media/2918/active-inclusion-challenging-exclusions-in-medical-education.pdf

active-inclusion-challenging-exclusions-supporting-students-of-faith.pdf (medschools.ac.uk)

From the regulators

Welcomed and valued - GMC (gmc-uk.org)

8. Bibliogrography

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