# Decolonising and Liberating MBChB

A Report into decolonising the medical curriculum at the University of Warwick under the Student Union run Decolonisation program.

Eseosa Akojie and Payal Seth were employed by the Student Union February 2019 to be 'Advocates for the Decolonise the curriculum project'. In this capacity the team were tasked to the medical school in Warwick University to explore its curriculum. This report details the findings, survey results, lessons learnt along the way and recommendations the team would now like to make to both the medical school and the organisation of the decolonisation project.

## i. Executive Summary

This research project aimed to analyse the different parts of the current medical curriculum including lecture content, seminar content, diversity within the class environment and the experience of students from ethnic minorities whilst on placements. A questionnaire was thus created and sent out to the entire medical school cohort; we received 109 responses back generally we found that:

- Almost 50% of the students did not think that the curriculum uses material that explores different data, models and theories related to ethnic diversity.
- Case-based learning seminars that introduce medical students to different types of cases they may encounter in their career, and encourage discussion around these cases, were said to use stereotypical narratives of ethnicity and race, and strayed away from being accurate representations.
- Individual responses from students highlighted various parts of the course content that was in need for inclusivity treatment, e.g. dermatology.
- Various students found that group work in classes could include more diverse groups, and more discussion around different cultures, stating that the current discourse on the topic was just 'skin deep'.
- Students from different ethnic backgrounds didn't feel that they 'belonged' on the course, and this was supported by the lack of students from different ethnic backgrounds that reached the final year of their course.

As we proceed with the report, we will take a look at the presented problems in detail, and discuss possible solutions that will help build a more inclusive and culturally relevant course environment.

## ii. Introduction

This report endeavours to analyse and deconstruct the current medical curriculum, in order to identify western pedagogies that alienate the diverse cohort of the medical school, and in turn explore new forms of teaching, research and assessment that will make the medical school more inclusive. In order to produce this report, representatives from the Student's Union collaborated with staff from the Medical School, as well as students enrolled on the Medicine course.

Before delving into the report it is important to understand what was used as a working definition for decolonizing the curriculum.
Decolonization is the process of 'ending the domination of Western epistemological traditions, histories and figures' (Molefe 2016:32), and beginning the process of incorporating global perspectives, theories and philosophies in the avenue of education and research.
The importance of including different cultural perspectives is more important than ever, and the prominence of this can be seen in changes made to workplaces and politics, but the speed of transformation within the educational field has been much slower.
How does one change the status quo within education without hampering the quality of education and jeopardising the future of many students?
Smith (1999) described the process of decolonisation, stating that it's about 'deconstruction and reconstruction; self-determination and social justice; ethics, language, internationalisation of indigenous experiences, history and critique.'

Dr Sharlene Swartz at University College London said that "Decolonising the curriculum centres on three key questions: what is taught? How it is taught? And who teaches it?" When first starting this investigation these were the three things that were considered. However it was later made clear by contacts at the medical school (Emily Reid Senior Careers Consultant and lead for widening participation) that changing the medical curriculum would be almost impossible since it would require the university to have to recertify the medical school with the GMC.
Our investigation therefore focused less on the content of the curriculum (what is taught) and more on the way that the curriculum is being taught, student experiences with the curriculum in lectures, case based learning seminars and practical work experiences in surgeries (how it is taught and how it is received).
Further, although we began creating a survey that would consider the 'who teaches it' element of decolonising the curriculum we did not receive the survey back from review by the deputy head of the medical school in time to send it out and wait for responses.
It's also important to understand that decolonising the medical curriculum is quite different from decolonising other educational fields, since the subject matter entails discussion on the human anatomy, it is more objective and less subjective.

## iii. Methodology

Using Smith's summary, our first step was to deconstruct the current curriculum, and this didn't just mean deconstructing the western ideologies that were supporting it, but also deconstructing the curriculum to identify the make-up of the teaching process, and understand the relevance of all parts of the teaching regime.
In order to do so, we spoke to Emily Reid (Senior Careers Consultant and lead for widening participation) from the medical school. Through meetings with her we were able to identify that the medical curriculum was taught using lectures, case based learning (a seminar session that presented students with medical cases and encourage them to think critically about the responses) and on-site training at hospitals.
We began to look into the ethical makeup of classes knowing that BAME students can sometimes have a different but valuable perspective which would serve to diversify discussions especially in case based learning seminars. We also became concerned with the experiences of these BAME students in lectures, case based learning seminars and on placements and so looked into this to ascertain to what extent BAME student felt that they could give their own valuable perspectives without rebuke, judgement or condemnation. The medical curriculum may be somewhat objective but the way students interact with it is not necessarily so objective - we therefore thought it important to find out how confident BAME students are in voicing those different opinions and to what extent they feel supported in doing so.

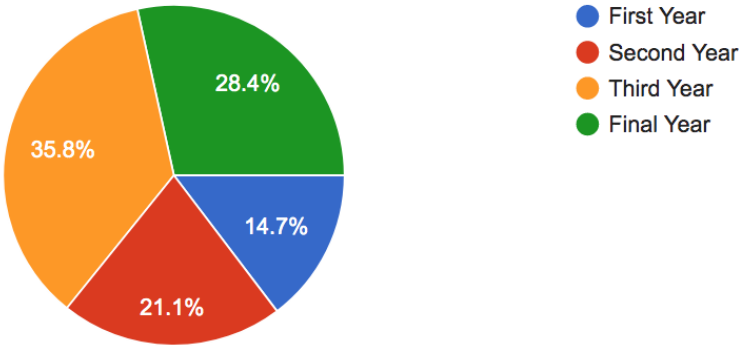
The best way for us to begin this deconstruction process was to first gather information from students and so a questionnaire was written using Google Forms. This platform allowed us to not only ask the relevant questions, but also study the data received in a visualised form, making analysis easier.

Ideally, we would have liked to gather this information in person, but gathering the medical students in the middle of the academic year proved to be quite difficult since many were preparing for exams or finishing their placements at hospitals so an online questionnaire seemed to be the best option. For our questionnaire, we used UCL as a research point again and adapted our questionnaire from their survey on 'Treating the Medical Curriculum' survey. The questions they posed were good starting points, and we took it further by creating one questionnaire for students and another for academics teaching the course so we could compare results, unfortunately the latter was not approved in time.

We wanted a clear picture from students on how inclusive and diverse they thought their curriculum was but it was essential to refrain from asking leading questions, so that the picture was accurate.
The first part of our questionnaire was focused on gathering personal information about the students i.e. what year they were in, what gender they identify with (if any) and their ethnicity so that we could also assess the diversity of the cohort.
The second part of our questionnaire shifted focus to the diversity of the curriculum with regards to reading lists, teaching styles, critical thinking and group work.
In the next part of this report, we shall analyse the answers received for each question.

### iv. Findings and main themes:

The responses were quite evenly spread across all years of the course.




However, the ethical makeup of our responses was not as evenly spread, since 57.8% of respondents were White- English, Scottish, Welsh, Northern Irish or British. Approximately, 42.2% of students that answered belonged to other ethnic minorities despite the medical school student body being only 23% BAME; this perhaps suggests that BAME students were more drawn to answer the questionnaire than their white british peers and are more engaged on this topic.

The next part of the survey discussed the issue of inclusion with the medical curriculum; the first question asked:
***'So far in the curriculum, I have had the chance to discuss different perspectives within and outside the UK related to ethnic diversity'.***
Respondents are given the following options for all questions in this part of the survey:
**Strongly agree, agree, neutral, disagree and strongly disagree**.
The responses for the question indicated that a large number of people (37) disagreed with the statement, whilst 33 people agreed with the statement, 22 people were neutral and 13 people strongly disagreed with the statement.

The next question was
***'The curriculum uses material that explores different data, models and theories related to ethnic diversity – even within an historical context'.***
The entire survey had 109 responses, and almost half of the respondents (51) disagreed with this statement.

The following question was
***'The curriculum has reading lists and resources that contain a diverse range of authors including those from different ethnicities, from outside the UK and from non-academic sources where relevant'.***
54 people were neutral about this yet 20 people disagreed. The total number of people in agreement was 22, which is just slightly more than the amount of people in disagreement. What also must be noted is that the number of people that felt neutrally about this statement could also be interpreted as unawareness as opposed to having a neutral stance towards the statement.

The next question on the list was
'***The curriculum develops my critical thinking and awareness of different perspectives on issues relating to diversity in ethnicity, culture and nationality***'
Whilst 38 people agreed with the statement, 29 disagreed.

This was followed by
***'The curriculum allows me to gain an understanding of how different factors e.g. Social, economic, ethnicity influence patient care'***
The counterpart to this question being
***'The curriculum allows me to gain an understanding of how different factors e.g. Social, economic and ethnicity influence medical outcomes'***,
These questions both collected the most amount of responses in agreement. This implies that there is a basic understanding of how ethnicity and socio-economic factors affect society, and education but it is essential here to pause and wonder whether understanding necessarily means that individuals are equipped to facilitate people from varied backgrounds.

The focus was then shifted to gaining more information on case-based learning which makes us a huge part of the curriculum.
Two questions were asked to identify the general consensus towards diversity in case based learning and they were:
***'Case based learning uses a diverse makeup of patients ethnically, socially and economically'***
and
***'When case based learning uses diverse patients it does not do so in a generic stereotypical way to indicate a specific condition'*** i.e. The black patient does not always have Sickle Cell disease.
The responses for these were almost 50/50 agreement or disagreement. For the first question, 35 people disagreed and 49 agreed, for the follow-up question 49 agreed and 43 disagreed. The remaining responses for both questions were neutral.
The discord when it comes to case based learning is fairly evident, and therefore the team had hoped to analyse the case based learning material personally, unfortunately the team were not permitted to do so further this would have taken a lot of time the team did not have.

The final few questions focused on group work and in-class discussions, the following two questions were asked:
***'The allocation of students to small group work enables the creation of ethnically diverse groups from different educational, ethnic or social backgrounds'***
and

***'Teaching encourages discussion from students with diverse backgrounds and includes topics where personal experience and views are expressed'***.
A majority of students that answered the question agreed with the statement (41 people agreed for the former, and 33 agreed with the latter), however one can argue that this doesn't paint a complete picture, especially if we take a closer look at some of the responses that people had provided when they were asked to expand on their answers.
A few examples can be seen below:

*"The current final year has a very low number of ethnic students. This was surprising to me in comparison to other university courses. Therefore opportunities to integrate learning from other ethnicities is minimal."*

*"I personally found quite a lot of the teaching in First Year on ethnicity and race to be extremely stereotypical and not at all sensitive. It was skin deep and did not reflect a true understanding of most of the cultures we were discussing."*

*"I strongly disagree that our teaching groups are meaningfully separated to create diverse groups."*

*"In first year we were taught white men as the default, and black men and all women as exceptions. I can find the slides that do this if evidence is required! When questions of inclusion and diversity arise they are handled in a stereotypical and slightly thoughtless way"*

*"I believe Soc pop tries hard to be inclusive and raise awareness of different impact of e.g. poverty, lower economic group and racism on treatment. However, beyond this I feel the course could improve. For example for lectures covering dermatology or dermatological conditions (e.g. AC1 sdl autoimmune conditions and most other lectures) we are invariably shown pictures with white patients, even when, like for SLE the disease is more frequent in Asian/Black background."*

*" I have felt alienated at WMS - the vast majority of students are from very wealthy, seemingly undiverse backgrounds and show little to no understanding or awareness of cultural and social differences. Sadly, the curriculum has done nothing to challenge unhealthy perceptions or to educate in diversity awareness and anti-racism."*

When students were asked about what challenges the universities faces when it comes to moving towards being fully inclusive, these were some of the answers:

*"The only time I ever actively thought about race on the course was when a fellow student who is black pointed out that not a single image in our derm teaching had black skin and how some of these would look different on her. Which made me not only feel ignorant for not considering this in first place, but it highlighted to me how white appears to be the 'norm' in our teaching.'*

*"Ensure there is a more diverse cohort. Naturally this will allow for conversations about differences and similarities. More lectures and module on national and international health."*

*"I think the sessions on ethnicity and race in First Year need to be moved away from the lecture theatre and into group work sessions, where patients from different backgrounds can explain to us how their culture influences their decisions, health behaviours and decisions about care."*

*The current financing of university is the biggest barrier. When the maximum loan+grant barely covers rent, if you're from a disadvantaged background (which disproportionately affects ethnic minorities) there's a HUGE barrier to accessing higher education.*

*Fear that it may cause offence. Use diversity more widely*

*I feel having senior staff who are more representative of our cultural diversity would benefit creating an inclusive culture amongst students*

*"Integrate ethnic diversity into each block CBLs, consider working with the BME society in the medical school, a more diverse staff base would be nice to see"*

Summary:

Whilst this questionnaire posed some very important questions, it was the first of its kind and therefore preliminary. The stark contrast in the amount of people who agreed that CBLs were inclusive, and the personal accounts that people shared in the second half of the questionnaire prove that this questionnaire has merely scratched the surface when it comes to discussing inclusivity.
Furthermore, almost 50% of the respondents disagreed when asked 'The curriculum uses material that explores different data, models and theories related to ethnic diversity – even within an historical context'. This is not a small number of people, and one can not wait for this number to get bigger before we take any action.
Through this work however, specific areas within the medical school that could be diversified or improved have been identified. These include using diverse examples when discussing dermatology, to identifying that CBLs often present stereotypical narratives of diseases when discussing other ethnicities. Whilst the entire CBL material can't be changed overnight, it is imperative to train the staff delivering this material. As seen earlier in the accounts, conversations about race and racial differences are feared and thus avoided. These conversations should instead be embraced, encouraged and facilitated by a faculty trained to deal with such subject sensitively so that stereotypical racial understandings from the past can be confronted, countered. Staff should be able to identify these regressive examples and help students deal with them in lectures, case based seminars and on placements.

## v. Recommendations

<u>Recommendations from results of research</u>
This report proposes four steps that the university should carry out with immediate effect to harbour an atmosphere of inclusivity at the medical school.

- Continued analysis of the curriculum with students in more depth. This report was formulated based on questionnaires that were circulated within the medical students, however this is not enough and should be followed up with personal interviews with candidates to get a more detailed narrative of their experiences.
- The analysis needs to be extended to staff and academics. Due to the time constraints that was presented to the representatives working on creating this report, the team was only able to collect opinions from students however the same questionnaires must be extended to staff and academics so that gaps in understanding inclusivity can be understood better.
- Training staff to tackle uncomfortable situations. Whilst creating this report, it was found that many textbooks and cases used in the curriculum consisted of regressive and stereotypical representations of race and ethnicity. Whilst these can't be removed overnight, staff should be trained adequately deal with these situations head on, and explain why they are problematic.
- Perpetual collaboration with the medical school**.** This report identified various points within the curriculum that could be altered for decolonisation. Examples included modules like dermatology and case-based learning seminars. These points were identified within the span of a few months and the possibly more potential points or areas for decolonisation. This report recommends constant collaboration with the medical school to identify all these areas together. Recommendations about the project

<u>Recommendations on improving the project</u>

- If this project were to be repeated the first thing we would wish to recommend is about the timing of the project. This project began towards the end of term two and ran until the end of term three. This timeframe however made it difficult; personally it was not easy to juggle this project and academic

pressure especially in term 3 when exams began. Exam preparation an”d general exam stress made it hard to make all the scheduled team meetings or even get back into the mental headspace to be able to give this project our full undivided attention. Further the timeframe also made it hard for us to reach students of the medical school for surveys or interviews because they were also in the midst of their own examinations. We would therefore recommend that this project is begun in term 1 and finished by the end of term 2/the first week of term 3.This allows those working on the project to fully devote all their free time and energy to the project and would increase student body participation and engagement.

- Our next recommendation is about the size and makeup of the teams. The medical school team ended up being only two people - Eseosa Akojie and Payal Seth - we feel more could have been achieved had there been a permanent third person allocated to our department as other teams on the project had. Further, we would definitely advise that within each team there is a student who is already a member of the department the team is looking into - i.e. a medical student on the team looking into the medical school curriculum. This is especially pertinent for the medical team since the medical school is so distinct from the rest of the university and not parallel or similar to the home departments of the current team members - Eseosa Akojie and Payal Seth. Having at least one member on the team who was familiar with the medical department would have been invaluable, especially at the beginning when the team was at first looking into the structure of the medical school, its teaching practices, reading lists etc.
- Finally, at the beginning of this project the team looked into other universities who were also embarking on similar endeavours and got into contact with the decolonisation program at University College London. Dr Faye Gishen from UCL gave the team the email addresses of the UCL equivalent of this team of students. Contact with a counterpart team at another university was useful and interesting, it created a forum to exchange ideas and advice becoming extremely valuable since we were all working towards the same goal at our respective universities. We would therefore recommend such contact with UCL and other medical departments at other universities be extended and formalised to perhaps begin to create a national forum - a space where all who are interested, could be supported on this agenda.

<u>Recommendations on what to do next</u>

- As part of the investigative survey sent out, students were asked if they would be willing to be interviewed more on the matter. 37 students indicated that they would be willing to do so and the media team in the medical department have expressed that they could film these interviews with students. We would therefore recommend that these interviews should be held in conjunction with the media team in the medical school. We would however recommend the interviews should be shot in such a way that obscures the identity of the student should a student request as such. The filming of such interviews will add a new dimension to the project, make it easier to share and understand the perspectives of students in regards to decolonising and, if the interviews are publicly shared, highlight to the wider community the necessity of such a decolonisation project.
- Further, we would also recommend that any further research project on decolonising the medical curriculum focuses on the case based learning seminars.There are about 150 cases in total but they are sensitive in nature so further collaboration with the medical school would be needed in order for those cases to be released to a future team for review. In this case, a team with at least one member who is a student of the medical department would be invaluable in helping to understand and unpack the cases. Although such work would undoubtedly be very time consuming and require several more weeks, we believe it would be very important in any future discussions about decolonising the medical curriculum. From discussions with a student in the medical department we already know that the diversity of patients in case based learning is low and often only an indicator for a certain diagnosis i.e. the ethnicity of an african patient denoting sickle cell disease. It would however be informative and valuable to understand to what extent this stereotyping occurs with diverse patients in case based learning seminars.

- We would also recommend a mapping of the medical curriculum much like Dr Faye Gishen and Hope Chow have done as part of UCL's drive to decolonise their own medical curriculum. Although this project took them over a year by mapping the curriculum in terms of class, gender, sexuality, patient experiences discrimination etc they now have a clear picture (map) of what their medical curriculum looks like. In terms of decolonisation here at Warwick we feel this would make it clearer and easier to analyse the curriculum. Much like the evaluation of the case based learning seminars, this would also take a lot of time and would need a team with medical students and perhaps members of staff and faculty from the medical department.
- Finally, we would recommend the questionnaire drawn up for faculty and staff that was not sent out - be distributed and the results from it collected. This will offer further insight into the 'who teaches it?' question that Shwartz posed as integral to decolonisation of the curriculum.

## vi. Lessons learned

- Using google forms to create the questionnaire worked really well. It was easy to do so on the platform because it had templates we could build upon. further it simply and visually distilled the responses to the questions in a way that made analysis of such responses easier.

- Engaging with stakeholders and contacts in the medical department was at first extremely difficult and for the first several weeks we had no response from the medical department. Although emails were sent and meetings requested these were not returned due to key people being out of the office, off sick or on leave. Engagement was therefore extremely hard and did hinder the pace of the project in the beginning - a lot of the basic background information we needed to know about the medical school (i.e. the structure of curriculum, chain of command, the importance of the GMC or methods of teaching) we had to research and learn ourselves or find out much later on, once contact was established. Meetings would have been a more preferred, easier and less time consuming way to learn such information. This could be made easier next time if there were medical students on the team who already know a lot of this information or understand the structure of the medical school to know who to approach and talk to.

- Getting responses from the questionnaire was much easier than expected. in total 109 students filled in the questionnaire and although general student population is around 700 we were very pleased with the response considering the timing of the questionnaire being sent out during what is the busiest part of their academic year. It particularly highlights the engagement of the student body that 37 of those 109 indicated in the questionnaire their willingness to be interviewed more on the topic.

- Working in teams worked really well. We were able to divy up the work and cover more ground. This was very important during exam season when one member of the team had exams one week they could rely on the other team member to carry on and vice versa when the other team member became busy with exams. It meant the project/research did not have to grind to a complete stop when one member was too busy. The only thing that would have helped, as previously mentioned in the recommendation section, would have been to have a third team member from the outset who was a student of the medicalschool

Before concluding this report we would like to make a special thanks to our supervisor, Suki Kaur, who was always on hand if we needed any resources and coaching. Suki was beyond helpful, encouraging and inspiring at all times because she was so ardent about the potential of the project . Another huge thanks must go to Emily Reid from the medical department; Emily was truly passionate about the project and her contributions, help and guidance were invaluable. Finally we must thank Larissa for beginning this project and giving us the opportunity to be a part of it - without her vision of a decolonised Warwick, none of this would have been possible.

## vii. CONCLUSION.

To conclude we would like to say that this project has been a real honour to be a part of. It has so much potential with such far-reaching positive consequences if continued, as such we would like to see more work in this area continued in the medical school. The questionnaire has highlighted several areas for improvement but also student eagerness for such change which cannot be ignored. The first step should be training faculty and staff to be able to tackle and identify race and racial stereotypes in the curriculum so they can facilitate liberation first hand in lectures, seminars or on placements in hospitals and surgeries. Further than that, more research into the cases used in case based learning seminars is advised. Ultimately, this project is part of a national, potentially international, conversation which the project should continue by establishing links with decolonisation programs going on in other further educational institutions in the UK and abroad if possible.