Decolonising and Liberating MBCHB 2019/2020 Report

The following is a report into the Decolonising and Liberating project sponsored by Warwick SU as it pertains to Warwick Medical School. This report takes direction and builds upon the findings from the 2018/2019 project of the same name. We would therefore advise the reading of the 2019 report for the fullest picture.

Eseosa Akojie and Lucy Mooring were employed by the Students' Union October 2019 to be 'Advocates for the Decolonise the curriculum project'. The project was entering its sophomore year and the team was employed to continue the work the previous team had begun. This report details the findings, survey results, lessons learnt and recommendations this team would like to make to both the medical school and Warwick SU in it's pursuance of such an ambitious but necessary project as this.

At this point, it should be noted that Eseosa Akojie who had worked on the project in its Freshman year with Payal, was re-employed to continue work on the project in its Sophomore year and partnering with Lucy Mooring to do so.

i. Executive Summary

This phase of the project looked specifically at teaching staff and faculty in the medical school in order to gauge their opinions of the curriculum and available teaching materials as they apply to a decolonised curriculum. The project also looked at the makeup of medical school faculty and their experiences on campus and (where applicable) in clinics/surgeries. A questionnaire was thus created and sent to teaching faculty in the medical school from the 20 responses we generally found that:

- 50% of respondents answered that they are only 'somewhat aware' of the issues that marginalised students or staff face within the department or more broadly in healthcare and that it is not mentioned in their departments
- 66.7 of respondents answered that they did not feel that they had received 'adequate support from the medical school or their employer' when they had experienced discrimination during their time in the medical school.
- 55% of respondents answered that they had witnessd discrimination among students or faculty or clinicians or patients.
- 40% of respondents are very confident that their reporting of discrimination would be taken seriously
- 45% of respondents believe their teaching 'develops critical thinking and awareness of different perspectives on issues relating to diversity in ethnicity, culture and nationality
- 50% of respondents believe they 'give students an understanding of how different factors e.g. social, economic, ethnicity - influence patient care and medical outcomes within their teaching.

Further in the report we will analyse the presented problems in depth and propose solutions that will bolster faculty in their teaching and deliverance of a more inclusive, culturally relevant and diverse course.

ii. Introduction

As with the 2019 report, the 2020 report will endeavour to analyse and deconstruct the current medical curriculum, in order to continue to identify western pedagogies that alienate the diverse cohort and faculty of the medical school. In turn the report will also explore new forms of teaching, research and assessment that will make the medical school more inclusive. Specifically, this report explores this from the angle of teaching faculty in the medical school.

It is important to understand that decolonising the Medical Curriculum is quite different from decolonising other educational fields. The subject matter is by nature more objective which makes it difficult for people to understand why it would need to be 'decolonised'. We would like to take this opportunity to point out that although science may be objective on the face of it, its application and practice is subjective and liable to the biases and prejudices of the people who decide how those scientific facts should be taught, understood and applied.

The 2019/020 team, following on from the work done by the 2018/2019 team to understand decolonisation as it pertains to the Medical school, adopted the following definition of decolonisation:
"Decolonization is the process of 'ending the domination of Western epistemological traditions, histories and figures"[1], and beginning the process of incorporating global perspectives, theories and philosophies in the avenue of education and research.'[2]

The team also worked with Smith's description about the process of decolonisation. Smith States that decolonisation is about 'deconstruction and reconstruction; self-determination and social justice; ethics, language, internationalisation of indigenous experiences, history and critique'[3]; for this phase of the project it was thought pertinent to continue the stage of deconstruction that had begun in the freshman year of the project.

More specifically, the team took guidance from Dr Sharlene Swartz at UCL. Swartz had posed that "Decolonising the curriculum centres on three key questions: what is taught? How is it taught? And who teaches it?".

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[1] T.O. Molefe, 'Oppression must fall: South Africa's revolution in theory" *World Policy Journal* 33:1 (2016) p32
[2] Eseosa Akojie and Payal Seth, Decolonising and Liberating MBChB 2019 Report
[3] Linda Tuhiwai Smith *Decolonizing methodologies: Research and Indigenous Peoples* (London: London Zed Books 1999) p

Last year, the project focused primarily on answering the second question ‘How is it taught’; to that end, questionnaires were sent to the student body which resulted in 109 responses highlighting the student experience with a colonised curriculum in lectures, case based learning seminars and surgeries.
This year, we again focused on answering the second question ‘How is it taught’ but there was significant emphasis on the third question ‘Who teaches it’; to this end the questionnaire from 2018/2019 was re-formatted, edited and then sent to faculty. The idea was to compare the answers from faculty to those that had come from students the previous year.

In this continued stage of ‘deconstruction’ the team were therefore primarily concerned with the impact the curriculum has on both students and faculty and their (differing) opinions of the curriculum as it pertains to decolonisation, liberation and inclusivity.

iii. Methodology

To continue this stage of ‘deconstruction’ the team decided to circulate the same questions that had been sent to students last year, to faculty. It was important to keep the questions on the questionnaire as similar as possible to those that were asked of students so that we could compare the two data sets and get an accurate comparison between the two. Most questions however had to be slightly amended in order to cover all faculty, both teaching and non-teaching.

The questionnaire was created using google forms which was useful in collating the responses into charts and graphs that were easy and accessible to read. However, when sending the questionnaire to faculty in surgeries we found that they could not open the questionnaire because google forms was blocked on their computers. The questionnaire was then transferred to qualtrics, a system we were assured that their computers could open. However, due to the outbreak of coronavirus in the UK, by the time we were ready to send the qualtrics questionnaire to faculty working in surgeries we decided against doing so, it would have been inappropriate considering the emerging public health crisis.

Ideally, we would have preferred to have gathered this information through in person interviews, but we understood that we could not change the methodology in such a drastic way from the previous year if we wanted to be able to compare the data sets.
As with the 2019/2020 questionnaire sent to students, the faculty questionnaire was adapted from the UCL survey on ‘Treating the Medical Curriculum’.
As with the student questionnaire we wanted a clear picture from faculty on how inclusive and diverse they thought the curriculum was and whether the available resources allowed them to confidently teach a decolonised curriculum.

The first part of our questionnaire was focused on gathering personal information about the faculty i.e. where they work, 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

In all we received 20 responses to the questionnaire. As the data pool is quite small we will not be releasing the job, gender and ethnicity data collected from the respondents for privacy reasons so that no single respondent can be identified.

Question 4
The second part of the questionnaire pertained to questions surrounding the issue of inclusion in the medical curriculum. Respondents are given the following options for all questions in this part of the survey:
Strongly Agree, Agree, Neutral, Disagree, Strongly Disagree and N/A

The following statements were posed:
"So far in my teaching, I have had the chance to discuss different perspectives within and outside the UK related to ethnic diversity with my students"
To this, 9 respondents Agreed - 3 Disagreed - 2 Strongly Disagreed - 2 were Neutral - 2 Strongly Agreed - 2 respondents answered N/A.
Overall, of the respondents that the statement was applicable to:
61% agreed with the statement and 27.7% disagreed.

"My teaching uses material that explores different data, models and theories related to ethnic diversity - even within an historical context"
To this, 6 respondents answered N/A - 5 Disagreed - 4 were Neutral - 3 Agreed - 2 disagreed.
Overall, of the respondents that the statement was applicable to:
21% agreed with the statement and 50% disagreed.

"My teaching has reading lists and resources that contain a diverse range of authors including those from different ethnicities, from outside the UK"
To this, 5 respondents Agreed - 5 respondents answered N/A - 3 respondents Disagreed - 3 respondents were Neutral - 3 respondents answered don't know/not sure - 1 respondent Strongly Agreed.
Overall, of the respondents that the statement was applicable to:

40% agreed and 20% disagreed with the statement

"I believe my teaching develops critical thinking and awareness of different perspectives on issues relating to diversity in ethnicity, culture and nationality"
To this, 9 respondents Agreed - 3 respondents were Neutral - 3 Strongly Agreed - 2 Strongly Disagreed - 2 Disagreed - 1 respondent answered N/A
Overall, of the respondents that the statement was applicable to:
63% agreed and 21% disagreed with the statement

"I give students an understanding of how different factors e.g. social, economic, ethnicity - influence patient care and medical outcomes within my teaching practice"
To this, 10 respondents agreed - 7 strongly agreed - 2 Strongly Disagreed - 1 respondent was Neutral
Overall:
85% of respondents agreed and 10% disagree

"From my involvement in case-based or small-group learning, I perceive that it uses a diverse makeup of patients ethnically, socially and economically"
To this, 6 respondents Agreed - 5 were Neutral - 5 Strongly Agreed - 2 answered N/A - 1 Disagreed - 1 respondent answered don't know/not sure.
Overall, of the respondents that the statement was applicable to:
61% agreed and 0% disagreed with the statement

"From my involvement in case-based or small-group learning, I believe they have been written to avoid generic stereotyping to indicate a specific condition"
To this, 8 respondents Agreed - 3 Disagreed - 3 were Neutral - 3 Strongly Agreed - 2 respondents answered N/A/ - 1 strongly Disagreed.
Overall, of the respondents that the statement was applicable to:
61% agreed and 22% disagreed with the statement

"From my involvement in lectures, I perceive that they use a diverse makeup of patients ethnically, socially and economically"
To this, 5 respondents Agreed - 5 answered N/A - 4 were Neutral - 4 respondents answered don't know/ not sure - 1 Strongly Disagreed - 1 Strongly Agreed
Overall, of the respondents that the statement was applicable to:
40% agreed and 7% disagreed with the statement

"From my involvement in lectures, I believe they avoid stereotyping to indicate a specific condition"

To this, 5 respondents answered don't know/not sure - 4 Agreed - 4 answered N/A - 3 respondents were Neutral - 2 Disagreed - 2 Strongly Agreed
Overall, of the respondents that the statement was applicable to:
37.5% agreed and 12.5 disagreed with the statement

"The allocation of students to small group work enables the creation of ethnically diverse groups from different educational, ethnic or social backgrounds"
To this, 8 respondents Agreed - 6 Strongly Agreed - 4 answered don't know/not sure - 2 respondents were neutral.
Overall:
70% of respondents agreed and no respondents disagreed with the statement.

"Teaching encourages discussion from students with diverse backgrounds and includes topics where personal experience and views are expressed"
To this, 9 respondents Agreed - 4 were Neutral - 3 Strongly Agreed - 2 Disagreed - 1 respondents answered don't know/not sure - 1 answered N/A
Overall, of the respondents that the statement was applicable to:
63% agreed and 5% disagreed with the statement

"The MBChB programme involves students in the formative and summative annual review of looking at content and attainment from an ethnic diversity perspective"
To this, 8 respondents answered don't know/not sure - 5 Disagreed - 3 Agreed - 2 were Neutral - 1 Strongly Disagreed - 1 respondent answered N/A
Overall, of the respondents that the statement was applicable to:
21% agreed and 31.5% disagreed with the statement

Summary
To summarise, the data generally shows us that faculty believe (in places quite strongly) that their teaching, the curriculum and academic resources are liberated and decolonised. Faculty seem to generally understand that students are receiving a balanced, decolonised learning experience in lectures, small group work and case based learning seminars.

Comparisons
This report will now go on to compare the data from these statements that faculty submitted with the data that students submitted. It must however be noted that whilst the faculty questionnaire got 20 responses, the student questionnaire secured 109. The data sets are not equally sized and therefore not perfectly comparable.
Ultimately though, large discrepancies between the students' questionnaire data and the data from the faculty questionnaire were found.

For instance, whilst 28% of faculty* disagreed that they ***"have had the chance to discuss different perspectives within and outside the UK related to ethnic diversity" (Q1)***, 46% of students disagreed.

Additionally, though 70% of faculty* agreed that ***"The allocation of students to small group work enables the creation of ethnically diverse groups from different educational, ethnic or social backgrounds"*** - Only 50% of students surveyed also agreed.

Furthermore, 40% of faculty* agreed that ***"reading lists and resources contain a diverse range of authors including those from different ethnicities, from outside the UK"*** - but only 20% of students surveyed agreed.

Again, though 0% of faculty* disagreed with the statement that **"case-based or small-group learning uses a diverse makeup of patients ethnically, socially and economically"** - 32% of students surveyed disagreed.

And, though 63% of faculty* agreed that **"Teaching encourages discussion from students with diverse backgrounds and includes topics where personal experience and views are expressed"** - only 42% of students surveyed also agreed with that statement.

In addition, 61% of faculty* agreed that **"case based learning or small-group learning [has] been written to avoid generic stereotyping to indicate a specific condition"** but only 39% of students surveyed agreed with this statement.

As another example, whilst 63% of faculty* agreed that **"teaching develops critical thinking and awareness of different perspectives on issues relating to diversity in ethnicity, culture and nationality"** - only 42% of students also agreed with this statement.

Finally, whilst 5% of faculty* disagreed with the statement ***"Teaching encourages discussion from students with diverse backgrounds and includes topics where personal experience and views are expressed"*** - 38% of students disagreed.
One student elaborating that "there isn't a lot of opportunity for our peers to share their own experiences which could be valuable".

However, there were some data points where student and faculty perceptions were more aligned.

For example, 25% of students agreed with the statement that their curriculum ***"uses material that explores different data, models and theories related to ethnic diversity - even within an historical context"(Q2)*** - with this 21% of Faculty* also agreed.

And

Additionally, 78% of students agreed that the curriculum gives an **"understanding of how different factors e.g. social, economic, ethnicity - influence patient care"** and 72% of students agreed the same with regards to a very similar question about **"medical outcomes".** This was posed as one question to faculty* and 85% agreed that they **"give students an understanding of how different factors e.g. social, economic, ethnicity - influence patient care and medical outcomes".**

Summary

Comparing the data it is abundantly clear that there is a chasm between the perception of MBChB that faculty have compared to students. Faculty believe their teaching and resources are generally inclusive and liberated but the students on the receiving end starkly disagree. Although the differences in the data samples means we have to be careful about making conclusive statements when comparing to two, it is very clear that faculty understand the curriculum to be more liberated than students. This report would recommend the reading of the 2019/2020 report to understand more the attitudes of students towards the curriculum because it is more nuanced than this comparison allows for. However, the team feels confident in concluding here that faculty and students do not interact with the curriculum with the same attitudes with regards to its inclusivity and liberation. When decolonising MBChB therefore, it will be of utmost importance to consult with students and faculty at every step of the process in order to bridge the disconnect and arrive at an end result that both parties agree is liberated.

Question 5

The next questions: **"What do you think are the biggest challenges we have to becoming fully inclusive? How might these be overcome?"** received a variety of responses. Here are a few:

"I think the biggest challenge to becoming fully inclusive is an excessive focus on fashionable issues such as ethnicity or LGBT status, whilst **other factors, such as disability, are neglected**"

"Habit and inertia are, unfortunately, big obstacles. We teach in the same ways that we were taught, generally using the same material. **We need time, encouragement and support to venture outside of these constraints**."

"The biggest challenge to me as white british is **my worry [that] I might say the wrong thing or use terms that are incorrect or offensive**. I would like examples of good/right ways of describing ethnicity etc"

"**Lack of role models, not just at WMS but in local trusts**. Lack of control over external teachers. Lack of staff time to refine teaching materials."

"More diversity in the CBL cases, still seems a weighting towards white British"

"**We need to hear from students and learn from them**. If students are involved in the solutions, then they are more likely to feel authentic. While we do have a range of ethnicities etc in our CBL cases, we don't have much (or anything?) in the cases that celebrates or educates about different cultures, so I think we could do more."

"We need to **train the trainers** on liberated curriculum first".

Challenge is **lack of diversity in faculty** and therefore failure to explicitly consider diversity (of all kinds). Therefore increase diversity in teaching staff and in involvement of patients in teaching

Almost all medical data comes from Caucasian groups with very few ethnic data. **Medicine is still taught as it was 20 years ago** and I believe we do not bring to attention those aspects of disease and cultures present in an ethically diverse society that we are now.

"As far as I am aware, whilst the demographic 'description' of the patients that are used in CBL are quite varied the ethnic / social / racial backgrounds of the patients are not encouraged as a topic of discussion in the facilitator prompts nor in the learning outcomes…. The focus seems to be on the clinical presentation. I feel that issues related to a variety of differences could be explored in some cases. This could be in terms of being more explicit that differences may be present and may have significant implications: for example, highlighting clinical issues such as differences in predisposition to some clinical problems, the impact of differences on approaches to management, discussing the challenges of communication where English is not the primary language and so on. This is not the thrust of your project but the **challenges within a clinical environment for disabled people, blind people and deaf people are also not explored in CBL**."

Comparisons

When students were asked these same questions in their questionnaire their responses differed slightly. The following quotes are from the student questionnaire in response to the same question posed in the faculty questionnaire.

Many students raised that their cohort was not diverse enough and that this was an obstacle to inclusion. E.g.

"the fact that our year isn't more diverse is a problem… we have 3 black males in a cohort of >170 doesn't reflect well. I think further work with widening access to encourage applicants from lower income families and more disadvantaged groups."

"Graduate medicine is expensive and there are more white middle-class students here than anything else"

"Ensure there is a more diverse cohort. Naturally this will allow for conversations about differences and similarities."

"The cohort has such a minority of BAME students. It's unlikely that white students simply outperform all bame students at all stages of selection. We must consider that institutional racism plays a role. Make an active effort to allow more bame students into the course. Discuss racial divides or challenges within the NHS in group sessions - as many of the cohort are unaware that ethnic differences affect BAME experiences in uni and when on placement."

Other students identified tuition costs as an obstacle to the Medical School becoming fully inclusive e.g.
"The cost of a medical education. More bursaries and scholarships for people from lower socioeconomic groups"

"More financial help for those less privileged! The lack of diversity is directly related to socioeconomic groups having less money for the endless costs involved in applications "

"Reducing cost of the first year of medical school is the biggest barrier for people from poorer backgrounds"

However, there were some points or agreements. Students concurred with faculty to assert that the lack of diversity in teaching faculty was an obstacle to inclusivity e.g.
"Lack of diversity in the staff team discourages inclusion of other values and cultures"

"Have more people of colour teaching the SocPop modules."

"More teaching from different ethnicities"

"The lectures in socpop should be delivered by people with lived experience of those issues eg the race lecture should not be delivered by a white person, the lesson about LGBTQ+ issues shouldn't be by a heterosexual cisgendered person."

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

Further, students also agreed with faculty responses that more needs to be done to 'diversify' CBL in order to ensure a fully inclusive curriculum e.g.
"Diversify the CBL cases more"

"Integrate ethnic diversity into each block CBLs"

"balanced CBL cases"

"A niggle I've always had is with lecturers making sweeping statements about certain global populations and not taking into account class differences present there. Also references to skin changes that don't take into account ethnic skin. Also also including cultural factors into CBL. So not just biological differences but also cultural ones too"

Summary

Ultimately, faculty agree with students on some of the obstacles to a fully inclusive curriculum. Although there are divergences, - faculty emphasise that they need training and students emphasise that they need a more diverse cohort - there are no contradictions. In order to decolonise MBChB both parties must be consulted and their suggestions implemented. Otherwise, if faculty are just supplied with support, resources and training, students will still feel dissatisfied because their cohort is not diverse enough to allow for the informal discussions and learning that students surveyed indicated was important for a well-rounded learning experience.

Likewise, if the cohort is diversified through scholarship programmes, grants and outreach, faculty will still feel ill-equipped to teach a liberated curriculum.

Question 6

The next question asked: **"Do you feel you are given enough resources, training or support in order to teach a liberated curriculum? If no, what do you feel you need?"**

There were 18 responses and only 3 indicated that they felt they were given adequate resources, training or support to deliver a liberated curriculum. E.g.

"Yes, plenty - it would be entirely inappropriate to add any more"

"Yes, I don't personally think that further training or resources would help"

The remaining 15 respondents all indicated that they would benefit from more training support or resources e.g.

"I would like more time dedicated to staff training on this and a pointer to where we can find relevant resources to help and also time be be able to check teaching resources to improve them"

"I'm not sure this has been explicitly raised with me at Warwick - so anything would be positive!"

"Staff training need[ed]- both at WMS & externally. Staff support to review teaching materials before delivery."

Their were some respondents who did not know what a liberated curriculum is/had not thought about the curriculum in this way e.g.

"I wasn't familiar with this terminology until now."

"I am offered the opportunity to provide feedback at the end of CBL cases. I have never thought to feedback about these kind of issues that have been raised in this questionnaire but feel that it would be reasonable to do so."

"I am not sure what a liberated curriculum is."

Summary

These responses are extremely interesting. 75% of respondents indicated that they are not given proficient resources, support or training to deliver a liberated curriculum. However, earlier in the questionnaire:

61% of respondents agreed with the statement **"So far in my teaching, I have had the chance to discuss different perspectives within and outside the UK related to ethnic diversity with my students".**

63% agreed with the statement, **"I believe my teaching develops critical thinking and awareness of different perspectives on issues relating to diversity in ethnicity, culture and nationality"**

And, 40% agreed that their **"teaching has reading lists and resources that contain a diverse range of authors including those from different ethnicities, from outside the UK"**

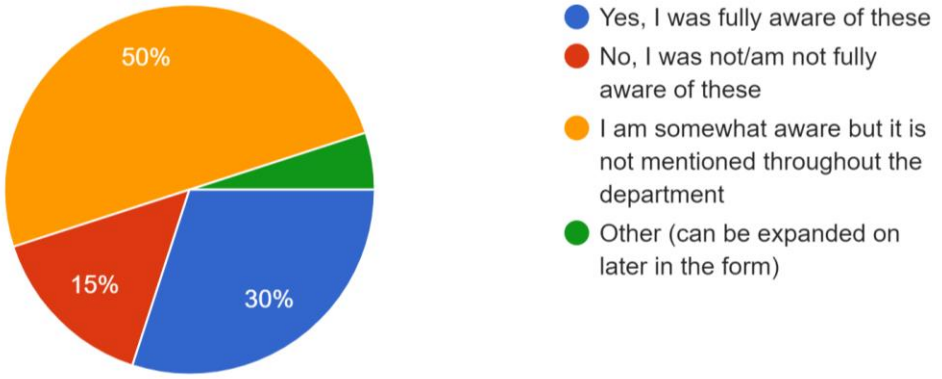
Data from earlier questions thus contradicts many of the responses to Question 6 and Question 5 too.

Question 7

The next question asked

"Do you feel like you are aware of issues that marginalised students or staff may face within the department or more broadly in healthcare? E.g have you heard/ were you aware of issues such as the racial pain gap, or the increased rate of mortality for black women in childbirth etc?"

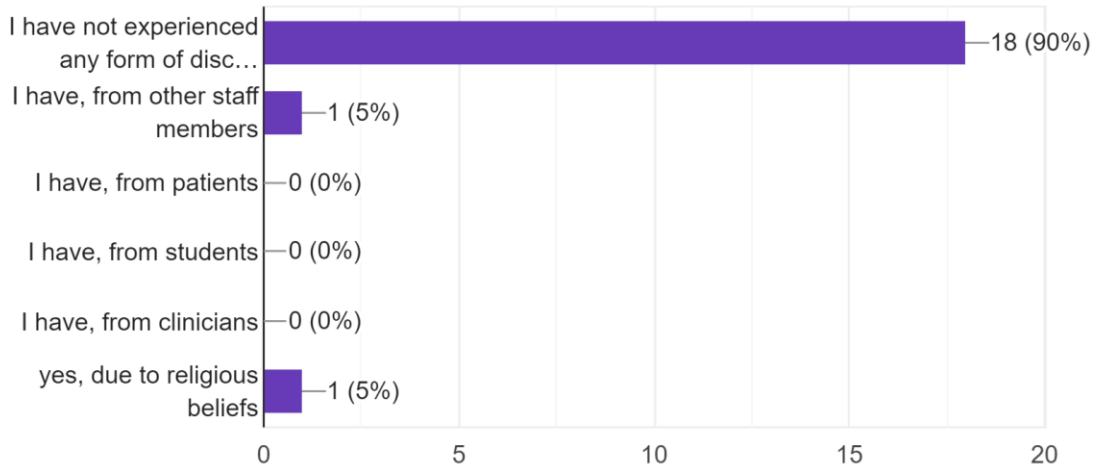
The responses were:



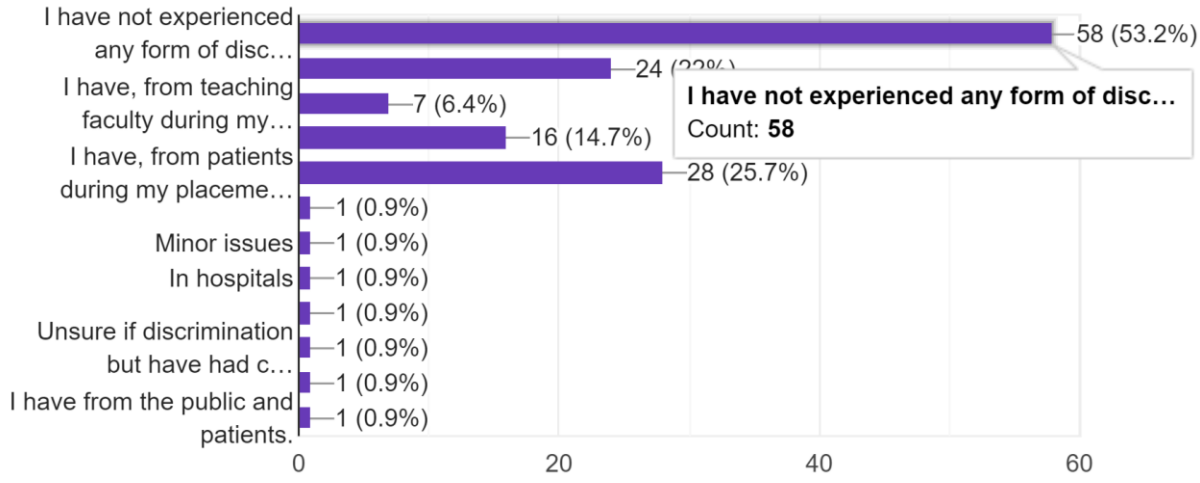
Question 8

"Specifically with regards to race, culture and ethnicity, have you experienced any discrimination during your time working with the Medical school, and if so where?"

The responses were:



Student responses to the same question were:

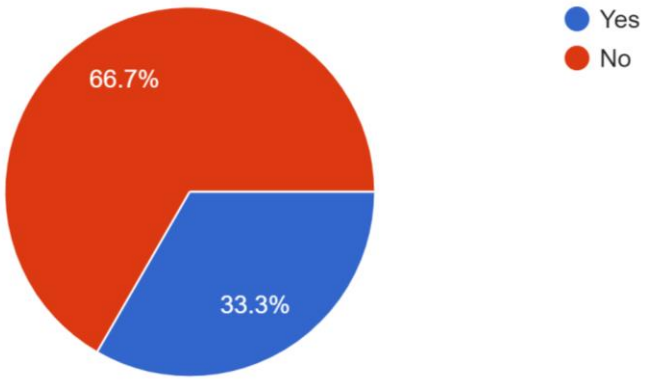


Question 9

This question asked:

"If you have experienced discrimination, do you feel you have received adequate support from the Medical School or your employer in dealing with this?"

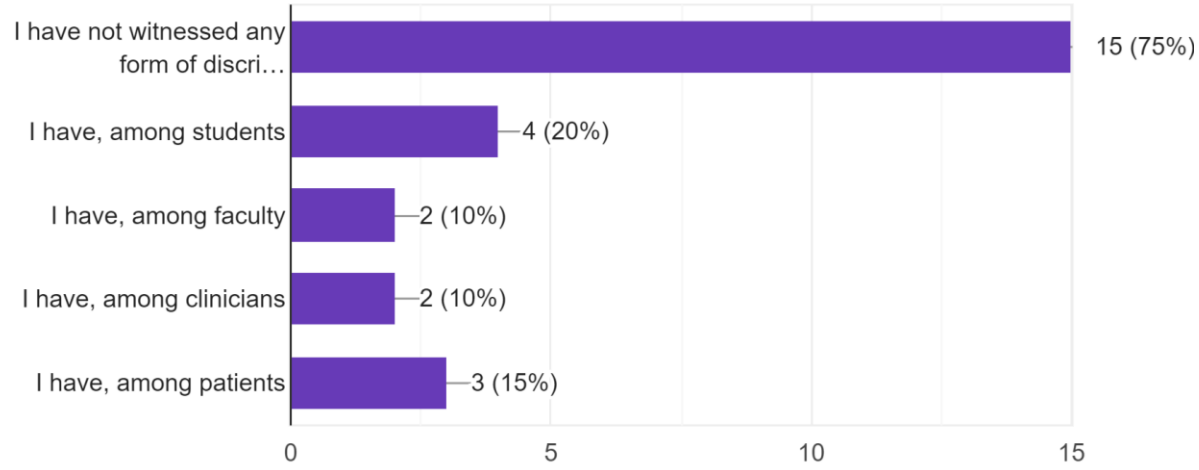
There were 3 responses:



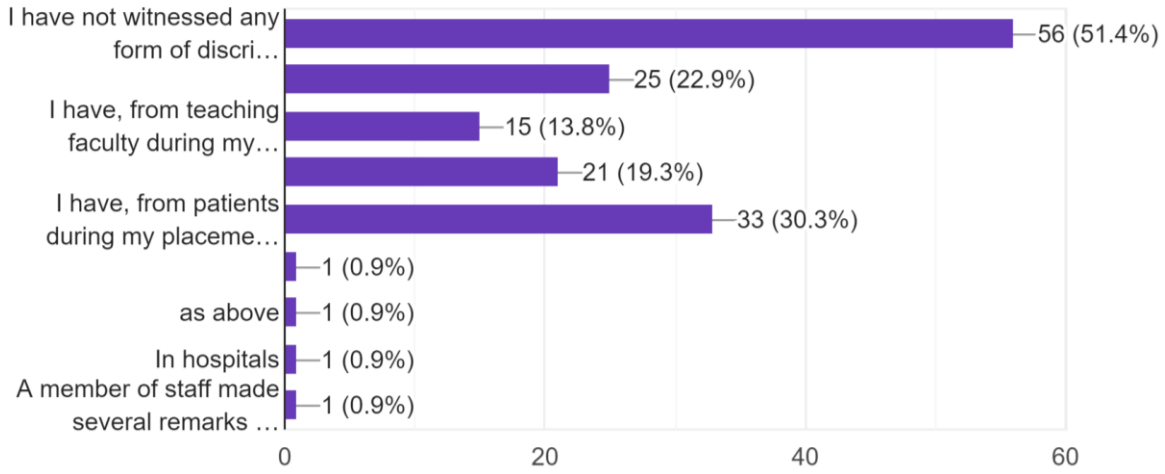
Question 10

"Specifically with regards to race, culture and ethnicity, have you witnessed any discrimination during your time working with Medical school, and if so where?"

The responses:



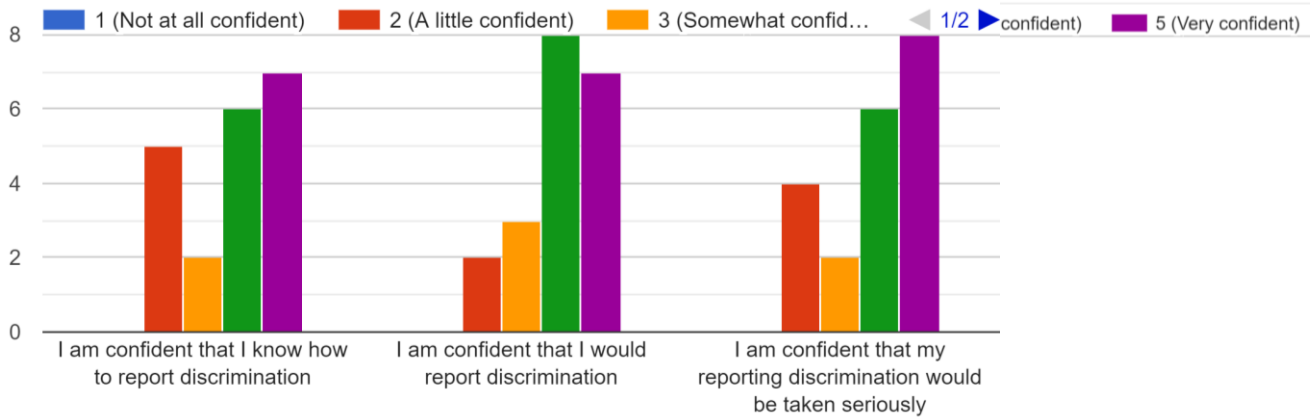
When students were asked the same question the responses were somewhat similar. Their responses were:



Question 11

"Relating to you or you as a bystander, rate your confidence with respect to the following:"

Responses were:



Given the opportunity to expand upon this, faculty respondents wrote:

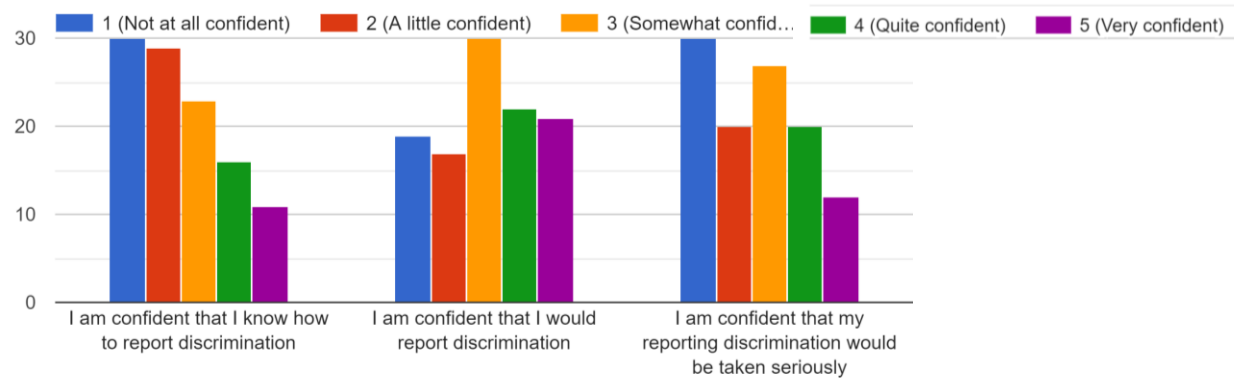
"actually on answering this question - apart from talking to the person themselves I have no idea how to report discrimination or to whom it should be reported"

"While I have reported racist events when they have been reported to me, I'm not sure about the process above me - i.e. whether there is a clear process that is followed reliably, and whether the students in question ever really get an 'outcome' from their complaint/concern"

"I have not witnessed discrimination in my time at Warwick Medical School but I am familiar with it"

Comparison

Students answering this same question however have alarmingly different answers
Student responses were:



Given the opportunity to expand upon this, student respondents wrote:

"The sort of discrimination I experience through interactions with senior professionals and peers involves inclusivity and may come across as paranoia which makes it hard to call out. Their behaviours may be so intrinsic that they don't realise they are making my peers/me feel like we're not included. It's hard to report and is probably hard to change too. I try to brush it off as paranoia but when the experiences occur so consistently to the same group of people, it's hard to not question whether it is due to discrimination"

"Whistleblowing is always very hard. Especially when you are unsure of what you want to come as a result of it. I fear too much responsibility would fall on my head and usually find myself asking if it's "that bad" to be worthy of the stress reporting causes. So far it's never been worth it"

"I have no idea where to report it to. I don't remember ever being told and I don't know my personal tutor well enough to go to them."

"I have previously reported discrimination, been promised follow-up, but heard nothing further and not seen any evidence of direct action from WMS in regards to the specific case."

"I don't trust WMS that it would not come to hurt me if I reported something. There is an atmosphere in the school that being outspoke will result in trouble for the student. The sense that the nail that sticks out gets hammered is pervasive."

"Unfortunately due to the majority of staff being white I am unsure whether they would understand the impact simply because they have probably never experienced it themselves and may not understand the nuances of many situations."

"I genuinely feel like I probably wouldn't because I don't think it would change anything. I have also often encounter micro-aggressions and subdued discrimination which I wouldn't feel confident I could have shared in the above sections as full blown discrimination but then have definitely made me and others feel very uncomfortable but I don't think would be taken seriously if reported."

Summary (Q8,10,11)
Whilst proportionately, students face more discrimination than faculty, they are less likely to report it than faculty. Faculty are evidently quite confident in their ability, likelihood and the success of reporting discrimintion whereas students are not. This may be because more students (having experienced/witnessed more discrimination than staff) have become more frustrated and disallusioned by the process to report discrimination than faculty (who proportionately have experienced and witnessed less discrimination). Or alternatively, students do not feel as safe and secure as facultydo to then feel comfortable and confident reporting discrimination.

v. Recommendations

Recommendations from results of the research
This report proposes four steps that should be implemented with immediate effect in order to begin cultivating a decolonised and liberated curriculum in the medical school.

- Training staff. When given the chance to expand on their answers faculty indicated that they felt they could only deliver a liberated, decolonised curriculum if they were trained to do so and then supported in that endeavour. Some faculty expressed that they felt uncomfortable talking on certain topics in case they used incorrect terminology which caused offence. Faculty should not feel restricted in their teaching because they do not feel confident that they have the appropriate language.
- Staff also need more resources. The questionnaire showed that faculty overwhelmingly felt that they did not have 'the material to explore different data, models and theories related to ethnic diversity - even within a historical context'. This should be remedied so that staff can explore the full remits of the curriculum as it currently stands.
- The disconnect between students and faculty was alarming. This report recommends that regular formal and informal feedback sessions are set up between students and faculty, with special attention to student perceptions about inclusivity and liberation at different stages and levels of their learning.

Recommendations on improving the project

- The team would have benefitted from an additional student who studied in the medical school in order to give situational insight and help push the project on Gibbet Hill through their networks. This would have been immeasurably valuable.

Recommendations on what to do next

- The next stage of the project should seriously consider mapping the medical curriculum much like Dr Faye Gishe 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 to complete, by mapping the curriculum with regards to class, gender, sexuality, patient experiences, discrimination etc they new have a clear picture of what their curriculum looks like and areas for decolonisation have been identified. Clearly this would take a lot of time and would require significant collaboration with medical school students and faculty.
- Work with the medical school BAME society. During the course of the project, the team met with some of the exec from BAME society. In the next phase of the project it would be a good idea to develop this connection. Canvassing of BAME society members and talking more with the exec in order to understand their opinions and any potential suggestions they may have about decolonising the curriculum would be valuable.
- Work with the Attainment Gap Working Group in the medical school. During the course of the project, the team were invited to an Attainment Gap Working Group meeting; Dr Sorinola and the group have done a lot of significant work on the attainment gap in the medical school and further collaboration with them could be excessively fruitful, resourceful and successful.
- Continued analysis of faculty's perception of the curriculum with the questionnaire. Unfortunately due to time constraints and the outbreak of Covid this questionnaire was not sent out to faculty who work in surgeries and clinics.. The team believes that the questionnaire should be sent out to these faculty for wider engagement in order to get a bigger data sample that can be compared with the results from the student survey.
- Small focus groups should be conducted with faculty and students. These focus groups should be for teaching/faculty positions and interested students for the purpose of ascertaining where the disconnect between student experiences and faculty perceptions begins, how it began and how it can subsequently be undone.

Before concluding this report we would like to take the time to make a special thanks to our supervisor Suki Kaur. Suki was supportive every step of the way, she always had an encouragement or unique word of wisdom to hand; she was also awash with extra resources and materials which the team found particularly useful. Another huge thanks must go to Emily Reid; Emily was immeasurably helpful at every step of this project and her contributions were greatly appreciated. Further, the team would like to thank Dr Sorinola for offering his support and inviting the team to the Attainment Gap Working Group that he chairs in the medical school. Finally, we must thank Chloe Batten - Education Officer in the Students' Union. Chloe took over as lead of the project from Larissa Kennedy after she was elected; Chloe prioritised the project, supported its aims and sought to further its reach. The project could not have continued successfully into its sophomore year without her continued support.

vii. Conclusion

To conclude this project has been exceedingly exciting to be a part of it. We are sure that an acknowledgement of the findings from the last two years could bring real and lasting changes to liberate the medical school. This report has highlighted several areas for immediate improvement but more work is needed in order to ensure the medical curriculum is fully inclusive, decolonised and liberated. We would therefore finally recommend that the project is extended, developed and entrenched. A permanent working group dedicated to the decolonisation of the MBChB should be established with participation from Warwick SU, medical school students and faculty.