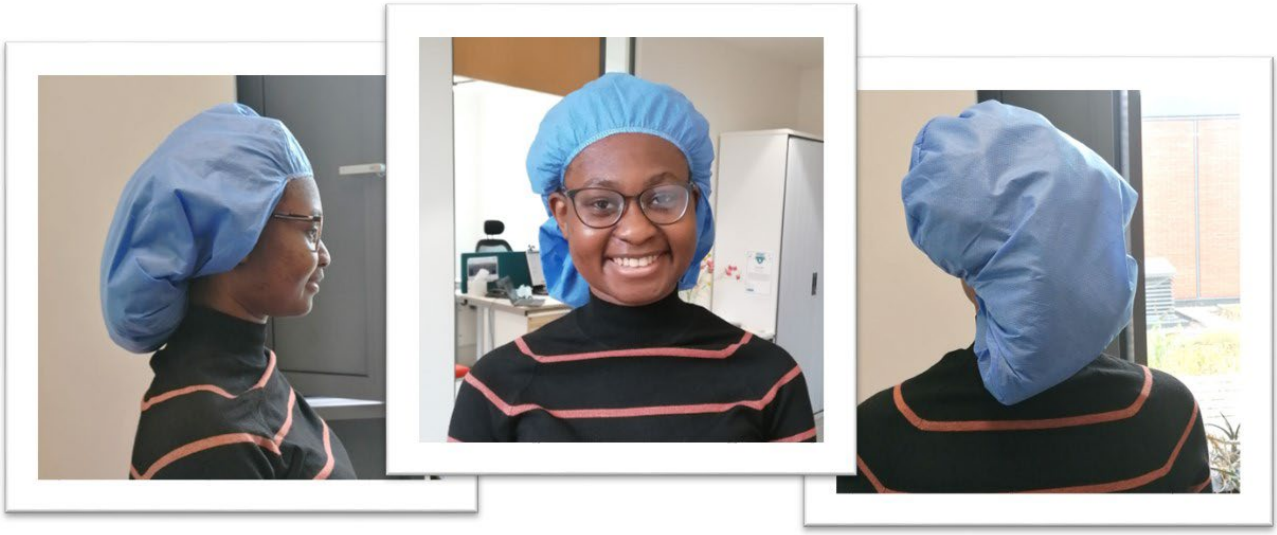
Leicester Medical School:
Racial Inclusion in the Curriculum Toolkit



PREPARED AND PRESENTED BY
'The MedRACE team'
medrace@le.ac.uk
V1.6 30.04.24

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Introduction

This document has been co-created by MedRACE students and staff to help guide efforts towards making our medical curriculum more racially inclusive. We undertook an initial scoping search of the literature, and draw upon, link to and reference this for related reading. We have intentionally included sources from both the primary literature and beyond to try and ensure a more accessible document. Some of these are also drawn from US literature, and we recognise that one cannot always extrapolate from that setting to our own, though some of those recommendations can help inform our own reflections.

Our objective is not to focus in detail on the theory and need for racial inclusion in teaching as this is well described elsewhere (1-6). Instead, we want to create a resource that introduces the process of developing more racially inclusive material for those engaged in medical education and make it more achievable. We also acknowledge that racial inclusion in medical education extends well beyond the formal curriculum.

We know that there is a significant awarding gap for ethnic minority students nationally (7). We know the reasons for this are multifactorial and include poor representation of ethnic minority colleagues amongst medical school faculty and critically a curriculum that does not always reflect student (or patient) populations. An inclusive curriculum has clear benefits for our students and for the patients they will care for in the future. Inclusion and a true sense of community and belonging is what we aspire to as a School for all our students and staff. We hope this toolkit – as a part of wider efforts in the School such as an EDI longitudinal curriculum theme – will help us work together towards this aim, and are also making this toolkit freely available to all medical educators for use in their own setting.

About this document

This document has been prepared as a guide for colleagues – students and staff alike – in the ongoing review and co-creation of our curriculum. Initially an internal document, we have now made it freely accessible through our website. It draws on student-staff work that began in 2021 in Leicester Medical School (LMS) with three Year 3 Student-Selected Components (SSCs) that explored actively creating a more inclusive learning environment for all our students addressing elements of curricular **development, delivery, content** and **assessment** (8). The recommendations from that work, whilst drawn from inclusion work on specific pre-clinical Units, can be applied and adapted across medical education[1]. This work helped inform the practical suggestions (pg. 5) on how we might start to challenge exclusion in our teaching.

[1] There have since been 15 further similar student-staff SSCs across our pre-clinical 'units' and clinical 'blocks'

Acknowledgements

We would like to acknowledge the contribution of the students and Unit and Block Leads who worked towards decolonising the medical curriculum with co-supervision from MedRACE staff colleagues (Kate Williams & Shameq Sayeed) and author of the UoL Decolonising the Curriculum (DtC) toolkit (Paul Campbell). Student-created posters from some of these SSCs are included as appendices in this toolkit.

How can I start making change? What can I do to challenge exclusions as an educator?

The questions below allow us to reflect on changes we may want to consider in developing a more racially inclusive curriculum. Linked and below (pg. 6) are resources you may also find helpful.

Delivery

Do we use (only) white male mannequins, photos and teaching aids?

Do we show signs and symptoms of disease for a range of skin colours?

Are our case studies inclusive? Do they represent other (protected) characteristics and intersectionality?

Are we ensuring our learning environments are accessible to all students (and not inadvertently excluding some?)

Are we using outdated terminology? (e.g. Caucasian)

Content (see also Assessment content)

Do we highlight that some developments used unethical practices e.g. J.M.Sims; Tuskegee experiment?

Do we teach who decides health research agendas nationally and internationally?

Do we include differences in health for different ethnic groups whilst also ensuring that students are aware that race is a social – and not a biological – construct? (see FAQ document below)

Is our teaching on history and developments in medicine truly global (and not just Renaissance/Graeco-Roman)?

Assessment

Are our assessors (including externals) and simulators drawn from a broad range of backgrounds? Do they receive training in cultural humility?

Are we including EDI teaching in question-writing training? Do assessment scenarios draw upon stereotypes of e.g. black women with cervical cancer (9) or South Asian men with TB[1]? Are such individuals included in scenarios where ethnicity is irrelevant to their presentation/diagnosis?

Are case studies diverse and do scenarios actively ensure inclusion/challenge exclusion?

Is assessment (formative and summative) aligned in its diversity with course delivery and content?

Development

Do we actively invite speakers – and encourage staff recruitment - from diverse backgrounds?

Are staff co-developing curricula and the learning environment with students to ensure the (usually greater than staff) diversity of the student body is reflected therein? (10)

Is inclusivity an integral theme across all aspects of learning and the learning environment? (11)

Are we comfortable discussing the impacts of (structural and interpersonal) racism on medical education (12) and healthcare?

Do we actively promote an anti-racist curriculum?

[1] The greater incidence of the former is simply not observed epidemiologically in the UK and whilst relative rates of TB are higher amongst non-white ethnic groups, the absolute number of cases of TB in the UK will of course be higher in the white population.

Resources for Educators

In addition to the linked articles and papers throughout this toolkit and references (pg. 10), below follow a number of resources for sourcing more diverse images. As the questions on pg. 5 indicate, an inclusive curriculum is of course about more than just diversity of images, though this is of course an important – and often easy to incorporate – aspect of inclusive learning resources. It is essential that these form the core of our teaching and are not simply referenced or buried away in references or further reading, where the likelihood of it contributing to learning will be diminished.

Appendix 1 also provides recommendations from student-selected components (SSCs) in specific pre-clinical and clinical subject areas, though lessons can of course be drawn from these for similar inclusive changes across the curriculum.

Resource Name/ Web link	**Brief description**	**Author/Source**
Atlas of Black Skin	This is perhaps the largest resource for pathological signs in darker skin, and is available online through our library	Moiin, A. (2020)
Mind the Gap: A clinical handbook of signs and symptoms in black and brown skin	This is an excellent (free) resource developed by Malone when a medical student, and has a good selection of clinical signs in darker skin.	Mukwende, M. (2020)
Skin of Colour Image Atlas	Another good (online) atlas for images with skin of colour	Journal of the American Academy of Dermatology
https://brownskinmatters.com/	A free community sourced database with pathology in darker skin	Weiss, E. (2018)
Skin of colour in dermatology education	The British Association of Dermatology has also collated several resources for skin of colour	British Association of Dermatology
Searching the primary literature (with appropriate key words) can be a good way of finding images of signs for particular conditions, often in case studies (e.g. limb ischaemia in dark-skinned patients)		

This is the beginning of our work in the School to challenge exclusions and create a real sense of belonging for everyone. We also hope that these examples and ideas begin to highlight some ways in which we all might gradually incorporate similar changes across our learning environment. The SSC curriculum inclusion projects – and review of their implementation as part of a student-led 'Seeing the Change' project - will continue to be offered. We recognise that this is but one aspect of a whole institution approach towards active inclusion which will include:

- Continued implementation of our EDI longitudinal curriculum theme
- Ongoing engagement and co-creation with students through existing governance structures and groups (MedRACE, medical school EDI committee etc.)
- Working with the Executive team, College and central University to ensure a whole institution approach towards active inclusion and challenging exclusions
- Quality Assurance through alignment with GMC, MSC, BMA and other national frameworks and review of local feedback
- Modification of data collection methods to better collect more granular data on concerns around discrimination within the learning environment
- Improved responsiveness to student and staff queries and concerns through regular feedback and updates to both via student-staff liaison committee meetings and whole School meetings (and to the School Education Committee and Executive), as well as the creation of an FAQ document on racial inclusion in the curriculum.

Frequently Asked Questions

What do you mean by diversity?

The below is an extract from Dogra et al's (2016) paper on 'Teaching Diversity to Medical Undergraduates' (1):
Consensus on definitions in this field can be difficult to achieve. In this Guide, diversity is not limited to viewing individuals as only being defined by a particular ethnic or racial group. The term diversity is not synonymous with "multicultural"; we extend diversity to include all facets that define the way individuals perceive themselves us (sic), so that there is no requirement to have ethnic diversity for cultural diversity to be present. This Guide views any difference as diversity. It does not make judgments about different groups but accepts that there is diversity within society and that future doctors need to be able to deal with diversity.

What do you mean by inclusivity?

In essence, this is simply ensuring that we are all doing what we can to ensure that everyone feels included within their learning environment, having a sense of belonging and feeling that the learning environment is a safe space for them and conducive to their learning and development as future clinicians.
The Medical School Council's recent framework (Dec 2021) on 'Active Inclusion: Challenging Exclusions in Medical Education' (see pg. 6-7 in particular) extends this understanding of inclusion to ensure this is not simply a passive process, but something that we are all working towards at an individual and institutional level.

What do you mean by decolonising (the curriculum)?

There is a lot of literature on this beyond medicine, and there are some references below to decolonisation of medical curricula too (Ref #4 for example provides a definition of decolonisation from the perspective of students and staff at Nottingham Medical School). A general definition from a locally developed University of Leicester toolkit (itself drawn from the Keele Decolonising the Curriculum Network) is as follows:
Decolonisation involves identifying colonial systems, structures and relationships, and working to challenge those systems. It is not 'integration' or simply the token inclusion of the intellectual achievements of non-white cultures. Rather, it involves a paradigm shift from a culture of exclusion and denial to the making of space for other political philosophies and knowledge systems. It's a culture shift to think more widely about why common knowledge is what it is, and in so doing adjusting cultural perceptions and power relations in real and significant ways.
UCL have also produced a guide ('So you want to decolonise your medical school?') which includes an introduction titled 'What actually is decolonising the medical curriculum?'

Given the objectivity inherent within the scientific method, why is there a need for such decolonising of our curriculum?

There are clear strengths in our (rather than 'the') scientific method(s). But it is this self-same scientific method - and many within the scientific community - that supported and gave rise to the now discredited pseudoscientific belief of 'scientific racism' (and the idea of distinct races) which was of course used to justify the horrors of slavery.
One of the strengths of our scientific method is of course the ongoing exploration that ensures we are constantly striving for the truth and thus the ability to correct inaccuracies in our worldview, but both history and logic suggest that it would be fallacious to assume that 'the' scientific method means we are immune to the dogma and grave errors made by scientists in the past, and the very real impact this has had – and continues to have - on individuals and societies.

What is anti-racism?

Anti-racism is an active commitment to working against racial injustice and discrimination. The BMA Charter to prevent and address racial harassment is one example of this. It involves making conscious and thoughtful decisions regarding our own (interpersonal) behaviours and our institution's processes and how they can/might negatively influence and impact stereotypes, biases and discriminatory actions. As expressed in this piece from the BMJ – *'health disparities are documented but not contested, and multi-culturalism and diversity training are confused with anti-racist pedagogy. Truly anti-racist teaching confronts prejudice through the discussion of racism, stereotyping and discrimination in society. It teaches the economic, structural and historical roots of inequality.'*

Similarly, an excellent piece in the Lancet (13) also proposes a move towards a race-conscious (rather than race-based) approach in medicine. In their introduction, they write:

Although clinicians often imagine themselves as beneficent caregivers, it is increasingly clear that medicine is not a stand-alone institution immune to racial inequities, but rather is an institution of structural racism. A pervasive example of this participation is race-based medicine, the system by which research characterising race as an essential, biological variable, translates into clinical practice, leading to inequitable care. In this Viewpoint, we discuss examples of race-based medicine, how it is learned, and how it perpetuates health-care disparities. We introduce race-conscious medicine as an alternative approach that emphasises racism, rather than race, as a key determinant of illness and health, encouraging providers to focus only on the most relevant data to mitigate health inequities

For anyone interested in a more general (sociological) introduction to the different types of racism, this is a very good introduction.

What do you mean by race not having any biological basis?

There are lots of good articles and summary pieces on this linked to below:
How Science and Genetics are Reshaping the Race Debate of the 21st Century: https://sitn.hms.harvard.edu/flash/2017/science-genetics-reshaping-race-debate-21st-century/
What Happens When Geneticists Talk Sloppily About Race: https://www.theatlantic.com/science/archive/2018/04/reich-genetics-racism/558818/
Race Is a Social Construct, Scientists Argue: https://www.scientificamerican.com/article/race-is-a-social-construct-scientists-argue/
Race is Real, but it's not Genetic: https://www.discovermagazine.com/planet-earth/race-is-real-but-its-not-genetic

Why are you only talking about racial inclusion and not considering other protected characteristics?

Although this work grew out of the BMA Charter's focus on prevention of racial harassment and discrimination, it would clearly be antithetical to be working towards racial inclusion whilst excluding other aspects of diversity! Thus, MedRACE's work – and racially inclusive principles, and this toolkit – apply not just to the nine legally protected characteristics but to a consideration, inclusion and celebration of cultural diversity more generally.

References

1. Dogra N, Bhatti F, Ertubey C, Kelly M, Rowlands A, Singh D, et al. Teaching diversity to medical undergraduates: Curriculum development, delivery and assessment. AMEE GUIDE No. 103. Med Teach. 2016;38(4):323-37.

2. Gishen F, Lokugamage A. Diversifying the medical curriculum. BMJ. 2019;364:l300.

3. Lester JC, Taylor SC, Chren MM. Under-representation of skin of colour in dermatology images: not just an educational issue. Br J Dermatol. 2019;180(6):1521-2.

4. Mbaki Y, Todorova E, Hagan P. Diversifying the medical curriculum as part of the wider decolonising effort: A proposed framework and self-assessment resource toolbox. Clin Teach. 2021;18(5):459-66.

5. Moghli MA, Kadiwal L. Decolonising the curriculum beyond the surge: Conceptualisation, positionality and conduct. London Review of Education.19(1).

6. Wong SHM, Gishen F, Lokugamage AU. 'Decolonising the Medical Curriculum': Humanising medicine through epistemic pluralism, cultural safety and critical consciousness. London Review of Education.19(1).

7. Woolf K, Potts HW, McManus IC. Ethnicity and academic performance in UK trained doctors and medical students: systematic review and meta-analysis. BMJ. 2011;342:d901.

8. Medical Schools Council EDI Alliance. Active inclusion: Challenging exclusions in medical education. 2021.

9. Shirley MH, Barnes I, Sayeed S, Finlayson A, Ali R. Incidence of breast and gynaecological cancers by ethnic group in England, 2001-2007: a descriptive study. BMC Cancer. 2014;14:979.

10. Konings KD, Mordang S, Smeenk F, Stassen L, Ramani S. Learner involvement in the co-creation of teaching and learning: AMEE Guide No. 138. Med Teach. 2021;43(8):924-36.

11. Forrest D, George S, Stewart V, Dutta N, McConville K, Pope L, et al. Cultural diversity and inclusion in UK medical schools. Clin Teach. 2022.

12. Kmietowicz Z. Are medical schools turning a blind eye to racism? BMJ. 2020;368:m420.

13. Cerdena JP, Plaisime MV, Tsai J. From race-based to race-conscious medicine: how anti-racist uprisings call us to act. Lancet. 2020;396(10257):1125-8.

Appendix 1

Examples of Decolonising the Curriculum SSC Posters

Decolonising the Curriculum: Decolonising Dermatology

Takunda Nhiwatiwa
Medical Student, Year 3 SSC: tdn8@student.le.ac.uk

Background

People of colour rarely see themselves reflected in the typically 'White' lens of medical teaching, resulting in **missed diagnoses and underestimated severity in people of colour**. This means overall, **students are underprepared** when faced with patients outside of the 'standard' (ie White) narrative.

Beyond textbooks and research, much of medical education is inherited from the workplace with **myths, bias and misconceptions about patients of colour** with it. In dermatology, a field in which the diagnosis of pathology has a significant dependence on visual components, the current standard falls short (1).

University of Leicester have **recognised the need for a formal decolonisation of the curricula**, with "Leics Decolonise" (2) and the Decolonising the Curriculum Toolkit, which aims to "help HEI educators make their module content, assessment and practice more racially inclusive and relatable to *all* students." (3). This project aims to apply this toolkit to Medicine, to **increase inclusivity, accessibility and elevate knowledge** so that medical students feel adequately equipped in treating skin of colour, crucial in a city with a BAME population of 49% (4).

Resources & Methods

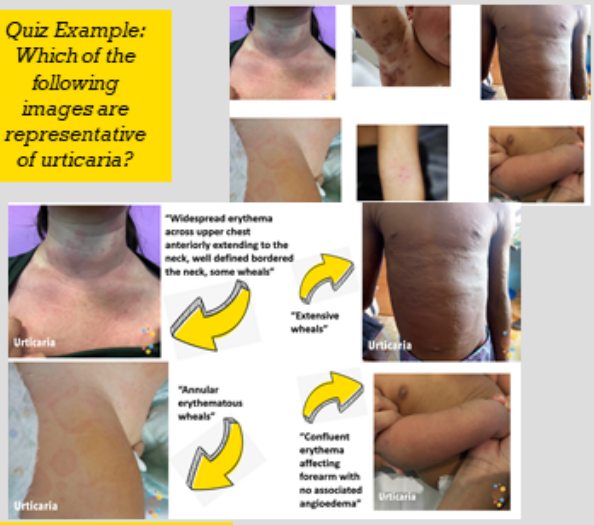
1. I reviewed the current unit content, including the Blackboard page for the Dermatology session. In this review I looked at diversity of image and case studies and made recommendations.
2. I undertook a literature and image search (see honeycomb diagram above). Search terms included "dermatology" "skin of colour" and "Fitzpatrick type [insert number]".
3. I used all above resources to develop an inclusive dermatology quiz.

REFERENCES
1.Decolonising Dermatology: Why Black and Brown Skin Need Better Treatment. [Online] https://www.theguardian.com/society/2020/aug/13/decolonising dermatology why black and brown skin need better treatment.
2. University of Leicester Students Union. Leics Decolonise. *Leicester Students Union*. [Online] https://www.leicesterunion.com/voice/campaigns/current/leicsdecolonise/.
3. Campbell, Dr Paul. *Decolonising The Curriculum Toolkit*. Leicester : s.n., 2021.
4.Leicester Population 2021. *Population UK*. [Online] https://www.ukpopulation.org/leicester population/.

Project Outputs

1. Quiz: Comprehensive questions that encourage students to consider skin of colour, rather than making skin of colour the sole focus. Rationale and descriptions are also provided with references when giving answers to encourage learning (see second slide).

Quiz Example: Which of the following images are representative of urticaria?



2. Group Work Review: Integration of **representative images** in the group work documents was paramount in my recommendations, in addition to including the terms "hyperpigmentation" and "hypopigmentation" to the definitions and glossary, **common dermatological findings in darker skins**. I also proposed written recognition that "erythema" and its derivatives are often used as a necessary hallmark of inflammation, without the consideration that this may not be the case in darker skins.

3. Blackboard: Much of the editing surrounded reducing big sections of introduction, as well as sorting resources by intended learning outcome (ILO), rather than by type of media, allowing for better structure and for students to hone in on problem areas.

Conclusion

This project, along with the other two SSCs on Decolonising the Curriculum (on Pharmacology and Health Enhancement) highlighted the need for review in all aspects of medical education, and has led to further outcomes:

- Adapting the Decolonising the Curriculum Toolkit to be Medicine specific.
- Annual review on Decolonising the Medical Curriculum in Phase 1 (Y1 and Y2) unit lead meetings.
- A specific ILO requiring students to have an awareness of differences in skin colour for Phase 1, as is already the standard for Phase 2.
- Work collaboratively across medical schools to make real change, by participating in the Diversity In Medicine and Health (DIMAH) Conferences.

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Y3 SSC: Decolonising the Curriculum (DtC)
Decolonising Compassionate Holistic Diagnostic Detective Course (CHDD)

Kiran Bhavra
Medical Student, Year 3, kb439@student.le.ac.uk

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Background

40% of UK medical students are from ethnic minority groups, however, teachers have often reported to feeling ill-equipped to discuss ethnicity. (1) A key part of 'decolonising the curriculum' is the conversation between students and staff to identify how we can make our learning environment as inclusive as possible. This is not only for student learning, but for better patient-centred care. (2)

CHDD is undoubtedly a unique module within Leicester's medical school curriculum. It teaches students to develop their central consultation skills, and as a result, has the opportunity to introduce thought-provoking scenarios and trigger subsequent individual self-reflection. These sessions also revolve mostly around student participation.

As a result, I believe these sessions have the ability to create a conducive environment for staff to teach about racial inclusivity in an integrated, sensitive and open manner where there is an open dialogue for learning between both the staff and student.

Methods

Step 1: Review of Blackboard materials, as well as tutor notes, to note any possible learning areas of improvement, with the aid of the DtC toolkit.

Step 2: Preliminary discussions with module lead.

Step 3: Brief literature review on PubMED.

Project Outputs

Add to CHDD Reading List

The Spirit Catches You and You Fall Down: A Hmong Child, Her American Doctors and The Collision Of Two Cultures - Anne Fadiman

Year 1: Diversity in Practice Session

Change 'Setting the Scene Questions

Before:

What does diversity mean to you?
Think back about the assumptions you made of your PKB patient – how can assumptions impact on a consultation?
How do you think they could avoid this impact?

After:

What does diversity mean to you?
How do you feel about treating patients who are different to you (e.g. patients of different colour, ages, gender, ability)?
What will you do to manage that?

Change names in role-play scenarios

Before:

Scenario 1: Mary Duffield and Alex Duffield
Scenario 2: Michael Dawson
Scenario 3: Nina Mistry
Scenario 4: Teresa Johnson

After:

Scenario 1: Samira Ahmed and Amir Ahmed
Scenario 2: Michael Dawson
Scenario 3: Christine Oh
Scenario 4: Preeti Kaur

Recommendations

On reflection of this project, below are recommendations for further discussion and outcomes for the CHDD Unit and DtC SSC.

CHDD Unit:

- Increase diversity of 'Patient Knows Best' patients.
- Encourage PKB Tutors to reflect and use their own experiences in CHDD sessions as well as encouraging compassionate curiosity in practice.
- Incorporate Active Bystander scenarios to CHDD sessions (potentially Year 2: Ethics session).
- Gather information from students on their experiences of CHDD and preparedness for diverse patient consultations.

DtC SSC:

- Completion and dispersion of Medicine DtC Toolkit.
- Annual review on Decolonising the Medical Curriculum in Phase 1 (Y1 and Y2) and Phase 2 unit lead meetings.
- Review previous Decolonising The Curriculum SSCs to ensure implementation/progress.
- Work collaboratively across medical schools to make real change, by participating in the Diversity In Medicine and Health (DIMAH) and Midlands Racial Equality in Medicine (MREM) Conferences.

References:
1. Woolf K. Differential attainment in medical education and training. *BMJ*. 2020:m339. doi:10.1136/bmj.m339
2. Dogra N, Karnik N. Teaching cultural diversity to medical students. *Med Teach*. 2004;26(8):677-680. doi:10.1080/01421590400016324

DECOLONISING THE CURRICULUM: ETHNIC INEQUALITIES

Mashuda Khandokar
University of Leicester Medical School
with thanks to Professor Kate Williams, Dr Shameq Sayeed, Dr Andy Cook and Dr Fiona Miall

BACKGROUND

With the UK becoming an increasingly diverse society, consideration of ethnicity in health inequalities is extremely important in the prevention poor health outcomes. This importance was highlighted during the COVID-19 pandemic whereby 64% of a 21% minority ethnic NHS workforce died [1]. In the medical school curriculum, health inequalities are typically taught as stand-alone lectures. This method of teaching is not enough to leave a lasting impact on students. Rather, a more sustainable method, is to have 'teachable moments' whereby the teaching of ethnic inequalities is dispersed throughout the curriculum [2]

METHODS

1. Identified recommendations from current research on how to best teach medical students about ethnic inequalities in a way that allows them to reflect

2. Paired with Dr Andy Cook, lead of Primary Care. to brainstorm ideas to implement findings from research. Also put in contact with Dr Fiona Miall to review the current EDI ILOs

3. Reviewed the Year 5 tutorials and chose topics whereby inserting information and discussion regarding ethnic inequalities can be slotted in.

4. Collated information in a document and reflective infographic

OUTPUTS AND RECOMMENDATIONS

1. Reviewing learning outcomes - highlighted where primary care ILOs and vertical EDI theme ILOs aligned. No EDI themed ILOs in Year 5 but Year 5 learning is to build on Year 3 teaching.

2. Year 5 Primary Care Tutorials review - integrating teaching of ethnic inequalities throughout the current tutorials was important to show how teaching can be modified throiughout a module rather than delivering a stand-alone session.. Examples of suggestions are given below. These suggested changes have been compiled in a document and presented to Dr Cook who will integrate the ideas when reviewing the Year 5 tutorial sessions prior to delivery during the academic year 2022-2023.

END-OF-LIFE CARE AND CONVERSATIONS ABOUT DEATH

For the student:
When talking about death with patients and their families, what questions are important to ask them to understand their cultural expectations?

For the tutor:
Example questions: *Do you have any cultural rituals to cope with death? What final arrangements are usually made in honouring the one who has died?* Use this opportunity to teach about cultural humility.

For the student:
What barriers do you think exist in understanding and accessing palliative/end-of-life care for patients amongst minority ethnic groups?

For the tutor:
- Palliative care is not a well understood topic for some ethnic groups
- Lack of referrals to hospices; lack of religious and cultural sensitivity when discussing death
- Language barriers and poor communication [3]

SAFEGUARDING

For the student:
What unconscious biases may have an impact on safeguarding in children from ethnic minority backgrounds?

For the tutor:
- Interpret behaviour differently according to race of child
- Preconceived concerns about whether a child's parents or carers are legal immigrants
- Adultification - children from minority groups are considered more streetwise so they may be viewed as a threat as opposed to someone who is vulnerable

3. Infographic - During my research, there were a number of statistics pertaining to ethnic inequalities that aligned with our modules in the medical school curriculum. Therefore I thought it would be quite powerful to pick one statistic per medical school module and create this into an infographic for reflection for both teaching staff and students. This could be included in the DtC toolkit

"RESPECT ALL PATIENTS, COLLEAGUES AND OTHERS REGARDLESS OF THEIR AGE, COLOUR, CULTURE, DISABILITY, ETHNIC OR NATIONAL ORIGIN, GENDER, LIFESTYLE, MARITAL OR PARENTAL STATUS, RACE, RELIGION OR BELIEFS, SEX, SEXUAL ORIENTATION, OR SOCIAL OR ECONOMIC STATUS"
GMC OUTCOMES FOR GRADUATES

References:
[1] Ethnic Minority and COVID-19. www.Kingsfund.org.uk. https://www.kingsfund.org.uk/blog/2020/04/ethnic-minority-deaths-covid-19. Published 2020.
[2] Treacy-Abarca, S., Aguilar, M., Vassar, S.D. et al. Enhancing existing medical school curricula with an innovative healthcare disparities curriculum. BMC Med Educ 21, 613 (2021)
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UNIVERSITY OF LEICESTER MEDRACE RAISING AWARENESS, CELEBRATING EXCELLENCE

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DECOLONISING THE CURRICULUM

PHASE 2: REPRODUCTIVE HEALTH BLOCK

Mira Chainrai
Supervisors: Dr Shameq Sayeed
& Professor Kate Williams
SSC 2022

What is 'Decolonising the Curriculum'?

'Decolonising the Curriculum' is an academic movement that aims to highlight inequalities present in modern teaching.

Within medicine, BAME students often reported feeling more isolated and less welcome compared to non-BAME students. This is speculated to be a result of various factors - from a lack of BAME representation in staff to a curriculum that does not reflect or represent the student population.

Evidence has shown that changing this lack of representation and diversifying medical curriculums has a positive impact on both students and the patients they will later go on to treat.

It is important that students are exposed to diverse teaching as this has been shown to result in greater confidence when approaching communication barriers within practice, reducing negative stereotyping, and improving clinical outcomes of patients in general.

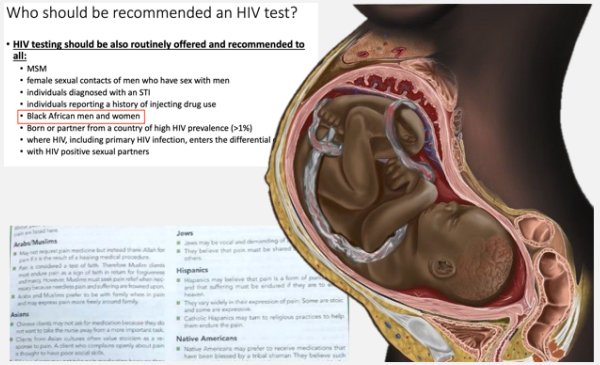
The aim of decolonisation is to address inequalities and challenge longstanding biases present within medicine, allowing students to go forward with a broader insight and awareness of medicine and patient care.

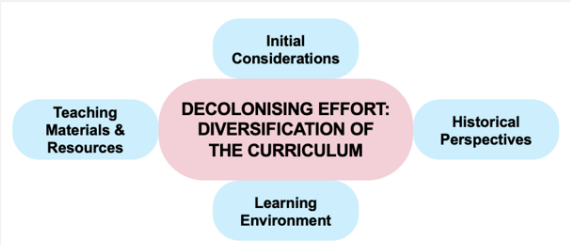
Aims

Evaluate current teaching materials within the Reproductive Health block

Highlight areas within that would benefit from 'Decolonisation' and further examination

Propose suggestions as to how these areas could be improved upon for future students and teaching.





Methodology

Step 1: Research into current health inequities experienced in reproductive health

Step 2: Review of teaching materials within the Reproductive Health Block with the aide of Decolonising Toolkit

Step 3: Present possible changes to be implemented to make the content within the block more equitable

Proposed Outputs

1) Inclusion of more diverse imaging – especially when depicting the normal

2) Amending the HIV testing teaching to acknowledge outdated guidelines regarding testing for black men and women and explanation of why this should be considered case-by-case rather than a generalisation

3) Acknowledgement of known racial biases currently within reproductive health, such as;

BAME	- Pain often poorly managed in groups, especially black women
mortality in	- Higher infant and maternal BAME populations
black women	- Higher miscarriage rates in
struggle	- BAME couples more likely to with infertility, but present later
than non-	BAME couples

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Decolonising the Psychiatry Curriculum.

Huma Hafeez, University of Leicester

UNIVERSITY OF LEICESTER

Background

The psychiatry curriculum in the West is based on a longstanding Eurocentric biomedical model of disease that assumes a position of superiority over the cultures and indigenous healing systems of the non-western world (Bracken et al., 2021). This reductionist culture-blind approach marginalises indigenous forms of psychiatry leading to a culturally insensitive practice that can dissuade those who need help from seeking it (Antic, 2021). This student selected component aims to introduce students to the narratives of patients who don't fit the default that is adopted as a textbook presentation for most illness scripts (Solchanyk et al., 2021) through case studies and encouraged reflection.

Preliminary discussions with module lead on possible avenues to explore.

Chose Psychiatry speciality block to focus on

Review of the current Blackboard materials to note any possible areas of improvement.

Identified a learning objective encouraging consideration of culture when managing patients, with no material provided to supplement it. Responded by creating slide insert created for the Psychiatry workbook..

Did brief literature review on PUBMED

Keywords " decolonising psychiatry", "decolonising medical education", then a general search on racial bias in global psychiatric practice using the keywords "bias/racism in mental health/psychiatry".

Social Prescribing Signposting

As part of the holistic overview and management of patients, doctors are expected to provide bespoke social prescribing as part of a management plan based on the biopsychosocial model, however there seems to be a lack of group specific resources signposted for patients and their families/carers to be referred to.
I have curated a basic list of general and group specific services that can be used to inform more tailored social prescribing. This list of faith and culturally sensitive resources is a step forward in bespoke social prescribing for BAME individuals, that can reinforce a holistic approach to medicine (Gupta, 2021).

Social Prescribing- Groups & Services available

For Specific Groups of People:

1. **BAATN**- The Black, African and Asian Therapy Network- directory of therapists,
2. **Black Minds Matter**- connects Black patients and/or families with Black therapists,
3. **The Empowerment Group**- charity offering subsidised online counselling for Black individuals,
4. **Taraki**- improving access through culturally safe activities for the Punjabi community,
5. **Sharing Voices- Bradford**- services for BAME communities in mental distress,
6. **SAMPAD- Birmingham** Specific,
7. **The Muslim Youth Helpline,**
8. **Nafsiyat**- London based Intercultural Therapy Centre,

General

1. MIND,
2. SANE,
3. Turning Point Leicestershire Crisis Helpline,
4. **PANDAS** Foundation UK- Pre and Post Natal Depression Advice and Support,
5. Samaritans ,
6. BEAT Eating Disorders,

Reflection

Reflection is encouraged by the GMC as an activity that doctors should regularly engage in throughout their career. The reflective practitioner is one who is able to learn from their experiences, maintain their emotional wellbeing and consequently improve the delivery of patient care (General Medical Council, 2019).

2. Read through the following cases to gain an insight into whether a patients cultural/religious/social background influences their experiences of mental illness and their interaction with mental health services. It is important to note that this does not imply that there is a direct causative link between their race/culture/social background and the disease pathophysiology, but rather the ways in which they can shape an individual's preconceptions about mental health services, their presentation and treatment journey.

- Megan's Story- Mental Health in Asian Communities, https://www.mind.org.uk/information-support/your-stories/talking-about-mental-health-in-asian-communities/
- Nada's Story https://healthtalk.org/experiences-psychosis/nada-interview-20
- Lorenz's Story https://healthtalk.org/experiences-psychosis/lorenz-interview-33
- Tariq's Story https://healthtalk.org/psychosis-young-people/tariq
- Naveed's Story- https://healthtalk.org/experiences-psychosis/naveed-interview-21

Learning to reflect begins as a student, which is why I have introduced an activity for students to engage in throughout their specialty psychiatry block, in which they are expected to write approximately 300 words on an encounter, event or observation that highlighted the impact a patients cultural/religious background made on their journey through the mental health services.
To prompt students on possible reflection points, a few cases documenting the patient journey of individuals from BAME backgrounds through the NHS mental health services were provided, sourced from the website healthtalk.org.

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DECOLONISING THE CURRICULUM

FUNMI SALAWU
LEICESTER MEDICAL SCHOOL - PHARMACOLOGY

UNIVERSITY OF LEICESTER

INTRODUCTION

The goal of this project was to identify any areas in the Leicester medical curriculum, particularly the CPT domain, that could be potentially harmful in respect to racial bias.

My aim was to recognize 3 key areas that could be flagged to those in a position to refine the curriculum or begin the process of adaptation myself.

METHOD

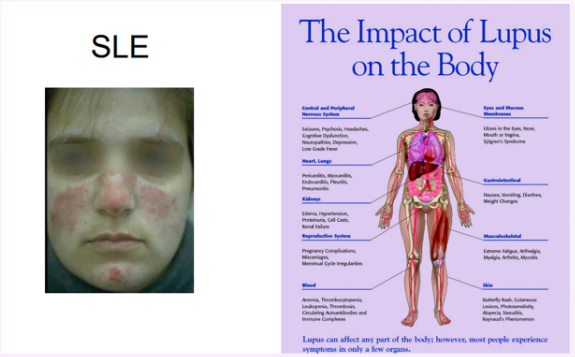
1. **Review CPT lectures and workbook**
2. **Liaise with CPT leads**
3. **Adapt lectures + integrate adaptations into group work**

FINDINGS

THE CPT WORKBOOK AND LECTURES HIGHLIGHTED AREAS OF RACIAL BIAS WHERE TEACHING WAS MAINLY TAILORED TO CAUCASIAN SKIN

Unclear use of the hypertension pathway in people of black ethnic background

Insufficient representation of darker skin in the immunosuppressant lectures



RECOMMENDATIONS

1. **Integrate a case into the Session 3 or 4 group work**
2. **Add a 15-minute segment into Session 8 group work (Evidence Based Medicine) that assesses the reliability of the oxygen saturation monitor**
3. **Adapt the CPT Session 10 lectures so there is more representation for darker skin types**

REFERENCES

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DECOLONISING THE CURRICULUM PT 1:

Identifying Neonatal Jaundice in black and brown babies:

By Kike Solanke - 5th Year Medical Student
k.solanke@hotmail.co.uk / ks509@student.le.ac.uk

The question of **'would this condition reflect the same way in black/brown patients compared to white patients?'** is one that is not asked enough. Ethnic minority groups continue to experience adverse outcomes in health care and health experience across the UK. This project aims to highlight some areas of discrepancy when examining patients of ethnic minority backgrounds as well as challenge students and medical educators to ask more questions in an attempt to identify the clear gaps that are failing ethnic minority groups.

BACKGROUND

NEONATAL JAUNDICE

Jaundice is a yellow colouration of the skin and sclerae (whites of the eyes) caused by the accumulation of bilirubin, a bile pigment that is mainly produced from the breakdown of red blood cells.1

Neonatal jaundice can result in the life-threatening neurological condition – kernicterus, as well as causing other complications such dehydration, infection and bruising.2 Current practice is that babies who appear clinically jaundiced must have bloods to investigate the cause and if necessary to treat it to prevent adverse outcomes. 1

During clinical paediatric placement, it was clear that jaundice was exceedingly difficult/impossible at times to see on darker skin. Upon questioning various health professionals, regarding this difficulty, the responses did not seem to draw usable solutions.

Responses included: "It will come with experience" - "Yes it can be difficult" "A good midwife/doctor will pick it up"

BARRIERS

NICE GUIDANCE

- Examine the baby in bright, preferably natural light, for example in daylight by a window.
  - Look at the skin of the whole body, and blanch to assess for jaundice (for example gently pressing on the nose).
  - Also examine the sclerae, gums, and palate.3

Will the skin of a black neonate ever look jaundiced?

Are there extra practical precautions when monitoring for jaundice in black babies?

How confident are health care professionals when approaching a darker skinned baby with jaundice?

AIMS + METHODS

AIMS

1) **Research** - To identify whether mortality as a consequence of kernicterus is higher in black and brown babies compared to white babies.

METHODS

1. I conducted a **literature search** using pubmed, google scholar, medscape, NICECKS, NHS choices, UHL trust guidelines and various paediatric journals. Key words included: kernicterus, hyperbilirubinemia, black neonates, ethnic minority neonates/babies, paediatric kernicterus.
2. I reviewed the **current content** of the workbook to see if there was any information on difficulties in identifying jaundice in darker skinned babies.
3. I spoke with healthcare professionals to get an insight into **how they approached darker skinned** babies during a jaundice assessment.

OUTCOMES

LITERATURE RESULTS

- The literature showed that kernicterus proportionally affects a significant number of black and ethnic minority neonates. 4
- Infants of ethnic minority origin may be vulnerable for two reasons: first, **clinical evaluation of the severity of jaundice may be difficult** and second, some ethnic minority groups have a high prevalence of haemolytic diseases such as glucose 6-phosphate dehydrogenase deficiency. 4
- A study recently reviewed in 2020 showed that **black neonates** account for more than **25% of kernicterus cases** in the US, despite **making up only approximately 14%** of all births. 5
- Outcomes from discussing with healthcare professionals showed that there is a **gap** when it comes to **confidence in examining black neonates for jaundice.**
- The reason as to why black and brown babies develop kernicterus in higher proportions than their white counter parts is unknown and **more research into to area is necessary**. 4
- Having scratched the surface of this literature search it was clear that more needed to be investigated with regards to why black and brown neonates were getting kernicterus so disproportionately.

NEXT STEPS

PROJECT OUTPUTS

1. **Identify other gaps** - Jaundice is not the only condition that needs highlighting. There are a range of clinical conditions and situations that effect ethnic minority groups that we are not equipped to manage.

2. **Question Checklist -** Create a checklist of questions that can be incorporated into group work/lectures that challenge students to think about how they would approach clinical scenarios based on ethnic minority patients.

3. **Develop a resource:** In order to decolonise the curriculum I looked into where the medical school could implement a useful resource into their curriculum and where it would fit.

4. **Gather information from the students** – To identify how students feel the curriculum so far has been decolonised.

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DECOLONISING THE CURRICULUM PT 2:

How do we start thinking: What about black and brown patients?

Kike Solanke
5th Year Medical Student
Email: ks509@student.le.ac.uk or k.solanke@hotmail.co.uk

The question of 'would this condition reflect the same way in black/brown patients compared to white patients?' is one that is not asked enough. Ethnic minority groups continue to experience adverse outcomes in health care and health experience across the UK. This project aims to highlight some areas of discrepancy when examining patients of ethnic minority backgrounds as well as challenge students and medical educators to ask more questions in an attempt to identify the clear gaps that are failing ethnic minority groups.

INTRODUCTION

It can be difficult to identify gaps in our medical knowledge when it comes to health in ethnic minority groups. This is due to the curriculum being predominantly white and medical students having limited exposure to diverse teaching materials. The lack of exposure prevents questioning around conditions that effect large groups of minority patients and as a result we are not equipped to deliver the best for all of our patients.1

The difficulty in the identification of jaundice on black/darker skin (see poster 1) lead me to ask myself, 'Is everyone asking these questions?' And more importantly if these questions are not being asked, what are the long term health outcomes for our ethnic minority patients'? 2

The University of Leicester Medical School have recognised that the 'decolonising toolkit', which is a set of guidelines and prompts to help educators in Higher Education Providers (HEPs) make their module content, assessment and practice more racially inclusive and relatable to all students, is an invaluable tool.3

The aim of this project is to utilize and elevate this toolkit and implement its content into every day medical teaching at the university. The idea is to provoke discussion around this topic as well as produce usable outcomes and strategies that medical students can use in practice so that they feel more comfortable treating patients of all races.

OBJECTIVES

- To identify whether medical students are aware of limitations that they may have when it comes to managing certain conditions in black and brown patients
- To create some common questions that allows this idea to be explored
- To gain an insight into how well equipped medical students feel entering the workforce and managing ethnic minority patients with certain conditions
- To identify any areas in the curriculum that already support this

METHODS

I looked for available resources on blackboard that took into account ethnic minority throughout the clinically based content.

I Looked to identify exam type questions/practice material that took into account minority ethnic groups.

I Gathered information via a short survey asking medical students questions specific to identifying conditions in black and brown patients/how equipped did they feel to approach these questions.

PROJECT OUTPUTS

- Create questions via google form - Create a bank of questions/checklist for medical students, that provoke thought and discussion around specific clinical conditions that affect black and brown patients. The aim is that this will encourage conversation, reflection and overall solutions.
- Collate questions into a Worksheet - Practically I would like to create a usable resource such as a worksheet, that can be used within the medical curriculum. eg: at the beginning of the year 3/4 induction/within GP tutorials.
- Gather student opinions on topic – I thought that it was important to gain an idea of how other students felt regarding this topic.

EXAMPLE QUESTIONS

1. How do you assess central capillary refill? Are there barriers to using this method on patients with darker skin?
2. Can you describe eczema in black skin. What are the main differences compared to white skin?
3. Were any of the questions above questions difficult to answer? If so what was the reason for this?
4. Have you ever thought about any of these barriers previously? Have you discussed them with others, e.g peers, tutors etc?

SUPERVISORS
Dr Kate Williams
Dr Shameq Sayeed

STUDENT RESPONSE

"The majority of what I have learned is from discussion with my pears/own reading. I am aware from these conversations that clinical signs differ (I do not recall being taught the majority of these). I do not know how to see these signs in black patients. For example, I was unaware until a few years ago that black skin did not blanch when pressed."

"I had to really think about the answers, I'm not even sure they're correct. And I may only be right because of the fact I've been part of MedRACE and take an interest in this area."

"I am embarrassed to say that it wasn't something that I thought about until last year or so"

"I have discussed these topics with peers but never tutors."

"Around 2020 there was a racial equality movement and we had some exam questions on black skin. I do not however recall this being taught this."

"Filling this out made me realise that although I had answers/ suggestions for how I'd go about some of the questions, I don't feel as confident performing these things in practice as I would with a Caucasian patient. I also have seen minimal images/ practical teaching of these things during med school."

"I have tried to follow apps on Instagram that show photos of dermatology on black skin but this has not helped enough."

"My colleague did a lecture on jaundice in black/brown skin babies and some questions were raised. It seemed this was a topic that was never thought about."

"Would it be reasonable to learn about dermatology initially on lighter skin where changes are more obvious and then move onto darker skin tones where pathology may be more challenging to elicit"

"Very necessary. Where ever you go to work in the world there is always diversity and so there should be. Doctors should be trained to have the right tools and skills to diagnose and treat everybody equally and misdiagnosis due to the colour of skin in my opinion is not good enough"

CONCLUSION/RESULTS

- The most common form of teaching/exposure that the students in the survey had was from: 1. Peers, 2. Social media 3. Social experience, eg. from ethnic minority friends. None of the students had discussed topics with tutors.
- 76% of students who took the survey stated that they felt that they had not been appropriately examined on conditions that affect darker skinned patients.
- Over 80% of students in the survey thought that teaching on this topic was 'very necessary'.'
- The survey questions allow students to be challenged on topics they may otherwise never have thought about. Allocating specific time where students can discuss these topics with tutors before the clinical years begin could be invaluable.

RECOMMENDATIONS

- Discuss whether this document could be included into the beginning of the phase 2 induction week.
- Develop the checklist to include more clinical conditions.
- Encourage as many students and staff to use questionnaires such as this to challenge themselves and encourage reflection.

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