Our shared journey towards a decolonised curriculum

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Background

This case study explores the journey that staff and students have undertaken at the University of Bristol Medical School (BMS), towards creating a decolonised and diverse medical curriculum, culminating in the formal recognition of a partnership between medical school staff and the BAME Medical Student Group (BAME-MSG).

The roots of this innovative partnership at BMS have been slowly growing for at least the last three years, starting with the acknowledgment and exploration of our own Black, Asian and minority ethnic (BAME) attainment gap data. This United Kingdom (UK)-wide gap in the success of students who experience racism is well recognised in undergraduate and postgraduate training (Woolf *et al.*, 2011) and acknowledgement is vital if organisations are to make sustainable changes to eliminate it. The reasons for this gap are multifaceted, but it seems clear that the complex social patterns of racial bias and racism that trainees are exposed to contribute to it significantly (Woolf *et al.*, 2016; Linton, 2020). BMS students shared this view and were clear that improving representation within the curriculum should form a key part of our response.

Fortuitously, BMS is in the process of implementing a new medical curriculum centred on case-based learning (CBL), designed to address better the needs of today's NHS. There has consequently been a unique opportunity to implement new, inclusive and decolonised teaching. This work began as an informal partnership between the 3D (Diversity, Disability and Disadvantage) Helical Theme lead and a group of passionate medical students who identify as coming from BAME backgrounds. Within this article, we share some of the key lessons that have made this partnership a success, using personal reflections by Dr Joseph Hartland, a White British medical academic, and fifth-year medical student Samya Sarfaraz, who identifies as British Indian Muslim. In sharing these experiences, we hope to inspire readers to take up this work in their own institutions, learning from both our success and our mistakes.

Decolonisation

Fueled by the increased focus on Black lives, following the death of George Floyd in the summer of 2020 and the exposure, owing to COVID-19, of BAME people's health inequalities (Godlee, 2020), there has been an increased focus on racism as a public health issue within mainstream medical education literature.

Recognising the impact of racial trauma on the wellbeing of our students (Telhan *et al.*, 2020; Comas-Díaz *et al.*, 2019), BMS felt it was an important time to make an institutional commitment to creating a culture of anti-racism. Appropriately, the BAME-MSG demanded both a say in the implementation of these changes and also a broader commitment to decolonisation. Formed in partnership with the 3D Helical Theme, this group has been a key conduit for students who experience racism to have their voices heard within the curriculum. Listening to the voices of students affected by racism is recognised as vital to guiding sensitive and relevant curriculum decolonisation (Nazar *et al.*, 2014). However, at BMS,

work by students and staff in partnership had until this point remained very isolated, occurring in pockets of good practice and with little recognition. Formal acknowledgment by the school's leadership created opportunities for representation in the newly formed Medical Anti-Racism Taskforce, as well as in key school committees historically under-representative of people who experience racism. Reframing diversification of the curriculum within the concept of decolonisation allowed us to reconsider our efforts to discuss race, racism and the authentic representation of dark skin within a recognised field of educational discourse.

Individuals who experience racism have for many years spoken about the need for better representation within medicine, but academic decolonisation was not widely recognised until 2011, following a Malaysian conference highlighting the importance of non-Eurocentric approaches (Charles, 2019; Alvares and Faruqui, 2012). Around 2015, student voices truly began to demand it, starting in the UK with the 'Why Is My Curriculum White?' protest (UCL, 2015). Previously focused on the humanities, this movement has more recently been looked at through the lens of medical education, in response to the perceived need for a medical curriculum which serves the diverse populations of the UK. Decolonisation emphasises the necessity for medical educationalists to review the way in which they discuss race and critically to examine curricula that have been predominantly designed from a White, Eurocentric male perspective (Lokugamage *et al.*, 2019). Although social health inequalities are complex and multifaceted, it is clear that a medical curriculum which fails to be inclusive is likely to contribute to inequalities faced by BAME communities in the UK. Indeed, when viewed in this way, it is equally clear that decolonisation of curricula can only help medical schools fulfil the General Medical Council (GMC) outcomes on inclusivity, unconscious bias and health equity required for graduating medics (GMC, 2020).

Our narratives

The following two personal reflections explore aspects of the decolonisation work at BMS. These reflections are deliberately honest in nature and seek to identify key messages for White staff who wish to act as allies and for students experiencing racism who wish to see institutional change at their medical school.

Samya Sarfaraz – BAME student narrative

> **Figure 1. Key lessons from a BAME student**
>
> 1. Support student engagement.
> 2. Create a space for open, non-judgemental and honest conversations.
> 3. Change can take time.
> 4. Step back and replenish your energy.
> 5. Intersectionality matters.

2003 was the year I moved to Truro, Cornwall with my Muslim-Indian immigrant parents. I went from being in the majority to a complete minority. Microaggressions became part of my daily life – for example, being told I smelt like curry or constantly asked where I was *really* from. Aged eleven, walking to school, I was told by a White man walking past me on the pavement that he wished I'd been run over by a car, a tame act of racism compared to the experiences of others, especially of my Black friends.

It was also challenging to grow up in a nation that does not discuss the impact of colonialism in its education system, despite remnants of that being ingrained within society. It has been an exhausting process, having to overlook racism

in our communities and education institutions, simply because of the fear of being singled out or left behind. On account of the times when I have spoken out, only to have my voiced silenced, that exhaustion is amplified, rooting me with a sense of weary detachment or 'us versus them'.

This feeling continued during my first day of medical school, when I noticed that most Black, Brown and Asian students had unconsciously clustered together, to one side. I often thought to myself "*How am I here?"; "Am I as clever enough?*"; "*I must work harder to prove myself*" and "*I'm not good enough*". This latter thought still haunts me and I know many of my peers who experience racism share the same sentiment. As a person of colour, I have felt the need to work twice as hard to prove that I am worthy of my place in medical school, especially coming, as I do, from a state school and a widening participation background.

It wasn't until 2017, when BMS conducted focus groups with BAME students on their experiences, that I got to hear first-hand from peers who were in the same boat. This shared experience marked the start of our decolonisation journey.

Lesson 1

The first lesson is the importance of *supporting student engagement*. Creating positions of leadership for BAME students, such as the University of Bristol BME Success Advocate Scheme, is a vital step in improving staff-student relations and helps students feel valued for their contribution. Equality, diversity and inclusion (EDI) is a fulfilling, rewarding and transformative field of work, but at times it can be frustrating, demanding and emotionally numbing. Students engaged in the work commonly have many other pressures on their time. It is vital that, when engaging with curriculum development, these students are given wellbeing support by a designated member of their faculty. My co-author, as the 3D lead, acted as an informal pastoral support during my engagement with decolonisation and I, in turn, was able to reverse-mentor him on the experiences of BAME students. Students should receive some form of reciprocal benefit for their input into changing curricula and ideally be paid for the time they commit.

Lesson 2

"*I can't breathe*", the words uttered by George Floyd on the 25th of May, sparked a revelation across the world. People were finally able to see how deeply rooted racial discrimination still is in society today. Conversations were finally being initiated. At our medical school, this was manifested in an online Year 4 and Year 5 student lead group chat (consisting of over 200 members), where a White peer spoke up about racism and how other students need to be effective allies. This provides an excellent example of effective 'allyship', as it created space for students of colour to come forward with their own stories.

Eventually, these stories were shared with the faculty, who supported us to create an anonymous 'story sharing form' to increase communication between the faculty and students, reducing, for BAME students, the burden of constantly acting as advocates for their peers. Staff valued this and took the stories into account when writing to students and implementing immediate changes. It is vital that both staff and students *create safe spaces for non-judgmental and honest conversations* to help understand racism, foster an engaging educational environment and create course content that resonates with

students. Additionally, as suggested by academics exploring the diversification of reading lists (Schucan-Bird and Pitman, 2019), it exemplifies the collaborative approach between staff and students needed for truly decolonising curricula.

Lesson 3

I became involved in working with 3D in my first year and, six years later, much has changed. We have a new curriculum and work is happening at a much faster pace as more of the faculty are making diversity and inclusion a priority. The lesson I would share with students working to diversify their curriculum is that *change can take time*. It may take weeks, months or maybe years. However, all the work you are doing makes a difference, creating an impact beyond your time at medical school. So, keep going!

Lesson 4

In "A Burst of Light" the American writer, feminist, and civil/LGBTQ+ rights activist Audre Lorde (2017) wrote "*Caring for myself is not self-indulgence, it is self-preservation, and that is an act of political warfare.*" When I first read this quote, I didn't appreciate its power, for my version of self-care was ice-cream and Netflix. Alongside being a full-time student, my work in decolonising the curriculum included many meetings, emails and, sometimes, representing the heart-breaking experiences of my peers. I realised I was burning out and so was open with faculty, who took on some of this work so that I would have time to learn what self-care looked like for me. I finally understood that taking a step back does not reflect on how much I care. On the contrary, because I care, I need to take a step back so that I can keep going. My lesson to both staff and students is that the nature of this work can be exhausting, so take time to *step back and replenish your energy* regularly. This will allow you to keep progressing and making an impact.

Lesson 5

Rarely does a person identify with only one of the protected characteristics; rarely do we only fit one box. I am a Brown, Indian, Muslim, heterosexual woman and these identities intersect. This intersectionality frames the way I see the world and the way it sees me. It is important that we recognise these overlapping identities… and the overlapping inequalities that may come with them. Diversity matters; representation matters; and these *intersections* of identity matter, if we are to represent people's voices authentically. Staff creating curriculum case studies, bringing in lived experience or seeking student input into diversifying the curriculum need to consider the fact that there are multiple facets to an individual's identity and incorporate this into the work.

Dr Joseph Hartland – White allyship narrative

Before 2018, my knowledge of racism and the barriers faced by people who experience racism was severely limited. My work in equalities was entirely filtered by my own experience of homophobia and ableism at medical school and within the NHS. I fell foul of a

Figure 2. Key lessons for White staff

1. Do not invalidate your students.
2. Reflect on – and be accountable for – your behaviours.
3. Take on responsibility for your work and education.
4. Leverage your own privilege.
5. Never assume your learning is complete.

common mistake made by those who consider themselves to be liberal or who come from marginalised groups: I did not seek to look beyond my own experience of discrimination because I unconsciously assumed I had nothing new to learn, limiting my ability to receive critical feedback about my own behaviour. My working, educational and social experiences were deeply rooted in a White status quo, with little interaction with people who experience racism. Though I was aware of racism, my knowledge of it was limited and the impact of it largely invisible to me on account of my own White privilege. My own training had included no signs or symptoms of patients with darker skin, a fact I had completely failed to recognise. However, as I began to listen actively to the voices of students, colleagues and patients who had experienced racism, my place of White racial comfort was challenged and I began to recognise the influence of racism all around me.

Lesson 1

As I began to make myself more available to students, encouraging them to come to me with their concerns and experiences, I entered an informal contract with them. These students shared with me their personal experiences of racism and their desire for change and I sought to use my position to enact change. As a gay man, I have experienced discrimination in the NHS. When I sought to confide in peers and seniors, I often had to sit through justification of these incidents. I know how this response isolates the person who experienced the discrimination and seeks to silence conversations.

Since it was important to me that I did not replicate this, as I listened to students who told me their stories, I sought simply to accept them. This led me to my first lesson for White colleagues working in this field: *Do not invalidate your students.* The simple act of not invalidating students empowers them to speak out more and to feel heard by those in positions to enact change.

Lesson 2

This rapidly led me to the second lesson, *reflect on and be accountable for your behaviours*. As I learnt more about microaggressions and racism in education, it became clear that I unknowingly participated in problematic behaviours. This is when reverse-mentoring, increasingly prevalent in medical education (Clarke *et al.*, 2019), became an informal part of my relationship with students who experience racism. Creating relationships which allowed honest feedback on my teaching and behaviours helped me to understand better my own part in racism and how I could best work to confront it.

Lesson 3

Progression towards a representative curriculum was slow and, though we had moments of success, the work was often something done on limited resources, especially time. It rapidly became clear to me that, although students were passionate to be involved in changing the curriculum, the burden of this work on them was considerable, contributing to the disadvantages they already found themselves facing because of the attainment gap. If I had sought it out, there was a huge amount of literature that I could have used to continue to educate myself. It was agreed with students that, for this to be a sustainable change, the work involved should not be shouldered alone by people who experience racism. This brings us to lesson 3: *Take on responsibility for your work and education.*

Lesson 4

One of the most important sources of support from the medical school was formal allocation of my time to this role, allowing me – for I recognised that we all have a role to play in decolonising our teaching – to seek out colleagues who could also contribute.

My inherent privileges as a White male in academic and NHS settings allow me to challenge both structural bias and individual bias in a way that is not available to those who identify as female and/or experience racism. Listening to these voices, I was able to leverage my privilege to open doors, help amplify their voices and create a space in which they could be heard. This is lesson 4: *Leverage your privilege.* However, it requires the mentoring of lesson 2 to ensure that you are creating space, not taking space up.

Lesson 5

The final one of these key lessons for White staff seeking to work as allies in the field of medical education is simple: *Never assume your learning is complete.* This work requires constant adaptation and learning and the point at which you assume that you as a White person know everything about racism is when you stop being an ally and once again become part of the problem.

Conclusion

This case study has presented you with a summary of the events at BMS that have led to the formation of innovative partnership between staff and students who experience racism. The key lessons visible in Figures 1 and 2 outline what we believe to be important for individuals to consider when they are seeking to decolonise their curricula.

Decolonisation is more than simply improving the diversity of images within dermatology; it is a cultural change at the deepest levels of a medical school – and every person has a role to play in implementing these changes. It is therefore impossible to describe our journey towards decolonising our curriculum without also considering the personal stories of those who have been advocates for change. Though alterations to curricula may affect an entire learning organisation, these changes start because of the actions of individuals and grassroots movements.

There is of course no one model for decolonisation, but it is our hope, as the authors of this case study, that other medical schools will learn from the mistakes we have outlined here and go on to mirror our success.

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