



VIEWS AND REVIEWS

Diversifying the medical curriculum

We need to evolve curriculums that are reflective of the populations we teach and serve clinically

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As patient populations grow increasingly diverse and complex, doctors and medical students should be equipped with the skills and knowledge to treat patients from minority groups equitably and non-judgmentally. Educating medical students on diversity related topics increases confidence in communication and has the potential to improve patient care. The implementation of such a “diversity curriculum” has largely been left to individual medical schools.¹ Existing cultural competence training programmes have been criticised, however, for being simplistic and flattening cultural differences down to lists, with diversity training in higher education accused of being tokenistic.^{2,3}

The Windrush scandal last year highlighted systemic inequalities within British organisational systems and points to the persistence of colonial influences within society. Medicine and medical education could, on some levels, be accused of “colonising” students, patients, and doctors. This analogy is drawn by Stern who describes “biomedicine and its training as ‘colonising’ both doctor and patient.”⁴ By colonising, Stern means that the cultural identities of students are shaped by medical schools and the “club” of medicine.

As clinical academics at a London medical school, we have run two university grant funded public engagement events on “liberating” (diversifying) and “decolonising” the undergraduate medical curriculum. “Decolonising” describes an academic movement across universities and other institutions to highlight inequalities resulting from historical colonial influences and to transform and modernise materials. The aim is to make teachers and students aware of any unconscious biases and remove colonial references, thereby creating fairer curriculums. Equality and diversity agendas tend to be top down endeavours from institutions, but the decolonising agenda is more about ground up activism from those affected by the legacy of colonial injustice.

Our goal is to enable students and faculty from minority groups, including from black and minority ethnic (BME) backgrounds, to feel less marginalised by traditionally white, male, Eurocentric content. It forms part of a broader equality, diversity, and widening participation agenda and resonates with the global movement to challenge and flatten power hierarchies. It fits with the notion of the patient, students, and the public as

powerful “agents of change” in coproducing curriculums. This mirrors patient and public involvement in healthcare and research, which we recognise as clinicians.

Following feedback from faculty, students, and the public, we have made several curricular changes. For example, it was highlighted that students are not taught practically to detect clinical signs such as anaemia and cyanosis in BME patients, which we now consider when teaching. In addition, since melanomas may be harder to detect on darker skins, we procured melanoma “stickers” to use as a teaching aid to illustrate this diagnostic point. The fact that certain laboratory tests, such as renal function, have different normal reference ranges in certain ethnic groups has been highlighted in teaching materials as a result of these discussions. Case studies using patients from varying cultural groups introduce more heterogeneity. This agenda also acted as a catalyst to tackle other widening participation platforms such as LGBT+case inclusion; for example, counselling a transgender male about breast cancer or a transgender female about prostate cancer, and familiarising medical students with taking histories comfortably from the LGBT+community.

The philosophy of patient centred care within medical education and the NHS naturally embraces equality, diversity, and decolonising movements in order to serve our patients best. Better communication and clinical skills means better care for all patients. Educators and clinicians need to ensure that learning materials and guidelines are grounded in human rights, as suggested by the World Health Organisation’s Sustainable Development Goals.

Any pedagogical development in this field should not be tokenistic and it should also be underpinned by sound educational principles. These are understandably emotive, sensitive, and political matters for many and as medical educators we need to find a path that evolves curriculums in a fair and measured way to produce student centred pedagogy, reflective of the populations we teach and serve clinically.

We feel that in this quest to diversify and decolonise the medical curriculum, we are paving new paths and may make mistakes along the way. We are forging through areas of sensitivity and historic injustice, where triggering unconscious biases and

wounds are equally possible. Diplomacy and an understanding of people's emotional triggers are required. We recommend that those leading diversity projects at higher educational institutions should consider being reflective about their own triggers and privileges.

FG and AL have received two grants from UCL to the department of clinical and professional practice for *Practically Creating an Inclusive Curriculum* and *Decolonising the Medical Curriculum*. AL is on the board of directors of the International MotherBaby Childbirth organisation and a trustee for the Birthlight Charitable Trust. She is a company director of a small publishing company called Docamali Ltd

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- 1 Nazar M, Kendall K, Day L, Nazar H. Decolonising medical curricula through diversity education: lessons from students. *Med Teach* 2015;37:385-93. 10.3109/0142159X.2014.947938 25156358
- 2 George RE, Thornicroft G, Dogra N. Exploration of cultural competency training in UK healthcare settings: a critical interpretive review of the literature. *Diversity and Equality Health and Care*. <http://diversityhealthcare.imedpub.com/exploration-of-cultural-competencytraining-in-ukhealthcare-settings-a-critical-interpretive-review-of-the-literature>.
- 3 Niemann Y. The social ecology of tokenism in higher education. *Peace Review: Journal of Social Justice*. 2016;28:451-810.1080/10402659.2016.1237098.
- 4 Stern H. Foreword. In: Shapiro J, ed. *The inner world of medical students; listening to their voices in poetry*. CRC Press, Taylor and Francis, 2009.

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