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'Decolonising the Medical Curriculum': Humanising medicine through epistemic pluralism, cultural safety and critical consciousness

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Abstract

The Decolonising the Curriculum movement in higher education has been steadily gaining momentum, accelerated by recent global events calling for an appraisal of the intersecting barriers of discrimination that ethnic minorities can encounter. While the arts and humanities have been at the forefront of these efforts, medical education has been a 'late starter' to the initiative. In this article, we describe the pioneering efforts to decolonise the undergraduate medical curriculum at UCL Medical School (UCLMS), London, by a group of clinician educators and students, with the aim of training emerging doctors to treat diverse patient populations equitably and effectively. Throughout this process, students, faculty and members of the public acted as collaborative 'agents of change' in co-producing curricula, prompting the implementation of several changes in the UCLMS curriculum and rubric. Reflecting a shift from a diversity-oriented to a decolonial framework, we outline three scaffolding concepts to frame the process of decolonising the medical curriculum: epistemic pluralism, cultural safety and critical consciousness. While each of these reflect a critical area of power imbalance within medical education, the utility of this framework extends beyond this, and it may be applied to interrogate curricula in other health-related disciplines and the natural sciences. We suggest how the medical curriculum can privilege perspectives from different disciplines to challenge the hegemony of the biomedical outlook in contemporary medicine – and offer space to perspectives traditionally marginalised within a colonial framework. We anticipate that through this process of re-centring, medical students will begin to think more holistically, critically and reflexively about the intersectional inequalities within clinical settings, health systems and society at large, and contribute to humanising the practice of medicine for all parties involved.

Keywords: decolonising, medical curriculum, epistemic pluralism, cultural safety, critical consciousness

Introduction

Any curriculum must, by definition, exclude – the question is what is excluded and why, and whether the purpose of our education system should be to perpetuate existing power structures and norms, or equip students with the critical tools to question them. (Gebrial, 2020: 26)

The term 'decolonising' has lent itself to multiple definitions throughout history, but in its recent resurgence within higher education, it refers broadly to a movement to: (1) recognise how forces of colonialism, empire and racism (and other forms of discrimination, such as sexism, racism, heteronormativity and ableism) have shaped the systems in which we participate every day; and (2) offer alternative ways of thinking about the world, re-centring perspectives of populations historically oppressed and marginalised by these forces (Bhambra et al., 2018: 18). This is the framework we adopt in this article to consider what forms of knowledge and ways of knowing must be prioritised in efforts to decolonise the medical curriculum. The decolonial outlook sheds light on power imbalances within systems, institutions and interactions, and prompts exploration of how power can be redistributed to achieve intersectional equity. In the context of medicine, it may be used to examine how health systems that have inadvertently served to ostracise and even dehumanise segments of society can be reimagined, to cater to the needs of the whole patient population (Gishen and Lokugamage, 2019; Lokugamage et al., 2020a).

While the arts, humanities and social sciences have traditionally led the charge within the Decolonising the Curriculum movement globally, medical schools have been slow to embrace this approach, despite student feedback, growing activism and ground-up initiatives in recent years (for example, Clynch et al., 2020; Mukwende et al., 2020; Nazar et al., 2015). This inertia may be partly attributed to the hegemony of the biomedical perspective in contemporary medicine, based on a hierarchy of knowledge deeply entrenched in colonial history. Gaines and Davis-Floyd (2004: 96) write: 'Like science, Western medicine was assumed to be acultural – beyond the influence of culture – while all other medical systems were assumed to be so culturally biased that they had little or no scientific relevance.' Consideration of the anthropological, historical and philosophical underpinnings of Euro-American biomedicine may help to explain the marginalisation of alternative perspectives that are regarded as non-scientific or antithetical to its foundational premise. Any attempt to de-hierarchise systems of knowledge mounts a challenge to the historical power imbalances upon which the medical profession in Europe and America has rested for decades. Within the culture of medical research in the Global North, quantitative research is held to be more rigorous and prestigious than qualitative research. This has resulted in a neglect of subjectivised knowledge, such as lived experiences of illness or patient perceptions of treatment. An increasing requirement for patient and public involvement and engagement (PPIE) in research production, interpretation and application may have an important part to play in mitigating this bias (NIHR, 2015). From a global health perspective, however, patient voices from the Global South continue to be excluded within PPIE and remain under-represented in medical research, which has marshalled academic thinking towards improving knowledge democracy on a global scale (Openjuru et al., 2015).

By laying exclusive claims to labels such as 'rational', 'modern' and 'objective', Euro-American healthcare systems and institutions seek to absolve themselves from their role in perpetuating the systematic marginalisation of minority ethnic populations, alongside other groups that have been traditionally sidelined on the basis of disability, sexual orientation or gender identity. This has contributed to a higher rate of maternal mortality among ethnic minority women in the UK and the US (Anekwe, 2020; Knight et al., 2020; Lokugamage, 2019), reduced access to health services and care among older LGBT+ patients in the UK (Kneale et al., 2019; Westwood et al., 2015) and gender bias in medical science (Graham, 2016; Hanratty et al., 2000; Risberg et al., 2006).

To further deconstruct the process by which this occurs, we must consider why the concept of 'evidence-based medicine' (EBM), regarded as a 'high altar' of science or the closest approximation of scientific 'truth', is a fallible one. One area of fallibility lies in the failure of institutions to acknowledge and account for biases within 'gold standard' models of research production, evaluation and regulation. These biases stem not only from methodological flaws within individual studies, but also from the continuous entanglement of research production with institutional, political and commercial interests (Every-Palmer and Howick, 2014; Goldacre, 2014) – without the corresponding level of transparency necessary for institutions to remain accountable to the stakeholder groups they serve. For example, ambiguity surrounding the grade of evidence behind published clinical recommendations (NICE guidelines, for example) has come under fire, especially as an increasing number of studies reveal a surprising lack of high-quality evidence behind widely accepted and practised guidelines (Fanaroff et al., 2019; Ghui et al., 2016; Lee and Vielemeyer, 2011; Prusova et al., 2014; Wright, 2007). This defensive denial of bias by major scientific institutions has even led to the suppression of critical or dissenting voices, perhaps perceived as a threat to the established dominance of the evidence-based medicine paradigm in the health sciences (Holmes et al., 2006). In a 2018 scandal involving the Cochrane Collaboration, an organisation dedicated to independent systematic reviews of healthcare interventions, one of its original founders was expelled for his vocal criticism of biased reporting (Enserink, 2018; Gøtzsche, 2019). This event led to debate within academia about the ethical implications of using scientific censorship to preserve trust in public health institutions in the name of public interest (Demasi, 2018; Greenhalgh et al., 2019). The colonial undertones of this discourse, which functions to '(re)produce the exclusion of certain forms of knowledge production' (Holmes et al., 2006: 185) to reinforce the stability of a hierarchical order, should not be overlooked.

The first step of decolonisation, as stated in the opening of this article, is to 'recognise' – to identify the biases within medicine that arise from medical education and training. It is only by first acknowledging that institutionalised forms of coloniality exist in our society today that we can begin to imagine what a postcolonial or decolonial reality may look like in a medical curriculum. Critiquing the unquestioned dominance of 'Western' epistemology within our spheres of knowledge through this lens can allow the 'reconstruction and the restitution of silenced histories, repressed subjectivities, subalternised knowledges and languages' (Mignolo, 2007: 451). In medicine, these 'silenced histories' constitute the exploitation of minority and indigenous populations in the name of science. These 'repressed subjectivities' are the perspectives of marginalised populations buried under the weight of medical paternalism. These 'subalternised knowledges and languages' are the healing traditions that have been displaced by the standardisation of a Eurocentric rhetoric about what constitutes medicine. In this article, we discuss our ongoing work with decolonising the medical curriculum at UCL Medical School (UCLMS), evaluate the need for a shift from diversity to decoloniality in medical education and propose a framework for this change. We suggest that to decolonise medicine is to humanise medicine – to allow counter-colonial narratives that accurately represent our patient population to emerge, and to begin to broaden our collective understanding of what constitutes health, illness and healing.

From diversifying to decolonising the UCLMS curriculum

There is a strong case to be made for a more diverse medical curriculum. Diversity-related teaching has been shown to increase medical students' confidence in handling

communication barriers in clinical practice, with the potential for lasting attitudinal shifts (Cocksedge et al., 2014). It may also reduce prejudice and negative stereotyping (Hill and Augoustinos, 2001), behaviours which deter patients from minoritised and marginalised groups from seeking medical care (Phelan et al., 2015). However, the misappropriation of the term 'diversity' to promote tokenism (see Niemann, 2016) in many institutions has led the Decolonising the Curriculum movement to call for 'decolonising, not diversity', in a bid for more extensive reform – to ensure that radical restructuring is not substituted by comfortable rebranding. We are also conscious of Tuck and Yang (2012) who reminded us that decolonisation is 'not a metaphor' that can be employed to a variety of ends without bearing witness to the historical and present realities of settler colonialism, which has led to the displacement of indigenous people, knowledge and traditions in space and time (Richardson, 2020). Neither is decolonisation interchangeable with words such as 'diversification' or 'liberation', which we adopted at the beginning of our work. Bearing this in mind, we describe our process in moving from diversifying to decolonising the medical curriculum at UCLMS and the journey that remains.

At UCLMS, medicine is taught in a six-year undergraduate curriculum (MBBS: Bachelor of Medicine, Bachelor of Surgery). The first two years focus on the scientific fundamentals of clinical medicine, with limited patient contact, the third year is spent completing an integrated bachelor of sciences (iBSc), while the final three years focus on clinical placements alongside teaching. Diversity teaching is largely delivered via the Clinical and Professional Practice (CPP) 'vertical' modules, which are taught throughout the six-year spiral curriculum. Overall, the aims of the diversity curriculum at UCLMS are: (1) to emphasise the perspectives of minoritised groups, particularly pertaining to their experiences within healthcare; and (2) to engage students to think critically about how these experiences may be improved and to participate actively in their learning. CPP learning is designed to show medical students how sharing power promotes deeper trust within the doctor–patient relationship (Skirbekk et al., 2011) and facilitates more meaningful patient-centred interactions, including through reflection (Morgan, 2018). Teaching takes the form of lectures complemented by tutor-facilitated small group work tutorials, which regularly involve role play where students, patients or actors take on different characters within a given clinical scenario. Students are provided with feedback on their clinical communication skills and are given the opportunity to reflect on how they felt within each role.

The original working group began as a project entitled *Liberating the Curriculum*, a UCL-wide initiative that started in 2016. This group was set up by two faculty members and a medical student. In the pioneering phase, we focused on performing a gap analysis of diversity teaching, to pave the way for deeper inquiry into why these gaps exist. Inspired by *Inclusive Curriculum Health Check* (UCL, 2018), we began our project with a student-led curriculum mapping exercise to formally assess the coverage of diversity-related topics and their integration into the curriculum (Chow et al., 2020). We classified formal teaching sessions in the UCL CPP curriculum for Years 1 to 6, with Year 3 excluded as there is no MBBS teaching in the iBSc year. The sessions were classified according to 12 diversity-related themes chosen following consultation with a faculty–student group: social class, race/ethnicity, discrimination, gender, challenging power hierarchies, sexuality, ethics/human rights, disability, diversity, marginalised groups, stigmatised groups and patient experience. To account for extra-curricular teaching, we asked UCLMS academic year leads to provide a list of relevant diversity-related activities that had not been formally programmed and relevant scholarly activity produced by the department.

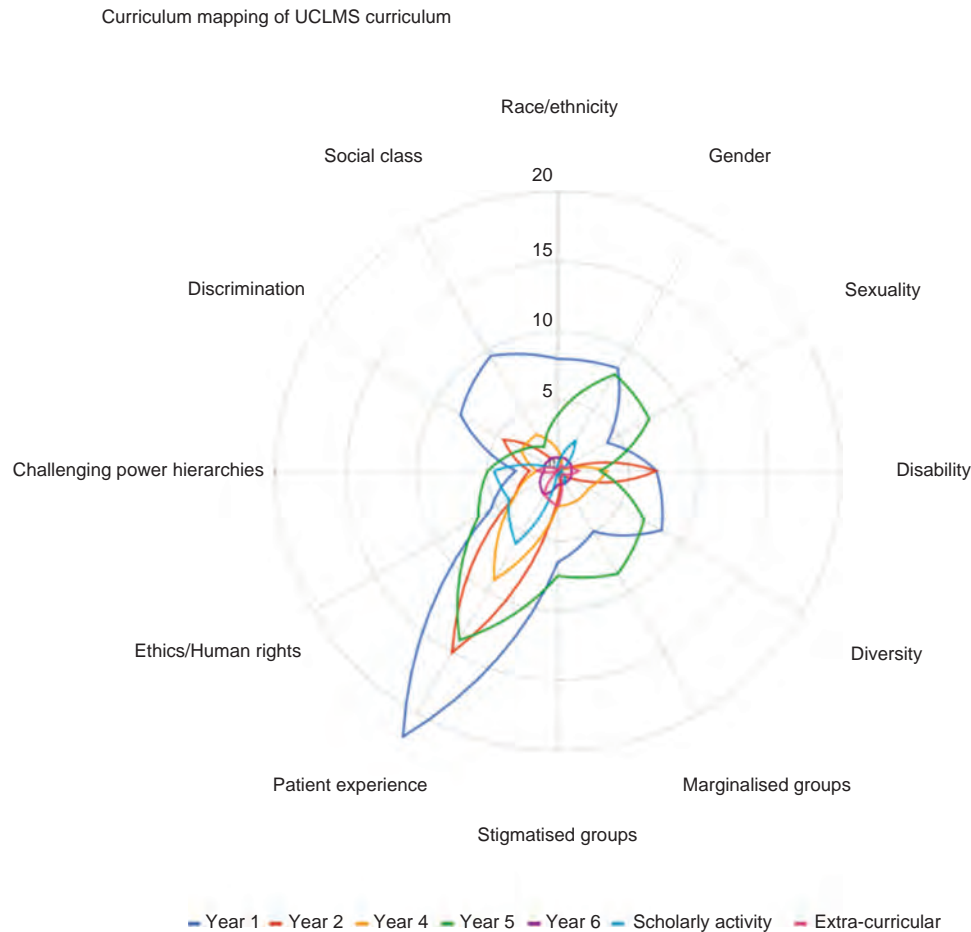


Figure 1: Wind rose diagram showing the relative coverage of Liberating the Curriculum themes across years (Source: Authors, 2021)

The mapping results are represented using a wind rose diagram (see Figure 1) to provide visualisation of the relative coverage of topics across five years. For a single teaching session, a score of 0 was awarded if a theme was not mentioned, 0.5 if a theme was mentioned but not in depth ('included') and 1 if a theme was central to the session ('key'). For each year, the total scores were then added up for each theme; the distance of each data point from the centre is proportional to the score allocated to each theme in each year. Overall, the results showed that each theme was covered at least once, with *patient experience* consistently having the highest representation in the curriculum across the years. This reflects a push for a patient-centred approach within medicine, discussed in a later section. Four extra-curricular events were recorded, including one-off events (for example, UCL Change Day) and annually occurring events (for example, UCL Student Support talks), which focused on four themes: stigmatised groups, patient experience, challenging power hierarchies and disability. Nine instances of diversity-related scholarly activity were recorded, spanning three themes: patient experience, ethics and human rights and challenging power hierarchies.

There were several limitations to this gap analysis project. First, the data collected may not be representative of all relevant teaching, especially of informal teaching that is subject to variability (Wachtler and Troein, 2003), and may be limited by reporting bias. Second, as these themes were derived from consensus among UCL

staff and students, they are not exhaustive and demonstrate considerable overlap. It must be noted that this curriculum improvement exercise was framed within the context of diversity rather than decolonisation (see Icaza and Vázquez, 2020). However, the project helped us develop our inquiry into subsequent decolonising work. In the first two years, the majority of sessions consist of small-group work to encourage deep learning, alongside some didactic lectures (Dao et al., 2017). This study reflected that it did not distinguish between intended, taught and received curricula (Kelly, 2009; Plaza et al., 2007). It is also noted that diversity themes were associated by students with sessions that course leads had not themselves identified as diversity-related, indicating that the received curriculum had diverged from the intended curriculum (Wachtler and Troein, 2003) and had not accounted for the hidden curriculum (Hafferty and Castellani, 2009; Hafferty and Franks, 1994; Lempp and Seale, 2004).

To address this discrepancy between the taught and received curriculum, two UCL grant-funded student, staff, patient and public engagement events were organised by our team: 'Practically Creating an Inclusive Curriculum' in 2017 and 'Decolonising the Medical Curriculum' in 2018 (Chow et al., 2020; Gostelow et al., 2018). These were platforms for educators and students to exchange their reflections on the UCLMS curriculum alongside members of the public and to share their experiences of the healthcare system. The open format encouraged active participation and contributions from the varied audience. Some findings supported results from the curriculum mapping exercise, including a presentation of a study revealing that UCL medical students were reticent to raise concerns about discrimination they experienced from medical professionals (Johnson et al., 2018), mirroring the low coverage of 'challenging power hierarchies' in CPP teaching. Other themes that were covered include the awarding gap in medical training, the history of medical and scientific racism, misidentifying clinical signs in darker skin tones, the eugenics inquiry at UCL and the relation of biomedicine to traditional and indigenous healing systems. Following the second event, we changed the terminology of our project to 'Decolonising the Medical Curriculum' (2021) in response to student feedback and the growing decolonising movement within higher education. We outlined six areas of decolonising in medicine: the body, the curriculum, learner experience, learner space, professional behaviour and ideas of healing (Lokugamage et al., 2020a: 267), to account for how the formal curriculum represents only one aspect of the wider framework.

In response to these initial findings, we implemented several changes within the UCLMS curriculum. An additional teaching session was developed to address how medical students can raise concerns through official channels, highlighting policies in place to protect students and keep their concerns anonymous. A review of teaching materials was conducted to ensure that they reflected the diversity and heterogeneity of patient populations, including case studies that featured patients of different ethnicities and pictured signs such as anaemia (having a low amount of red blood cells), cyanosis (lack of oxygen) and rashes across different skin colours and types (see Mukwende et al., 2020).

The decolonising agenda encompasses dismantling barriers to healthcare faced by groups oppressed under colonial regimes, including indigenous people, minority ethnic individuals, women, people with disabilities and people who are non-heterosexual or gender non-conforming. As part of the Equality, Diversity and Inclusion (EDI) team, we developed a half-day LGBT+ health programme for first-, second-, fourth- and fifth-year students based on input from LGBT+ service users and student feedback from previous years (Salkind et al., 2019). This session covered appropriate terminology to describe sexual orientation and gender identity and how

to take medical histories from LGBT+ patients. It included a 45-minute session with a transgender-identifying patient. Students reported positive outcomes from this session, including increased confidence when communicating with patients who are LGBT+ and identifying their needs.

Another initiative was the organising of diversity theme-related reflective practice Schwartz Rounds for medical students, first piloted at UCLMS in 2015 (Gishen et al., 2016). Involving both undergraduates and faculty, Schwartz Rounds are led by trained facilitators with the goal of facilitating meaningful conversation and reflection in a confidential forum, to help students sustain empathy through the course of medical training. Following the death of George Floyd and the Black Lives Matter response in May 2020, two Schwartz Rounds based on the theme of racial inequalities at medical school were organised. At each event, a panel of UCLMS students shared openly about their experiences of racism, discrimination and bias within healthcare, prompting other students in the audience to offer their reflections.

In these efforts, students, faculty and service users acted as collaborative 'agents of change' (Fielding, 2001; Harland and Wald, 2018) in co-producing curricula. This reflects a decentralised approach we have adopted towards diversifying the medical curriculum at UCLMS (Gishen and Lokugamage, 2019) and beginning to imagine what its decolonisation may look like. Examples of sessions that have been developed over the past few years include teaching on the history of eugenics at UCL, perspectives on disability, feminist perspectives on women's health (with regard to the birth experience, domestic violence and female genital mutilation), the limitations of evidence-based medicine, sustainability in healthcare, global health economics and the introduction of an online mindfulness platform for UCLMS students. In May 2020, a team of students led the collaborative development of a Decolonising the Medical Curriculum reading list (Wong et al., 2020a) to guide the project, which was circulated to UCLMS faculty and students. They also organised a series of reading groups and a seminar involving student representatives from different medical schools, to discuss how the decolonising agenda may be taken forward in medical education. This team continues to work closely with EDI faculty at UCLMS to review and revise EDI-related CPP sessions, with the purpose of integrating decolonial perspectives on topics such as race, culture and history of medicine into teaching. One such session was a lecture on cultural safety delivered to second-year students, described in an article by one of the authors (Wong et al., 2020b). New CPP sessions were also developed by EDI faculty and students on topics such as racial microaggressions, inclusive history taking and health inequalities.

Some challenges we faced included a lack of ongoing funding for the project and limited curricular space open to input from our working group. There has also been some student resistance to sessions considered extraneous to core medical teaching, such as the newly introduced session on the history of eugenics for second-year students. On the whole, student feedback on the new teaching sessions has been positive so far, but we have yet to organise a follow-up project to comprehensively evaluate the impact of these changes and initiatives. Aside from surveys to ascertain the impact of individual sessions on student experience, it is difficult to measure the longitudinal effect of these teaching sessions on their personal and professional development. It is our hope that in the coming years, we will further develop the infrastructure required to ensure the sustainability of this project. This includes acquiring funding for student-led initiatives, promoting student-staff collaboration and organising periodic reviews of teaching materials across the entirety of the medical curriculum, ensuring that they remain pertinent in addressing forms of discrimination, inequity and injustice within medicine and society at large.

A decolonial shift in medical education

According to guidelines from the General Medical Council (GMC, 2016: 33), the regulatory body for medical education, training and practice in the UK, medical curricula should give students 'the opportunity to gain knowledge and understanding of the needs of patients from diverse social, cultural and ethnic backgrounds'. However, the implementation of diversity teaching has largely been left to the initiative of individual medical schools (Nazar et al., 2015) and varies widely.

The impetus for a shift towards decolonisation in medical education spans moral, professional and legal domains (Lokugamage et al., 2020a). This shift has been mirrored by initiatives within our broader institutional setting, such as the *Why Is My Curriculum White?* campaign launched in 2014 at UCL, alongside the *Liberating the Curriculum* and *Dismantling the Master's House* working groups campaigning for institutional action against racial injustice. In 2018 mounting pressure from faculty and students led to an inquiry into the history of eugenics at UCL, producing a report and list of recommendations that were published in February 2020 (Fazackerley, 2018; UCL, 2020a, 2020b).

There is still debate about whether the 'decolonial demand' (Gebrial, 2020: 29) can ever be fully realised within a university setting, let alone within a single faculty. Decolonising curricula initiatives usually operate at the level of the formal curriculum, but arguably the most significant changes have to occur within the 'taken for granted' (Hafferty and Castellani, 2009: 25) aspects of the hidden curriculum. This signals the need for a reflexive paradigm in our efforts to reform the medical curriculum (Cribb and Bignold, 1999), which we enter into with a sobering cognisance of the limitations of our scope and as members of the institutions we seek to transform. In the roles that the authors of this article occupy – those of a final-year medical student and clinician educators – our main focus is on the implications of this transformation for improving care for our diverse patient population. Towards this goal, in the remainder of this article we outline three scaffolding concepts to frame the process of decolonising the medical curriculum: epistemic pluralism, cultural safety and critical consciousness (see Figure 2). While there is demonstrable overlap between these three areas of inquiry, each offers a lens by which colonial-era power imbalances in medical education can be evaluated within epistemology, diversity teaching and curricular scope respectively.

From a biomedical gaze to epistemic pluralism

Perhaps we should begin by problematising the term 'Western medicine', also referred to as 'conventional', 'modern' or 'evidence-based' medicine, especially when juxtaposed against 'alternative' medicine. This latter encompasses a whole gamut of diverse healing traditions with far-reaching historical, geographical and cultural roots, which represent the vast majority of healthcare provision worldwide (Sodi and Bojuwoye, 2011). An overt dismissal of all 'non-Western' modes of thinking about healing as outdated, marginal and irrelevant has characterised decades of paternalism within the medical profession ('doctor knows best'). Various strategies have emerged in medical training, such as an emphasis on patient-centred care (Bleakley, 2014; Kitson et al., 2013; Stewart, 2001) and the expansion of the biomedical model to a biopsychosocial model (Engel, 1977) to address the discrepancy between biomedical concepts of disease and lived realities of illness. However, paternalistic thinking in medicine may not be so easily eradicated. Some of this intellectual arrogance may be traced to a colonial-era belief in the inherent superiority of a dominant culture, which justifies their encroachment on to, and even eradication of, other cultures. This

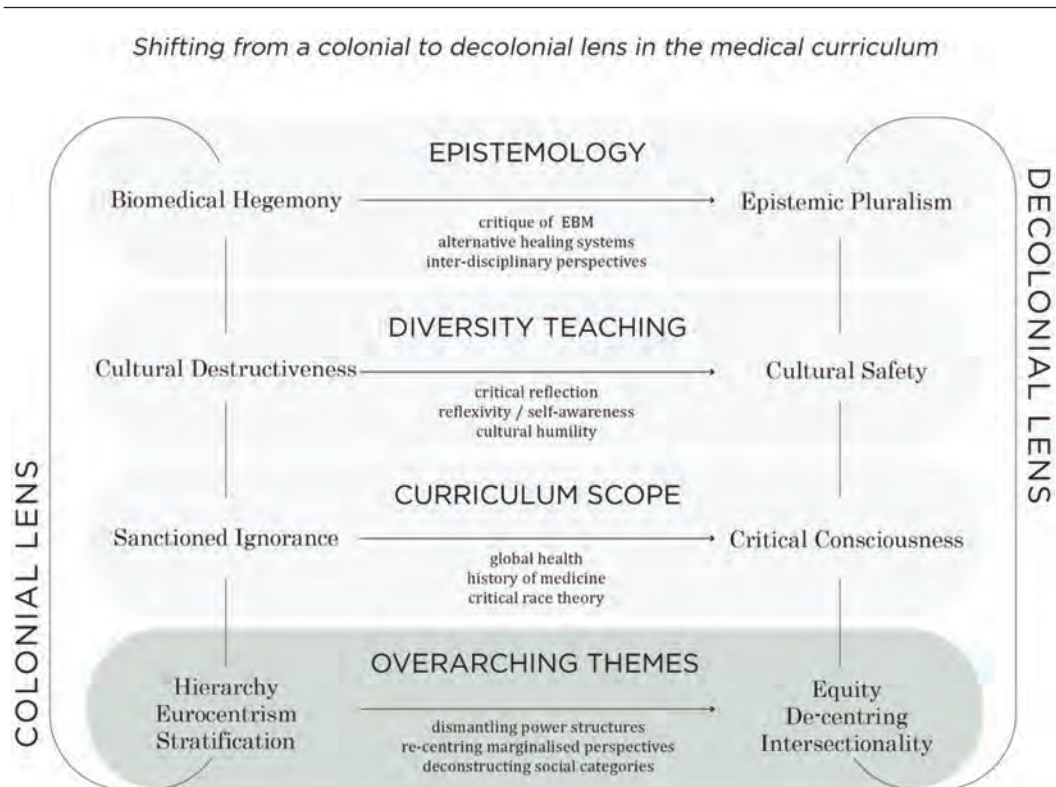


Figure 2: A decolonizing framework for the medical curriculum scaffolded by epistemic pluralism, cultural safety and critical consciousness, with a summary of overarching themes (Source: Authors, 2021)

attitude reinforces the key limitation of biomedicine, which is its exclusive claim to *knowledge that matters*.

Armed with this claim, proponents of biomedicine often adopt a defensive stance towards non-biomedical frameworks of health, citing their lack of an evidence base. However, as discussed in the Introduction, knowledge purported as 'evidence-based' in medicine may not live up to this descriptor (Wright, 2007). Examining guidelines published by the Royal College of Obstetricians and Gynaecologists, Prusova et al. (2014) found that only 9 to 12 per cent were supported by the highest standard of evidence (Grade A) based on systematic reviews or individual randomised control trials. Scientific academia is largely centred around a positivist, 'one-size-fits-all' study design (Lokugamage et al., 2020a) – a randomised control trial well-suited to investigating the efficacy of a pill can become riddled with confounding bias when applied to complex interventions. In addition, quantitative data are privileged over qualitative data, reflecting a fixed preconception in clinical research about what constitutes a good treatment outcome (see Greenhalgh et al., 2014). One example of a common bias in study design may be found in randomised control trials around medical acupuncture, which have been critiqued for their use of an inadequate control (Chae et al., 2018) and neglect of qualitative outcomes (Lokugamage et al., 2020b). Another area of bias is in research funding, which comprises epistemic, geographic and institutional disparities in resource allocation. The result of this is 'undone science' (Frickel et al., 2010) – research benefiting minoritised and disadvantaged groups in society that remains 'unfunded, incomplete or generally ignored' (Frickel et al., 2010: 445) – as resources are channelled into research that supports existing institutional agendas (Richardson, 2020). Aside from an understanding of other healing systems,

students should be educated about these gaps in medical literature, to appreciate the bias inherent within research production and how it distorts our perception of the efficacy of indigenous/traditional complementary therapies with origins in the Global South.

A medically plural curriculum should accept that a health system does not exist as a discrete and immutable entity – in the same way that this is true of culture (Kleinman and Benson, 2006). Perspectives that have emerged from the field of medical anthropology suggest that closer attention be paid to the role that culture plays in shaping our perceptions of health and illness. Every system of healing is a collection of beliefs and practices shaped by a long history of interaction with other traditions within an interconnected global landscape, such as the contribution of indigenous knowledge of medicinal plants to the development of modern pharmaceuticals (Jamshidi-Kia et al., 2018; Maridass and De Britto, 2008). Biomedicine is a singular way of interpreting the world that needs to be synthesised with other perspectives to give rise to integrative and holistic medical practice (Baer, 2004). Failure to adopt an objective and critical lens towards biomedicine can lead to over-(bio)medicalisation (Lock and Gordon, 2012), complacency (Kleinman, 1995) and over-reliance on simple guidelines that do not account for complexity and individual variability in healthcare (Greenhalgh et al., 2014; Plsek and Greenhalgh, 2001). This resistance to change has led to a ‘narrowly focused therapeutic vision’ (Kleinman, 1995: 28) in much of contemporary medicine that must be broadened through an openness to epistemologies historically considered ‘other’. While components of traditional and folk medicine from Africa, the Middle East, Asia and South America – including yoga, meditation and herbal medicine – have gained a degree of mainstream acceptance in Europe and America, others that cannot be adapted for the biomedical agenda are often dismissed as pseudoscience, placebo or both. This selective co-opting of alternative therapies into biomedicine, divorced from knowledge of their historic and cultural origins, belies the ideal of epistemic pluralism and can be considered a form of medical cultural appropriation (see Lokugamage et al., 2020a: 270).

Even though concepts such as subjectivity and cultural literacy have long been mainstays in other disciplines, medicine has yet to draw deeply enough from these to equip medical students to navigate the cultural complexities of medical practice. In some ways, this reflects a colonial hierarchy of disciplines (Bhambra et al., 2018: 5) that prioritises a singular Eurocentric biomedical view, which claims neutrality (Last, 2020: 219), over the social sciences and humanities, which afford a degree of knowledge devolution. While there has been growing emphasis on sociology in medical education from a public health and health policy perspective (Collett et al., 2016), this interest has not been extended fully to the vast literature available within medical anthropology, global health, history of medicine and medical ethics. As a result, there has been focus on social determinants of health without analysis of how these determinants are deeply embedded within contexts of culture, identity and world view (Kirmayer, 2012). For medicine to progress beyond the biomedical towards a more holistic paradigm, medical education must be open to contribution from a diversity of epistemologies and disciplinary fields (Le Grange, 2016; Last, 2020).

From cultural competence to cultural safety

Diversity teaching in medical schools has mostly been delivered through a cultural competence model (Betancourt et al., 2003; Dogra et al., 2010; Kripalani et al., 2006) that is criticised for its tendency to reinforce unhelpful cultural stereotypes (George et al., 2015) and to teach political correctness rather than cultural humility (Shapiro

et al., 2006). A decolonising approach to diversity challenges these assumptions and refutes simplistic conceptions of race, culture and identity, recognising how they have been utilized to further European colonial projects (Quijano, 2007: 171). Cultural safety is such an approach, which recognises the cultural destructiveness of colonial ways of thinking about (and classifying) difference. It overcomes the limitations of cultural competence by transcending superficial understandings of culture and evaluating the broader historical context of cultural prejudice that contributes to healthcare inequity (Curtis et al., 2019). Furthermore, cultural safety is a reverse innovation (an innovation brought to the forefront from a culturally colonised society) (DePasse and Lee, 2013; Lokugamage et al., 2019), pioneered by a Māori nursing educator in New Zealand to address the colonial roots of health inequities between indigenous Māori and non-indigenous populations (Ramsden, 2002). This signifies how the premise of cultural safety is formed by the lived experiences of individuals from historically oppressed communities, challenging Eurocentric conceptions of culture by foregrounding a more expansive, inclusive perspective on cultural identity and why it matters in medicine (Lokugamage et al., 2021).

Therefore, to decolonise a medical curriculum, educators need to start focusing on cultural safety rather than cultural competence. Cultural safety disputes the notion that biomedicine is acultural and impartial (Lupton, 2012), recognising that medicine's dominant 'culture of no culture' (Taylor, 2003; Taylor and Wendland, 2015) can lead to ignorance in the medical profession and of health professionals towards their own cultural bias. This lack of critical self-awareness may translate to clinicians practising a superficial empathy founded on expectations of professionalism, rather than nurtured through a complex awareness of the lived realities of patients through how they relate to one's own. Through subverting the clinician's role as an observer, and transforming them into the object of study, the cultural safety model has the potential to neutralise some biases of the hidden curriculum in 'diversity teaching' (Ramsden, 2002). As Curtis et al. (2019: 17) write: 'In contrast to cultural competency, the focus of cultural safety moves to the culture of the clinician or the clinical environment rather than the culture of the "exotic other" patient.' Furthermore, through its broader critique of institutional racism in society as a threat to minoritised cultures, the cultural safety model positions health systems, organisations and providers as the focal point for interventions to promote health equity. By facilitating an inward process of self-examination while turning one's gaze to the broader structural factors that produce health inequalities, it reveals the psychological, social and historical underpinnings of power imbalances in the doctor–patient relationship that disadvantage minoritised patient groups across societies today (Curtis et al., 2019).

The decolonial mindset is an uncomfortable and challenging space to occupy in medicine. Clinicians may struggle to reconcile the tension between contemporary expectations of political correctness and their personal beliefs regarding race-based differences (Hoberman, 2012). This is why opportunities for critical reflection around sociocultural issues, exposure to diverse patient narratives and the practice of reflexivity (Iledema, 2011: i84) should be offered throughout medical school, including early exposure to interdisciplinary perspectives. These enable medical students to practice engaging with complexity and ambiguity in the clinical encounter (see GMC, 2018) and develop the intellectual (Miller, 2013) and emotional (Cameron and Inzlicht, 2020) capacity for empathy early on in their professional journeys. The cultural safety model provides a platform to deepen connections between practitioners, patients and their wider community (Pimentel et al., 2020). It also represents a re-imagining of the medical curriculum that holds medical institutions accountable to their past

and medical practitioners to protecting the rights of their most vulnerable patients. In the following section, we explicate how critically examining the relationship between medicine and colonial history may empower students (Harland and Wald, 2018) to advocate for structural change within their social milieu.

From sanctioned ignorance to critical consciousness

The concept of ‘critical consciousness’, developed and popularised by the Brazilian educator, philosopher and activist Paulo Freire (1973), integrates critical theory with pedagogy and social justice within a three-component formulation: (1) critical social analysis and reflection; (2) political efficacy, that is, perceived ability to enact political change; and (3) participation in civic and political action, that is, praxis (see also Watts et al., 2011). Within medicine doctors play a crucial role in advocating for patients disadvantaged by healthcare practices, policies and environments. Equipping clinicians to-be with knowledge of the origins of these structures, along with their agency to effect change within the system (Geiger, 2017), is a crucial component of the arduous task of dismantling barriers to health justice. In this section, we discuss how future doctors may learn to enact critical consciousness through praxis by incorporating teaching on global health, history of medicine and critical perspectives on race into the medical curriculum.

Globally, the COVID-19 pandemic has revealed the fragility of our health systems and networks, along with gaping disparity in the distribution of health resources across the world. The importance of global health perspectives in medical education is two-fold. First, it trains future medical professionals in global health trends and practices, strengthening the capacity for medical systems to operate more robustly within a globalised world (Drain et al., 2007; Peluso et al., 2012). There have been various efforts to challenge colonial-era paradigms of global health and to re-imagine models for equitable health partnerships and resource sharing (Bhatti et al., 2017; Boum et al., 2018; Depasse and Lee, 2013) between lower- and middle-income countries and high-income countries. Knowledge of these models may help to undo epistemic biases against evidence produced in lower- and middle-income countries that offer important contributions to the global repository of medical knowledge. Second, a global historical perspective provides insight into the contribution of empire to global health inequity internationally, as well as on migrant, refugee and asylum-seeker patient populations within our local context. As Gebrial (2020: 28) remarks, allowing the ‘classed and racialised dynamics of colonialism’ to shape conversations about migration, national identity and entitlement may facilitate an attitudinal shift away from xenophobia toward hospitability in treating foreign-born patients within public healthcare systems (Gebrial, 2020; Shahvisi, 2019; Walia, 2021).

In this article, we have described how biomedicine has often projected a neutral, acultural and apolitical image as an attempt to shed the trappings of its colonial past. Hoberman (2012: 7) suggests that ‘colour-blind writing about medicine’ has led to the dismissal of historical racism as irrelevant to medical science today, when in fact it provides insight into the more insidious manifestation of modern-day racism in clinical practice. Furthermore, it is an essential component of global health education (Greene et al., 2013). Throughout the course of imperial history, healthcare was a highly contested site, where biomedicine was regularly pitted against traditional medical systems, health beliefs and healers from indigenous cultures (Arnold, 1993). Historical commentators have highlighted various failures of public health policies implemented by the British within Australian and African colonies in the nineteenth and twentieth

centuries (Bashford, 2003; Cole, 2015; Swanson, 1977), where the well-being of British officials took precedence over that of colonised populations (Cole, 2015; Frenkel and Western, 1988).

Continuous with this colonial legacy, the history of medicine reveals numerous instances of racism and outright abuse of human rights in the name of medical research. One of the most well known is the Tuskegee Syphilis Experiment (1932–72), which damaged the trust of the African American community in researchers and medical institutions, contributing to their under-representation in clinical trials in the US and reluctance to access healthcare (Alsan et al., 2020; Freimuth et al., 2001). In other cases, the veneration of White doctors within the medical profession implicated in acts of racialised violence continues unopposed, such as in the case of James Marion Sims, hailed as the 'father of gynaecology', who experimented with surgical techniques on Black slaves without anaesthesia (Feagin and Bennefield, 2014). Under the influence of the eugenics movement in the twentieth century, individuals from minority ethnic groups and persons with disabilities fell victim to 'public health' policies (for example, coercive sterilisation, institutionalisation and marriage restriction) aimed to restrict the size of their populations across Europe and America (Mitchell and Snyder, 2003). While some of these events have been chronicled and evaluated retrospectively (Hoberman, 2012; Skloot, 2011; Washington, 2006), many memories remain repressed by the passage of time and the perpetuated silencing of minoritised and indigenous voices throughout the world (Mosby, 2013). Spotlighting the darkest moments in the history of medicine reveals the lingering effects of colonial hierarchies in the present day, including notions of inferiority and superiority that remain deeply entrenched in political discourse.

Finally, a critically conscious outlook should also deconstruct essentialist conceptions of race (Chadha et al., 2020). The scientific validity of racial constructs has been disputed by findings in genome science and physical anthropology (McCann-Mortimer et al., 2004; Morning, 2011). This has led to calls to deconstruct the notion of 'race' in the medical curricula (Braun, 2017; Lim et al., 2021; Tsai et al., 2016) to refute the belief that 'Black', 'White', 'brown' are discrete and naturally occurring categories within the human population, rather than terminology steeped in colonial connotations (Wekker, 2016). Through the lens of critical race theory, systemic racism is preserved through the false attribution of health disparities to racial difference, concealing how ethnic minority populations are disadvantaged by broader sociopolitical determinants of health (Brown, 2003; Ford and Airhihenbuwa, 2010; Jensen et al., 2020; Pollock, 2012). Exposure to such perspectives may help medical students critique with the goal of expanding their understanding of what race and ethnicity entails, challenge racialised prejudice that confounds clinical judgement and critically evaluate race-based recommendations in clinical practice.

The counterpoint to critical consciousness is sanctioned ignorance – the purposeful exclusion of certain knowledge considered extraneous to the mainstream curriculum. This stance has been dubbed 'inseparable from colonial domination' (Spivak, 1988: 6), as it enables not just a hierarchisation of knowledge but, more dangerously, the monopolisation of a global narrative on race, modernity and civilisation. Recentring displaced narratives distributed across time and space is an act of decolonising that serves to contest cultural arrogance within the 'Western' medical tradition through offering an honest appraisal of its failings. We anticipate that this shift will promote empathy, humility and critical thinking among medical students, accompanied by a will to advocate on behalf of patients most disadvantaged by the present system.

Conclusion

Mignolo (2002: 73) observes that 'colonial difference is reproduced in its invisibility'. The elusive focuses of decolonial work pose an insurmountable challenge to all who engage with it – that within a self-perpetuating system structured by coloniality, the task of decolonising will never be complete. There are various limitations to this model, and the three perspectives we have outlined in this article – epistemic pluralism, cultural safety and critical consciousness – only represent a marginal fraction of what decolonising the medical curriculum entails. The call for reform extends to every aspect of medical training: from the inclusion of non-White bodies in teaching imagery (Louie and Wilkes, 2018; Mukwende et al., 2020) to representation of minority ethnic voices in research (Oh et al., 2015); from the history of medicine to its present and future, including the domains of artificial intelligence (Hao, 2020) and planetary health (Horton and Lo, 2015; Lokugamage et al., 2020a); from education around the rights of vulnerable and marginalised populations to health access (Bax and Middleton, 2019; Robinson, 2019; Torjesen, 2019) to re-examining disability models through perspectives from the Global South (Meekosha, 2011) – all while understanding the crucial role that each of these play in health equity (Munro et al., 2020; Rajkomar et al., 2018). Furthermore, while our focus has been on what can be accomplished through the explicit or intended medical curriculum, it neglects the extensive reform required in the implicit and hidden curricula dictated by broader institutional cultures, processes and policies.

The importance of humility and reflexivity should not be understated as we negotiate this rapidly evolving field of inquiry. In this movement, we are venturing into spaces of discussion that are highly emotive and may trigger unconscious biases with deep historical roots (Gishen and Lokugamage, 2019). Those who lead decolonising initiatives at higher education institutions should continue to demonstrate a willingness and patience to engage sincerely with others who are less receptive to this change. It is our hope that these reflections on how the decolonising agenda may transliterate in medical education will serve as a catalyst for radical reform within UCLMS and beyond. Moving forward, we aim to strengthen networks of collaboration between medical schools, faculties and institutions. By drawing from the pool of expertise and innovation across the whole spectrum of stakeholders in our healthcare system, and subverting dominant paradigms of what constitutes meaningful knowledge, we may aspire closer to our goal to humanise medicine.

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Authorship statement

Sarah Wong Hui Min, Faye Gishen and Amali Lokugamage conceptualised the article together. Sarah conceived the outline of the article and contributed to the writing of the manuscript from a student perspective. Amali and Faye critically revised the manuscript and provided input from a clinician educator perspective and from their experience with diversifying and decolonising the medical curriculum at UCLMS.

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Declarations and conflict of interests

The authors declare no conflicts of interest with this work.

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