Diversifying the medical curriculum as part of the wider decolonising effort: A proposed framework and self-assessment resource toolbox

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Abstract
The narrative of decolonisation has recently amassed momentum, with the student and public voice providing the greatest advocacy, resulting in medical schools and universities embarking on a broader range of initiatives in response to the wider decolonisation agenda. Part of this wider effort is the diversification of the curriculum to create a more culturally responsive and equity focussed experience and training. Diversifying the curriculum poses considerable challenges due to limited expertise and/or relevant resources. It is from identification of this deficit, as well as our own experience in a UK medical school of diversifying our medical curriculum in the context of our decolonising efforts and the nature of the work required, that we developed a framework and created a toolbox of reflective questions, examples and resources to aid this work. As authors, we acknowledge that this process will be ongoing as we educate ourselves and reframe perceptions of the world, learn from lived experiences and incorporate advice from experts. The aspiration of this toolbox is to support those involved in efforts and initiatives to undo the effects of colonialism in medical education and research, and more specifically those who seek to diversify their curriculum within this context. This will ultimately benefit the education of our students, with the objective of equipping them with the knowledge, understanding and skills to provide equitable care to their patients.

1 | INTRODUCTION

Global events around inequity and racism have amassed momentum to decolonise the western view and thinking, to acknowledge the impact of colonialism on Indigenous and underrepresented groups and advocate for them to have a voice, be heard and have more influence and leadership.¹ The process of decolonising or undoing of colonialism is multifaceted and complicated by the fact that the term decolonisation is not always correctly understood or used.² Notwithstanding this, many institutions are embarking on decolonisation efforts to redress the effects of colonialism on education.

As part of the wider decolonisation efforts, the aim of this toolbox is to provide guidance and structure to those embarking on diversification of their curriculum. It is from our experience in doing this work in a large United Kingdom (UK) medical school in a university with campuses in China and Malaysia, as well as acknowledging the importance of sharing resources, that we developed this toolbox. The proposed framework and practical advice will be useful to educationalists as they review their programmes and learning environment.

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Historically, the perception of medicine in western society was deemed ‘unrepresentative’, ‘inaccessible’ and ‘privileged’ as practitioners were typically White, male, heterosexual and from affluent backgrounds. In recent times however, the global shift in the political, economic and technological landscape has meant health care practitioners and the communities they serve embody the ethnic and cultural diversity of modern society. Mirroring this shift are the diverse and complex health care needs of the population; therefore to provide effective health care, medical education training received should be reflective of these societal changes and cultural diversity.

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Defining decolonisation is multi-layered and open to diverse interpretations depending on the context. Currently, the ‘norm’ is based on western, colonial and Eurocentric views and knowledge stemmed from discriminatory legacies. In taking a holistic approach, we advocate an interrogation of these systemic ‘norms’, with critical work undertaken to eradicate universal untruths and inequalities. Furthermore, to successfully disrupt these inequities, decolonisation in medicine requires an understanding of the history of medical knowledge and necessitates recognition of the professions’ and individuals’ implicit biases, with the need for all to embrace inclusive attitudes and practices, thus paving the way for equitable provision of health care.

Additionally, any decolonisation narrative should amplify equity, diversity and inclusion (EDI) efforts through the positioning of marginalised and underrepresented student, staff and patient communities as ‘experts’ within the curriculum space. Specifically, this should involve embedding the voices of all stakeholders from ethnically diverse groups with considerations of other characteristics (age, disability, gender reassignment, religion or belief, sex and sexual orientation). Moreover, the scrutiny and advice of external experts from different ethnic and minority groups, for example, members of the Black and LGBTQ+ communities and those with disabilities, should be included.

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Our initial plan for diversifying the curriculum was shared with staff and students within our institution for the purposes of feedback and recruitment of a staff/student team to work with the authors. This work revealed the substantive workload and time required, as well as the complexities and challenges for educators exposed only to a specific education framework (in the case of the authors a western framework). Moreover, staff personal and professional development initiatives and expectations of ‘new learning’ in this area would be required.

Our framework comprises four categories: Initial considerations, Historical perspectives, Learning environment and Teaching materials and resources (Figure 1). These categories were formulated from interrogation of the literature as well as local discussions.
with staff and students. With notable success in our diversification effort so far, this toolbox showcasing our framework provides others with comprehensive guidance, reflective questions and resources.

2 | INITIAL CONSIDERATIONS

Initially, based on experience we recommend programme leads, programme contributors and students undertake a review of their existing curriculum (and learning environment), with the objective of identifying key areas for prioritisation. We therefore suggest four areas as presented as follows.

2.1 | Demographic profile

The demographic profile of an individual will depict a symbiosis between lived experiences and perception of the world and may influence their educational practices. In considering the learning environment, we recommend identifying and increasing the contributions made by ethnically and culturally diverse individuals (staff, students, patients, wider community and expert groups), with emphasis on the importance of the contribution made by patients and the wider community to the learning experience. Any lack of heterogeneity and diversity clearly must be rebalanced.

2.2 | Knowledge production

As discussed previously, knowledge in medicine has been depicted through a western-biased lens, and as educators, there is the need to take action to rectify this. Consideration of the following questions may help: ‘who is involved in knowledge production?’, ‘why might some people not be included in the knowledge production process?’ and ‘what does it mean if only certain people have the opportunity to produce knowledge?’ Answers to these questions should serve as a directive that informs strategies for the implementation of an inclusive curriculum.

2.3 | Representation of ‘Others’

Considering former colonised areas such as in regions of Africa, Asia, Latin America and Oceania, it is important that there is an awareness of how/whether these regions are represented in the curriculum and whether there are any geographical biases. In addition, Indigenous people continue to suffer the effects of colonialism despite international law to guide policy makers of their collective rights. Therefore, when considering global research and knowledge production, questions to reflect upon could be: ‘is there an opportunity to include knowledge from ‘Others’ in your curriculum?’, ‘is there representation of ‘thinkers’ from different parts of the world whose research was used by the west and often without acknowledgement of contribution?’ and ‘are communications about science discoveries reflective of diverse teams?’

2.4 | Inclusive learning environment

Whilst we have provided a comprehensive guide on the learning environment later in this toolbox, there are relevant questions around creating an environment to carry out this work. These include: ‘do contributors to the curriculum possess the knowledge and skills to embark on this work?’ ‘do they need training?’ ‘do you openly discuss challenges and inequalities within your subject?’ ‘is there reflective space for students to bring their own identity and lived experiences into their studies?’ and ‘is the assessment presented in a format that encourages students to engage with other traditions or sources of knowledge?’

3 | HISTORICAL PERSPECTIVES

The history of medicine does present with uncomfortable truths due to the fact that some medical and scientific advancements were formed from principles of dehumanisation. Moreover, the explicit dismissal of other traditional forms of healing, for example, those from Indigenous communities, does further evidence the narrative of a colonial power imbalance. With these omissions from the western medical dialogue/narrative, there remains the legacy of implicit biases within medical education, the profession and the development of our health systems, that need addressing. Reconciling with this history within the context of decolonising efforts and diversification of the curriculum may require approaches through the boundaries of law and ethics, global health and anthropology. It is therefore important

| TABLE 1 Summary of historical perspectives to consider when reviewing the curriculum |
|----------------------------------|
| **Historical perspectives** |
| • Do you teach history of ideas within your subject? |
| • Do you clearly explain how your subject exists in the context of society, and not in a vacuum? |
| • Do you consider ways in which your subject has been implicit in ‘othering’ people, to create or reinforce structural inequality? |
| • Do you discuss the impact of those systems on the people who were/are affected? |
| • Do you consider the means by which we obtained the knowledge we have today? In pursuing knowledge production, is the controversy surrounding unethical human experimentation on ethnically and culturally diverse populations/groups covered in the curriculum? |
| • Are there thinkers, authors or researchers in your field who are known to have held views which conflict with our current understanding of equality and rights? Do you make space to discuss these, contextualise them and specifically discuss how dominant ideologies seeped in through your subject? |
to acknowledge and where possible reverse the policies and practices that have resulted in ‘brain drain’ and resource depletion in the countries and societies stripped by colonialism. Moreover, an understanding of the national and global inequities and impact of encouraging migration and settlement to meet workforce shortages (over generations) should be considered. Table 1 provides examples of questions to consider when interrogating the history of medicine to diversify your curriculum.

4 | LEARNING ENVIRONMENT

It is important to reflect on what constitutes the learning environment. As authors, we have considered a variety of aspects/factors that constitute the overall learning environment. These include university/medical school’s influence and contribution via its organisational structure(s) with its specific cultures, mission and values; the make-up and qualities of the academic, support staff (academic, support and administrative) and student populations that constitute the overall learning environment. These include determinations (over generations) should be considered. Table 1 provides examples of questions to consider when interrogating the history of medicine to diversify your curriculum.

**TABLE 2** Summary of the structural/organisational considerations within the learning environment

| The Teaching and Learning Environment |
|--------------------------------------|
| **Structural/organisational considerations and reflections** |
| • Do your institutional and medical school values, cultures, policies and processes reflect the decolonisation agenda? |
| • Does the university/medical school prioritise and resource decolonisation efforts? |
| • Does the university/medical school consider decolonisation separately from equality, diversity and inclusion (EDI) initiatives? |
| • Has there been an acknowledgement and redress of the colonial past and how the institutions and medical schools may have benefitted from past colonialism? |
| • Are there attempts to increase the understanding of colonialism and the impact it has on students and staff? What work is still to be done and is there a plan and timeline? |
| • Who was/is involved in developing university and medical school strategy and policy? An understanding of colonised nations, people and community perspectives and history is required. |
| • Were the voices of underrepresented stakeholders heard? Do they reflect the diverse community and all global viewpoints and circumstances? |
| • Do your staff (academic, support and administrative) and student populations reflect the diversity of society and their future patients? |
| • Do you ensure that patient volunteers, examiners, simulated patients reflect patient populations and actively recruit from ethnically diverse, underrepresented and marginalised groups? |
| • Do you have university/medical school staff roles to progress decolonisation and broader EDI activity of the school and all pedagogical activities? |
| • Do you have staff/student co-chaired committees to progress decolonisation and broader EDI activity of the medical school and all pedagogical activities? |
| • Have policies and processes been challenged and reviewed by appropriately diverse stakeholders, students and educators to reflect on their inclusivity and to exclude discrimination and the impacts of privilege? Are policies and processes enabling some and impeding others? |
| • Do you support cultural and religious difference? Is there a policy on religious observance? Are there prayer room facilities? |
| • Do your associated institutional organisations’ values, cultures, policies and processes reflect the decolonisation agenda, including regulatory bodies? |

| Support and Development |
|-------------------------|
| Support and development is integral to the student experience and it is therefore important to understand that some groups of students come from backgrounds where support seeking from specialist services is uncommon. |
| • Are all your support staff White? Do male students from ethnically diverse backgrounds access support? |
| • Does your personal tutoring programme enable engagement by students from all ethnically and culturally diverse backgrounds? |
| • Is there knowledge and understanding around barriers to accessing support, cultural awareness and appropriate training and signposting? |
| • Are there support/therapeutic groups for students from ethnically and culturally diverse background groups? Do you signpost your students to accessible and appropriate support? |
| • Do you reflect upon the equality of opportunity for developmental opportunities and CV building? Are your careers advisors addressing unconscious bias? |

| Support Signposting suggestions |
|-------------------------------|
| • Melanin Medics is a non-profit charitable organisation for the present and future African and Caribbean doctor. |
| • Leading routes’ Black in Academia campaign. |
| • Student societies such as African Caribbean Medical networks, The Student National Medical Association (USA), Asian Medical Student’s Association (AMSA). |

| Placements |
|------------|
| In medical education, most placement providers are outside of the university environment, and thus, a different set of institutional values and practices are observed. In the United Kingdom, the NHS continues to benefit from its colonial past with a large proportion of its staff still coming from ex-colonies. |
| • Are your placement providers reflecting on their position and are they decolonising and diversifying their establishments? |
| • Do you consider and reflect upon the equality of experience of placements, that is, what the different challenges are? Do students from ethnically and culturally diverse backgrounds get the same opportunity as White students? Do you consider cultural and religious obligations and responsibility when allocating students to particular placements? |
| • Do you reflect upon and consider the effect on students from ethnically and culturally diverse backgrounds of different placement patient populations when considering micro aggressions, racism and harassments? |
and administrative staff and learners, with their perspectives and influences, the nature of the curriculum (including the hidden curriculum) and the pedagogical delivery and resources used. All the elements of the learning environment must therefore be considered in any decolonisation and diversification effort to ensure an effective, sustained, consistent and permanent change.

5 | ORGANISATIONAL STRUCTURES AND VALUES

A commitment to decolonising the institutions in which learning is delivered is essential and educational policy makers and regulators must continue to influence this effort. Universities, medical schools and associated educational partners must review their structures, policies and processes in accordance with the decolonising agenda and adjust accordingly to ensure equality of opportunity, parity of experience, diverse representation and accessibility of support for all. Therefore, there should be a commitment to prioritise and resource an institutional-wide effort to increase understanding of their current hegemony. Table 2 illustrates these considerations and summarises areas of critical reflection required.

A commitment to decolonising the institutions in which learning is delivered is essential.

6 | TEACHING AND LEARNING CONSIDERATIONS: TEACHERS, LEARNERS, CURRICULUM AND PEDAGOGY

Decolonising and diversifying the learning environment must include consideration of all aspects including your curriculum, assessment and

| TABLE 3 Summary of the teaching and learning considerations within the learning environment |
| --- |
| **Teaching and Learning (T&L)** | **Assessment** |
| Curriculum, curriculum design and the hidden curriculum | • Do your exams assess and thereby acknowledge different ethnic and cultural aspects of the curriculum? |
| • Do you go through regular evaluation and reflection of all learning experiences, including stated curriculum, delivered curriculum and hidden curriculum? | • Does your assessment deal with aspects of social justice and equality? |
| • Can your students see their own ethnic and cultural backgrounds reflected in the curriculum? | • Is there consideration of timing of compulsory sessions and assessment deadlines and are you mindful of major religious festivals and cultural events (e.g., exam dates can occur during fasting periods)? |
| • Do you discuss complex patient–doctor relationships involving individuals from diverse backgrounds? | |
| • Do you include teaching on understanding of different spiritual, religious, social and cultural factors and beliefs? | |
| • Do you acknowledge cultural misappropriations and discussions around lack of integrity including ownership, discovery and history of knowledge? Does your curriculum encourage professional reflection and learning around cultural safety, human factors and cultural humility? |
| • Do you have curricular sessions on unconscious bias, how to be anti-racist and bystander training? | |
| • Have you included broader more global learning, geographical bias and historical colonial content in your curriculum and space for decolonising and diversification discussions with appropriately trained staff, and do you prepare students to respond to and cope with patient xenophobia and racism? | |

Ways of teaching and pedagogical practices

• As a contributor to the curriculum, do you consider your own positionality, need for self-education and impact on your students? Does your style, practice, unconscious bias exclude certain groups? Are you mindful of your own behaviours?

• How does your teaching legitimise and respect experience and culture?

• Do you acknowledge any limitations in the demographic representation and endeavour to change the situation?

Do you randomly select seminar groupings? Students have reported that friendships built through sharing of course material, reflection, collaboration and learning, break down cultural barriers.

• Do you know who does/does not attend your sessions?

• Do you highlight areas of inequality within your curriculum when considering access to health care in different groups both nationally and globally?

• Do you discuss differences between access to public or private funded health care?

• Do you discuss why certain people are more likely to be affected by issues in your field than others? Do you critically analyse why this might be?

• Do you make an effort to learn and pronounce students’ names? (resource: https://www.anpu.london/name).11

• Would your staff (and students) know how to handle disclosures or experiences of harassment or hate crime?

• Have you taken part and reflected on bystander training?
| Questions to reflect on | Actions you can take | Resources and examples |
|-------------------------|----------------------|------------------------|
| Do you use mannequins, diagrams, or photographs to teach? If so, are these materials diverse and representative of the patient population? Are they used effectively in teaching? | Increase the diversity of mannequins including different skin tones, male, female and children. Simulation scenarios using diverse mannequins can help reduce bias, change behaviours and increase awareness of patient cultural characteristics. | There are many companies now recognising the need for multicultural training mannequins with different multicultural features and skin tones reflecting the diversity of the population, for example, Simulais LTD, Laerdal, CAE Health care, Limbs & things, Kyotokagaku Co. Ltce-book: ‘How to use simulation-based training to reduce implicit bias and promote equitable care’—a guide to integrating diversity and inclusion in your clinical training. Downloadable book obtained from (https://laerdal.com/us/information/diversity-ebook/). |
| | All clinical presentations should acknowledge similarities as well as differences. Moreover, failure to educate on similarities and differences seen in all ethnicities must be addressed. Inform yourself on the variety of image banks available and start utilising them in your learning material. | Mind The Gap: A Handbook of Clinical Signs in Black and Brown Skin https://www.blackandbrownskin.co.uk/ |
| Do you highlight the fact that certain laboratory tests (e.g., renal function) have different normal reference ranges in certain ethnic groups (or any similar information)? Do you explain that calculations are based on a 70 kilogram adult White male? | Many clinical lab tests differ among self-identified racial and ethnic groups in healthy patients. Body mass index, creatinine clearance and some sex steroid measurements are all potential examples of racial biases in clinical measurements. Early stages of clinical drug development tend to include adults within a narrow range of body size and does not reflect the population distribution. | Creating ethnicity-specific reference intervals for lab tests from electronic health record (HER) data. |
| Is the language of your materials inclusive? Is the terminology you use correct? | Use adjectives instead of nouns e.g. Black or Asian patients. Avoid irrelevant ethnic descriptions e.g. use ‘a professor’ rather than ‘a Chinese professor’. | British Medical Association (BMA) guide to effective communication: inclusive language in the workplace. |
| Do you understand and account for cultural and religious difference? Do you emphasise that whilst patients are different, it is important to understand cultural differences without stereotyping. | Ensure you reflect the cultural and religious diversity of your students and their patients in your teaching materials, case studies and examples. Know the cultural and religious year. Consider health effects on people who are fasting. Consider who is an ‘average’ person that you are basing teaching on. Knowledge of cultural customs can enable health care professionals to provide better care. | Cultural variations in the clinical presentation of depression and anxiety: implications for diagnosis and treatment. Ethnic differences in cancer symptom awareness and barriers to seeking medical help in England. |
| Do you use diverse case studies in your teaching which focus on intersectionality, but also challenging stereotypes and prejudice, differences in disease prevalence and impacts of health inequality and racism? | Include examples of refugee health and experiences. Discuss some communities’ complex relationship with authorities and medical professionals. | General Medical Council (GMC) statement on ethnically diverse medical school teaching materials. |

(Continues)
pedagogy. Integral to this facilitation of a cultural change should be through the implementation of education and training requirements for all stakeholders.

Cultural change involves defining desired values, behaviours and outcomes as well as appropriate alignment with strategy, process and training. Therefore, diversification of assessment strategies, reflection of personal and departmental pedagogical process and identification of deficit knowledge and skills to inform training needs would be initial first steps.

Table 3 illustrates and summarises areas that need to be covered within the learning environment highlighting the importance and influence of the hidden curriculum. The hidden curriculum is different from the explicitly stated and published curriculum, and it reflects the complete social–cultural learning environment that is said to be the implicit, undeclared and unstated curriculum and involves learning about discipline specific values, norms and expected professional behaviours. The very nature of the hidden curriculum in itself is inaccessible for many as it is based on assumptions, prior experience, being in with the crowd, confidence to be involved, understanding the environment and detecting social cues. The hidden curriculum conveys essential knowledge and expected norms, but the inequality due to its disparities of experience among students from different social statuses and different cultural and ethnic groups means that there is a requirement to understand its meaning, with educationalists needing support to ensure they are equipped to address this deficit.

As such, the consideration of the hidden curriculum arguably may have the most influential impact on the learner’s educational capital gain and development and type of health care professional they may become.

### Table 4 (Continued)

| Questions to reflect on                                                                 | Actions you can take                                                                 | Resources and examples                                                                 |
|----------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|
| If students have contact with patients speaking about their personal experiences, do these patients represent a diverse population? | Review guidance or protocols for recruitment of patient volunteers or simulated patients, lay committee volunteers. | Actively recruit simulated patients from ethnically and culturally diverse backgrounds. |
| Are simulated patients representative of a diverse population?                          | Review guidance or protocols for recruitment of patient volunteers or simulated patients, lay committee volunteers. | Actively recruit simulated patients from ethnically and culturally diverse backgrounds. |

7 | TEACHING MATERIALS AND RESOURCES

Pedagogic practice is informed by the regular review and updates to learning material, as well as employing effective and inclusive delivery modes. When diversifying your curriculum, it is important to evaluate and review all such material and incorporate the ideas and recommendations discussed in the preceding sections. Whilst to date there remains a dearth of resources available for us to share, the necessity following recent activities to decolonise and diversify the curriculum has propagated work in this area, resulting in the production of more examples and resources to facilitate such work. Table 4 illustrates some practical steps that could be addressed, with provision of the associated resources and examples. It is important to understand that some of the recommendations around resources have important patient safety implications such as the immediate need to improve the resources around variation in biochemical markers. For example, the current reference ranges are mainly based on a White 70 kg adult which means that those from ethnically diverse populations are likely to be placed at increased risk of misdiagnosis resulting in such patients having inappropriate treatment or not receiving the treatment in a timely fashion.

It is important to understand that some of the recommendations around resources have important patient safety implications.

8 | RESEARCH CONSIDERATIONS

As the teaching and learning environments in universities are so closely linked to, and influenced by their research activity, it is also pertinent to consider how inclusive the research environment is, and to interrogate this area by asking research specific questions such as ‘do you have representative research and who determines what the...’
research priorities are? ‘is there representation from culturally and ethnically diverse groups in clinical trials?’ ‘what implication might there be if you only undertake clinical trials on one group of people?’ and ‘what does it mean if we lack research or data in certain demographics?’

9 | CONCLUSION

In conclusion, as a toolbox aimed at medical schools and medical educators involved in developing a culturally responsive and equity focussed curriculum and wider learning environment, we have proposed a framework of four distinct areas, Initial considerations, Historical perspectives, Learning environment and Teaching materials and resources. This toolbox also provides ideas and examples on how to approach the cultural change required to equip our medical students and future doctors/health care professionals with the knowledge, behaviours and skills to treat patients from diverse backgrounds effectively, appropriately and equitably.

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