BMA Charter to prevent and address racial harassment in medical schools.
Focus Group Report November 2021.

Executive Summary

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Introduction

The British Medical Association (BMA) Charter's Aims.

The charter is a set of actions the BMA are asking medical schools to commit to undertaking to prevent and effectively deal with racial harassment on campus and in work placements.

The Charter group actions are identified into four areas:

- supporting individuals to speak out
- ensuring robust processes for reporting and handling complaints
- mainstreaming equality, diversity and inclusion across the learning environment
- addressing racial harassment on work placements

The aim of the focus groups as set out by the Charter group were to provide a safe space for students to speak up about their experiences of discrimination and gather suggestions from students about how the Medical School can make improvements.

This report articulates the findings from the facilitation of 6 focus groups with 18 black and minoritised medical students at Imperial College London. These focus groups were undertaken in June and July 2021.

The report is set out based on central themes that emerged from the focus groups. The themes are; Marginalisation and Isolation, Racial Harassment, Bullying and Microaggressions, Clinical Placements, Theatre and wearing Hijab, Curriculum, Assessments, Systems of Support for Students.

This report seeks to articulate and represent the dialogues, experiences, reflections, and recommendations of the black and minoritised students. Each section includes student testimonies and their recommendations for change.

1. Marginalised and Isolated

Students expressed feelings of being '*on the edge'* of the culture of Imperial College, isolated from the student and academic body, and at the same time they also expressed feeling as though they were in the spotlight. This dynamic of standing out yet not being part of an accepting, self-affirming group contributed to considerable stress and pressure upon them.

This experience fed into being an 'outsider/the other'. One student described Imperial as '*cliquey and hierarchical'*. The persistent experience of racism had become normal and accepted for these students and the traumatic ongoing impact of this only became apparent for many in being able to talk and express this in the focus groups. The whiteness of the culture and lack of interventions and challenges to these norms meant the students felt at times very dispirited, invisible and powerless in the face of inertia in this area. One student summarised these feelings and reflections.

'I think what we're getting at is as a culture, we don't inherently see ourselves in, and so, when

I when I started medical school, I'm coming from a state comprehensive school from London where most of us have some sort of experience of being in the majority as a racial minority.

Illustrative of this culture students shared numerous examples:

'So, when it comes to the socializing and I think if you're younger in the medical school, there's this massive hierarchy in all student societies where the younger you are, the more you shut your mouth and you listen, and people just say whatever- racist, Islamophobic, anti-Semitic, just in passing.'

''It's just like also people use the N-word around me and then respond, 'oh sorry', and then continue to say it again. So, it's really not like a small thing and it really hurts like especially if it's multiple things multiple times over the years, like I think I've left events and not knowing why I was sad, and then years later I'm like, oh it was because of all the feelings of like otherness…. So, it's way bigger'.

Students shared the prevalence of outward displays of racism, one mentioning their experience of sitting on a board. Many were unsure early on in their time at Imperial if they were being '*too sensitive'* as this was what they were told when they challenged the racism.

'I would like to add that as a black minority we are often held as the face of our race, you have to be the most ethical person, otherwise people are going take anything you do as another example of your race in relation to the media. There is also pressure on you to know everything about where you come from. No one expects that of white people, no one expects them to know every single thing about their culture'.

This burden and pressure was shared by all the students in the focus groups with the spotlight and gaze squarely upon them.

- **Recommendation:**

This culture of whiteness permeates and establishes a culture of dominance, any difference or opposition to this norm is rejected, minimised and leads to the subjugation of black minortised people.

A deeper examination of this white norm and culture, its institutional practice alongside the delivery of change is needed at a strategic level to align with the BME Charter and rights and responsibilities under Legislation and supporting policy directives around Equality, Diversity and Inclusion (EDI).

This broader and deeper examination of the operational culture, traditions and histories within Imperial Medical School will provide a bedrock for sustainable systemic change. This could involve application of a co-production type model, working with both black and minortised and white students and staff, in a re-examination of the systems, practices, and traditions within a meaningful time frame.

2. Racial Harassment, Bullying and Micro-aggressions

The recording of racist incidents across the higher education sector is in general very low. In 2019, The Equality and Human Rights Commission reported that UK universities recorded 560 complaints of racial harassment over three and half years, while 60,000 students said they had made a complaint. This highlights the systematic lack of any adequate reporting and recording strategies within universities. The British Medical Association (BMA), highlighted in the launch of their charter to medical schools to "prevent and effectively deal with racial harassment" that 40% of medical undergraduates are from BAME communities, nearly double the 22% in universities generally. Importantly, racial harassment is recognised as a significant contributing factor to the gap in attainment seen between black and minoritised students and white students and progression into the medical profession.

One notable and well-known case amongst the students both from the focus groups and beyond was as a white student that has caused a substantial amount of distress amongst the black and minoritised students as well as a number of the white students.

*'This student has been witnessed multiple times saying n**ga in conversation and in reference to other people as well as saying interracial relationships made him feel "uncomfortable" and discussing how he sees it as acceptable for "white women" to go for "black men" but not for 'white men' to go for 'black women' and referencing interracial relationships with 'dog breeding'.*

It was reported that students had organised a spreadsheet with individual names co-signing a letter detailing all the comments that they had experienced from this student. In total 33 students co-signed this letter requesting for action to be taken against this student. This letter was in addition to specific complaints that had already been made by a number of individual students with no response.

The students did not feel they received an adequate response to this. '*All they said was that they couldn't tell us what the student's punishment would be'.*

This case was profoundly disheartening to the students involved with the following sentiments being expressed by one student that captured the feelings on this.

The fact that someone with these beliefs resides in this same university with no reprimands is highly disturbing and to see that someone could think of another student in this way and still be able to go on as if nothing happens is emotionally damaging. I feel, as do many of the imperial and specifically BME students, that this behaviour is completely unacceptable at such a renowned university. None of the BME students moved from schools with white predominance to again experience the same discrimination at university or even from areas they considered as safe spaces to somewhere they no longer feel respected even as a human being by fellow students and we want action to be taken to show that our university actually cares about such things'.

In addition to students facing intimidatory discrimination from students, experiences were shared that highlighted staff intimidation and bullying towards them.

One student recounting her incident, was visibly shaken and upset at her treatment. She felt shocked, scared and helpless as she was unsure where she could go for help. She did share with her friends and they agreed, given the status of the person they could not do anything'. The members of the focus group affirmed her experience of racial harassment.

One member of this focus group felt this incident was part of a wider culture of staff bullying and intimidation, that left students unable to challenge higher levels of leadership. A student who held a welfare role within the college shared how many students had disclosed and reported numerous experiences of bullying and problems involving staff. This impacted significantly upon the students emotional and mental health. This pressure impacted upon the student's grades, ability to communicate their experiences and additionally being told repeatedly that it's because of their '*academic abilities or a problem failing to thrive in this culture*' and '*this is Imperial and it's the best and by implication you're not up to it'*.

Students raised the constancy and everyday nature of micro aggressions and the cumulative effects of these on their own mental health and wellbeing affecting their ability and capacity to learn and remain focussed on their programme of study. The nature and extent of these micro aggressions offer real challenges as to how and where to raise these every day incidents.

'Micro-aggressions build up constantly, especially when you are one of the only people around of your ethnicity or gender. It's a problem from multiple different people. They'll say little things that are small, but then the more they do it all adds up, and some of the things you don't want to make a fuss of because you're the only person who sees it as a problem and is upset by it, and if you do say something they'll be like, no, it's fine, It's funny. So, it's like, oh, you don't want to make a fuss because you are the one that's disrupting the social environment'.

I have thought about how to handle this.... but it's really difficult generally because it's not like one person. It's not something that would ever really get dealt with because it's not like a big thing, how do I explain to the person being micro-aggressive? It was really the worst thing in the world, and made me feel othered, but it was like a social thing, so it wasn't the environment to talk about it, but it happens all the time. It's like little things like that, just throughout the medical school '.

This student finished sharing this experience and was righteously angry and went on to describe the impact on her life in terms of her self-confidence and questioning her own abilities, feeling angry as to what she can do. Whilst describing a variance of responses depending on the person and the situation, she included having to cut people off and not engaging in conversation with them ever again.

Huge concern was expressed in the focus groups on the lack of consequences or actions taken to those who perpetrate racist incidents.

'If I think about an incident that happened to my friend, an extremely racist incident, where then the perpetrator also became very aggressive, which was something she brought forward to the school, and so then meetings happen, and they talk to that student. One barrier for people even accessing help is that we don't really see any results when we do say something bad happened, and then nothing happens. The student that did something absolutely awful is still facing no consequences. The only bad thing that happened to them was that they had to go sit in some meetings with some faculty member, probably grovel a little bit, and now they get to carry on and have a fantastic career as a white man. Whereas my friend continues to live with the impact of this trauma for the rest of her career. We are not seeing consequences for the people who are doing the bad things, so we need to find ways to protect ourselves'.

The students expressed frustration and lack of confidence in Imperial's complaint procedure, they shared that the process lacked any robust responses to racist abuse. One student who was participating in a University wide sporting event between Imperial students and medics experienced racist name calling and after reporting it through the formal channels a year ago

never received any confirmation or response to date. The group collectively shared this lack of response reflects the racist culture of normalisation and minimisation of racism.

'I was in the middle of a game when a young man called out to the audience and his friends 'is racism off the cards boys' and then continued to shout out racist slurs at me. I was shocked as half of them laughed no one stopped or challenged him. He knew what he was doing, it was not a heat of the moment comment he planned to abuse me in that way and generate support from his team mates. I reported this to the coach, my captain, as they knew the young man and I filled out an online complaint form that went to the welfare officer. They knew who I was talking about as he had been involved in other incidents. I did not receive any confirmation of my complaint or update of any outcome'.

As a result of any serious intervention or consequences to racial harassment it has become embedded into the college culture and normalised as this student identifies.

'I am in year 5 year, reflecting upon my experience at Imperial realising that racism is normalised, people blatantly when singing songs use thing N word and it is used throughout daily college activity and interactions as well. In particular when I was a fresher, I did not feel socially confident to challenge this abuse when I attend societies comments from certain members of a sports club would make comments about me 'like not all black girls can dance then!' also, when they walked into bars, they would say let's go only black girls in here'. They would also tell racist jokes, make comments about black women and other minority groups such as, Asian women skin tone linking them to levels of attraction. On the whole these students were unchallenged in fact other students laughed and went along with it saying nothing. This behaviour dominated and created a racist culture'.

'In a society activity there was only me and one other black person in the society at the time. A certain individual would say and point at us black people and say 'black out' pointing to the exit door. This term in musical theatre called 'black out' refers to when the curtain is coming down. This happened quite a few times and the culture at that time was very disrespectful, it's very hard when you are younger, a fresher, trying hard to fit in when the senior students who are acting out racism and creating this culture. It is white people who make racist remarks in smaller groups, but when we are in larger groups other minoritised students will use such language and the N word. They justify this by saying they are not white therefore can't be racist'. As a black woman the form of abuse and assumptions about our sexuality our body and sexualised abuse is constant and is carried forward into the university culture'.

'Until I came to university, I had never experienced people making assumptions about your background, I have been called an Oreo and been told I am white. Other minorities have called me a bad black person, or I am acting white.' I have never reported any of the comments.

The group further discussed this dynamic of the white students using racist commentary in small groups, while mainly the men from other minoritised groups would openly and freely make racist abusive remarks and language. When challenged the response would be to minimise and reduce its impact into 'it's only a joke' with justification of how can a minority member be racist. This rationalisation and justification of racist ideology only reinforces and obscures the reality of the structural systemic nature of it and reinforces institutional power dynamics. In terms of the intersectional relationship with sexism this minimisation to humour and jokes and the sexualisation only reinforces the objectification and sexualisation of black women.

One student expressed her dismay that she only found out there was a reporting process in her final year. She also highlighted the student group did not have much confidence in this system as it appeared nothing will be done. There is a fear that if you are known to make complaints you will be banned from joining the General Medical Council and this assumption is shared by the wider student body. It is only since the Student Union welfare team sent out a form asking students to share experiences of racial harassment and racism, alongside the Black Lives Matter movement that racism has been highlighted. This survey has been submitted to the BME charter group.

These shifts are a result of the actions and initiatives led by the Student Union, for example, they have commissioned an organisation called 'Beyond Equality' to offer training for club captains and secretaries as often they are the protagonist of co-creating the racist culture and not fulfilling their pastoral role and role modelling as an older student.

Students felt disillusioned by Faculty and College responses.

'I don't think our faculty have done a very good job when it comes to raising concerns, even though we have a policy around 'raising concerns', the whole discussion around racism and how to report it and expectations of support is very poor. The discussion within Faculty's around the support for students is very recent, what students say is that there is a problem in every step of the process, often they can't identify when racism happens. However, when the Student Union conducted a survey and asked have you ever experienced racism there was a good chunk of students who reported yes, and a very small number said no'.

'There was a group of students who said they were unsure, which is often reacting to the micro aggressions of racism that are less blatant, which leads on to the problem we have when people are not trained to identify it in this way and would not recognise that it warrants a complaint or escalating it up as a concern'.

Racism is complex, nuanced and manifests across the personal, professional and organisational realm, positioning white people and white operational cultures as superior and powerful. This unquestioned positioning of white dominance acts to disassociate the real lived experience of black racial minoritised people from being a person, objectifying them as somehow not subjective. A young woman shared how she was abused by a man who barraged her with an aggressive set of questions regarding her Palestinian origin. She said he was not interested in her, or her experience but in his actions of dominance and righteousness. This experience left her feeling vulnerable as she had no actual proof and therefore did not feel justified in reporting this incident.

Students who felt confident in challenging racism often experienced a backlash from their peers and cited as being aggressive and feeding into the wider negative stereotypes of black people. This, uncomfortableness which may manifest in conforming to the status quo reflects the dualistic status that black minoritised communities are positioned into. The following exemplifies this:

'In the second year I was asked by a black woman how do I respond to racist abuse from elderly white patients. I explained that I would call it out, challenge the racism. I then got gas lighted for being aggressive, over reacting to a situation and reinforcing the stereotype of aggressive black people. I explained that this was not an overreaction but a response to a lived reality one in which I will speak up against racism and take appropriate action by feeding into the reporting pathways.

'I am from a working-class community and when I joined Imperial my student peers told me that my community were drug dealers from Pakistan. Growing up in working class communities I have experienced the sharp end of racism so learnt to fight against it. Coming to Imperial the experiences that middle-class students face often buffeted from this harsh reality, however I was shocked to the extent racist slurs have been normalised into their language'.

'In my second-year placement I noticed that when I was in a space with other white students the doctors and nurses would acknowledge and respond to them. For example, there were four of us in a consultation with a doctor, one white student and three black, the doctor just ignored us looking at the white student and responding to their questions. This makes you feel invisible and further isolated exacerbating the feeling of not belonging. How can you report this to any one and if you do the stereotypes of being a black man get activated and you are seen as aggressive? I have had to overcome great challenges to get to medical school as an Asian man, when I have final reached my goal, I am looked down upon even further'.

Recommendations:

The students had little confidence in the intention and purpose of the formal complaint's procedure within Imperial College, they remarked and shared experiences of the lack of consistency and satisfactions with the resolutions.

- **Racial Harassment**

It was recognised within the group that racial harassment occurred most frequently within the social settings and in particular clubs and societies. One group member said the role of the club captain who is a position of influence, and a role model should have an enhanced welfare role and be responsible to 'call racism out'. The recruitment of club captains and the monitoring of the role should have accountability measures and training with regard to racism and sexism.

'*If patients knew some of the things that these captains who are now doctors did in sports nights and behinds the scenes, they would be very worried. It is concerning that these captains and club members who participated in racial harassment are current Alumni and practicing doctors. This, for me calls into question their fitness to practice as doctors'.*

There is a very real need for a comprehensive educative programme on race equality for all students within the Medical College.

- **Racial harassment and complaints process**

A strong feeling amongst students was, for a complaint process to be effective it needed consequences that were transparent and clear. These comments echoed this point:

'I have witnessed racism and bullying amongst my peers at the medical school. Some of these incidents were reported according to the processes that were in place and the repercussions for the aggressors amounted to less than a slap on the wrist. These were terrible cases of bullying and racism that led to students withdrawing from their medical studies. I think racism and bullying within the student body should be treated more seriously by the medical school, at the very least to the same standard that English courts would deal with incidents of racism and bullying'.

'People need to be fully taught, like literally educated and empowered to speak up about this shit….in terms of like societies, like committees being empowered or educated to say something when they see something …. have actual policy in place…. if they do another offense they get removed from the society for ten days.

'We need actual consequences at a minimum, make people think before they say anything there needs to be consequences to motivate people to really think about it, clear ones very clear if you do that, like if you do a micro aggression, if you call someone the N-word, if you call someone whatever, like the P word, this is what happens. You don't do it. Right'.

'I think there should be a clear process in place in order for us to see that we know where to complain or who to complain to, and I think the repercussions need to be more significant. I feel like a lot of times I've heard stories where, like doctors have done egregious things, not just racist things, but also sexist and all sorts of things, and they've been let off with a slap on the wrist and they continue, and I feel like the repercussions need to be more severe or at least more transparent in terms of what's happening and why it's happening'.

At the heart of this a coherent and systematic programme both integrated into the curriculum as well as specific training/teaching is needed for all students on race equality.

- **Reporting**

There needs to be recognition and clarity in the reporting process for medical students, as it is a little more complicated compared to other students who have ordinance in terms of the standard student complaints process. Medical students have exposure to other settings and staff, NHS staff, patients, members of the public and alumni. If a patient is racist how do they report it. Also, for NHS staff how do we report it. There needs to be a wider door as possible to allow this broader scope of issues and complaints to be made and additional developments will be needed to manage this process.

It appears that students do report incidents of racist abuse, however, it's the quality of the recording process, such as the complaints procedure and following through this process with accountability and feedback to the aggrieved student. The system needs to review staff training around the application of this process and quality assurance mechanisms in place to monitor its due process. At a higher strategic management level, a monthly review of the complaints data with considered outcomes should be formulated as a standard agenda item.

Students felt the complaint system needs to be a central system across the whole college, not confined within the medical school. They felt the complexity of the different schools' systems was unnecessary and divisive.

'I think they 'brown-wash' some of these issues away which is a problem. I don't know if you have heard from many black students, but there is no black representation in the Faculty and they have such terrible stereotypes and uneven treatment from fellow students, I think there needs to be an open system and it needs to go outside of the Faculty of Medicine and outside of the School of Medicine because at the moment it's like we self-regulate'.

College wide communication needs a strong statement condemning racist abuse and harassment which is consistently actioned and publicised.

3. Clinical placements

There were a range of concerns associated with placements shared by students in all the focus groups. These primarily included racism from medical staff and patients.

'In my clinical years, I have had appalling experiences. I would like to reiterate that while most of my interactions with clinical tutors have been understanding, supportive and productive, I have had a few experiences of blatant racism and prejudice from some clinical tutors. The details of these incidents can be elaborated upon if necessary but, suffice to say, they were blatantly racist and homophobic in nature. This is concerning for a number of reasons. These were doctors who were charged with looking after the health of the general public. It is frightening to think about the historic harm their actions and inactions could have done to marginalised groups. Further, they were free to continue doing potential harm and influence academic assessments (particularly practical assessments) and progression. The systems in place in the medical school were inadequate to report such abuses and frankly the repercussions were insignificant for the aggressors. This needs to be addressed'.

This student describes her and her Asian student colleagues experience whilst on placement. It was a small team. They describe the two white doctors they worked with as, '*horrible'.* The doctors would ask questions and if they answered incorrectly, they would respond rudely, on one occasion saying '*you two are so shit aren't you'.* The student described it as *'classical medical training bullying',* On the last day the student shared this experience.

'One of the doctors asked why are you uncomfortable? I'm giving you this time to teach. I have spent this time with you. And then he sat down on the floor saying, I'm sitting down. I'm no longer six-foot white guy talking over you, surely, you're comfortable now, so you don't need to sit so defensive and I'm thinking, if I want to sit with my arms crossed. I will. But I was like, okay, fine. So, I sat there like with an iPad and my pen as I tend to like to hold it, he carried on and asked load of questions and then he questioned us on different diseases. He focused on stereotypes- a forty-seven-year-old woman who's come from Nigeria with a cough. They've got tuberculosis. That's how we're taught it, and a twenty-five-year-old man born in Africa now in the UK he's got HIV'.

'You just rely on those stereotypes, we can't really change that, that's how the exams are written. As a student, I don't have any way to change that. But we continue having this conversation and he was testing us and I was like, still not that happy to be there. I didn't really want to be engaged in this conversation with someone that felt quite uncomfortable'.

The doctor then proceeded to lecture the two students about a cake that Indian people eat. Both students explain they are from different areas and explain they do not know of this cake.

'It's literally just butter and sugar and they just eat that, we have patients they'll tell us they're eating well, when they have just eaten this cake which causes the blood sugar to spike. And he was telling us and they eat this cake and it's the cake that is the problem, he went on you guys, you know, you can ask them, ask them about it. And so, we sat there just like nodding. And he was like, but you guys should tell your families. They should be really careful. And I was like, well, actually, we don't use fat in our cooking, and so we just ignored him but and he just carried on going and we just let him'.

After the students had left, they reflected together on the situation they had been forced to be in. They shared how there are lots of other sweet products that are equally problematic to diets to any patient.

'We had to literally sit there get him to sign us off and then leave. I was so furious because there was nothing that I could do in that situation to change that dynamic. I had to get his sign off and then leave. I rang my mum as soon as I left. She really thought I would have spoken my mind. She's like, what did you say? I was like, well, nothing. He said during this discussion, I'm not being racist I'm just telling you about their diet, I thought it's not a fight worth taking. I've seen this scenario quite a few times, you have doctors that will just say comments 'off the cuff', and when you try to track them down later to make complaint its difficult when you have finished your placement, so it never happens. I think it's because a lot of people don't feel comfortable and confident in the support from the faculty'.

The students lacked confidence and agency in being able to challenge the doctor within the hospital system, which was compounded and somewhat facilitated by the lack of perceived support from the faculty.

Most of the students in the focus groups shared experiences of encountering racism from patients, they felt unprepared for these encounters by the college, feeling unable to share this and generally unsupported.

One student shared how they were taking a patients history when the patient asked where they were from and after responding *'I'm from a small country in Southeast Asia and the man says, 'Oh, they're everywhere'.*

The student shared '*I just felt quite disgusting in a way, it just made me feel very disgusted, really, I felt powerless, I didn't know what to say'.*

This student expressed her anger that they were not prepared for this, they mentioned a clinical communication session in year 2 that they felt was inadequate and described it '*as useless'*.

Another student described a racist encounter in their rural placement saying.

'It shook me to the core. I think something that really should have been done when sending in an ethnically diverse group of people to a small town where things like this can happen and they know can happen. I think pretending this kind of stuff doesn't happen does more harm than good. They could have told us or provided a bit of training or if anything happens, please contact us to go through it, because I feel like I can't do anything. The GP that I was with said call the police. That was terrifying to me, you know what I mean?'.

This student left the placement early as a result of this incident. They described these constant encounters as exhausting and echoed the point requiring better preparation by the college before starting placements.

'We need to be trained explicitly as to how to deal with these situations, because it's not something that I want to carry on dealing with the rest of my life'.

The ambiguity, which plays out due to a lack of awareness and confidence for students and little or no track record of the faculty dealing with and challenging racism whilst students are on placements leaves students in a vulnerable position.

'I think there is a problem as students are not trained to deal with micro-aggressions in the moment in particular when we are on the wards as there are lots of instances when patients are overtly racist and use micro aggressions in the dialogue and actions towards us. This lack of experience and any substantive evidence of the implementation of any code of conduct policy from the wards leaves students in a compromised position. Students are being taught, as a doctor the patient's agenda and priority is the most important and to show respect and etiquette'.

'However, we are not taught how to respond, how to deal with racism from patients in a sensitive and tactful way. Even if you do want to report it, students don't know where to go or how to report it or what the process is. Even if you do jump through all those hurdles and report it, most of the time students are not satisfied or disappointed with the outcome. It's often the case no feedback is given and you assume it's just fallen through a large rabbit hole somewhere and nothing happened. I think there is systemic problem in the reporting process, which starts from a lack of clarity in identifying racism and continues through to the end of feedback and ongoing communication'.

Black and racial minoritised students said, this lack of any systematic process and approach located them as the cause and the effect of the problem and responsible for finding any solutions, which compromised them considerably. They felt there was no responsibility taken by the white students and medical professionals to challenge the situation and 'call it out'. This passivity reinforced and sustained the institutional notion of racism.

'In the fifth year we get a little more input on how to talk and deal with patients, however, the resounding attitude is that you have to deal with it yourself. I was once told I could step out of the room if a patient was being racist. Realistically in the middle of a consultation you are not going to do this. This approach can have many effects such as impacting upon learning missing out on what is being taught, and being compromised within the team being seen as not being able to deal with things'.

'The risk of raising concerns with the team regarding racist patients is if they don't see it as a micro-aggression, then you know that the team has not got your back which is very disheartening when you are with them every day. When the onus is on you to raise the concern, it places you in a vulnerable position. There are usually two routes that team members go down. First when the team say we are sorry this has happened to you and do nothing, which is the most common response. Second, if the team raised it as a concern, and went on to discuss how best to respond, acknowledging that this treatment is unacceptable this is very different. However, this is not usually the response. The outcome of the second response, makes you feel the team has your back and you are part of the team and not a guest'.

'We are also paying a considerable amount of money/fees to have a learning experience to remove oneself from the learning experience would be detrimental to our learning and performance in exams'.

'In my second-year placement I noticed that when I was in a space with other white students the doctors and nurses would acknowledge and respond to them. For example, there were four of us in a consultation with a doctor, one white student and three black, the doctor just ignored us looking at the white student and responding to their questions. This makes you feel invisible and further isolated exacerbating the feeling of not belonging. How can you report this to any one and if you do the stereotypes of being a black man get activated and you are

seen as aggressive. I have had to overcome great challenges to get to medical school as an Asian man, when I have final reached my goal, I am looked down upon even further'.

- **Recommendations:**

The relationship in terms of student support and advocacy between Imperial Medical School and the clinical placements need immediate improvements and reviewing. The experiences the students have shared are shocking and as one student reported;

'The systems in place in the medical school were inadequate to report such abuses and frankly the repercussions were insignificant for the aggressors. This needs to be addressed'.

(1) Incidents of racist abuse from clinical staff and patients' needs to be reported, acted upon and outcome monitoring in a robust fashion. Review of the placements contracts and possible performance standards could be introduced within them to protect students and give them formal channels for redress.

(2) Consultation with students, creating forums for student participation with a focus of listening to lived experience of medical school and placements, with a view to formulate an action plan for change.

(3) It would help to have a team of clinical staff, across a few specialities who can be named contacts for students regardless of the placement they are on. Their position as members of staff in the hospital would allow them to better navigate a lot of the politics. There is also no clear process on how to make complaints about clinical environments or staff, a guide to how complaints work and whether they are best made via college or trust would also be beneficial. An easy-to-understand guide of relevant sanctions would help, as often students are reluctant to make a complaint after being told that the outcome of any complaint will be 'unnecessarily' punitive for the member of staff.

One student shared their understanding of the relationship needed between the college and each Healthcare Trust

'I think a lot of it comes down to the relationship between the college and trust. Each site has a teaching coordinator who acts as the link between the college and firm leads. This means at most sites there is a teaching coordinator and member of administration staff, alongside the specific firm lead and named consultant who are responsible for student welfare. This works well for large firms with multiple consultants and students at hospitals that students know well. However, this does not work when there are very few students on a placement with a small clinical team'.

4. Theatre and wearing of Hijab

This specific theme was significant for each and every Muslim student who wears the Hijab. Each one shared an experience of the medical staff in the theatre making inappropriate racist comments towards these students in relation to their fitness to scrub in theatre.

These are a selection of those incidents and experiences.

'A consultant asked me, 'why don't you take off the hijab and just wear scrub caps, as its hot in here'. So, I was like, no, it's okay. I'll just be fine. Don't worry. He became very insistent on trying to get me to wear the caps instead of the hijab. He mentioned that his Muslim colleague

wears a cap so why can't I? This made me feel really uncomfortable as it's not fair to expect one person from one culture to behave like everyone else from that same culture'.

Another student shared *'I know to bring in freshly washed one (Hijab). I always make sure to do that anyway. And even despite that, I feel like I'm made to feel unwelcome'.*

A survey was undertaken by the Muslim students themselves the results of which were shared but to date there has been no specific action or discussion on the way forward.

'My friend and I took this issue up and contacted about 50 students who wore Hijab, about half responded sharing their negative experiences'.

The overriding finding from the survey indicated that year on year Muslim students face consistent questioning and disapproval of wearing Hijab.

'Theatre is a very precarious place to be, in the sense you have to scrub to control infections. I was told I couldn't scrub in as I wore a headscarf. This usually came from the nursing staff and or the head surgeon When I was in third year I thought this was a one off. I spoke to other students who wore the headscarf and they faced the same problem. One of them had tried to raise it within the NHS trust and nothing had happened in response to this. As a consequence of raising this, she was gaslighted, so I thought nothing will change'.

'Then in fifth year it happened again I was on my OD placement, it was going well the head surgeon asked me to scrub in, I was really excited and then one of the nurses said she can't scrub in she has to remove the headscarf. It was the lead surgeon who pushed for me to be scrubbed in saying I would be covered anyway'.

'I had a friend also who was on placement and had faced similar issues. We approached a Black woman fellow because we knew she would understand us. After we explained what had happened and asked about the dress code or alternatives to scrubbing in, she acknowledged that this situation was unacceptable and she emailed the consultants. My friend and I got an apologetic email back from the lead clinician and a report that he had informed the nurses of the dress code and how unacceptable their behaviour was. This was a very good outcome'.

In reality the students reported that wearing of Hijab does not compromise hygiene, as the medical gowns covers all clothing and has ties to keep it secure. Some medical schools across the country have sterile material to cover the head and act as a hijab.

Another student in her third year shared her experience of the surgery rotation, in particular the wearing of hijab, she said she was left feeling frustrated after a nurse challenged her in relation to hygiene standards and she was adamant that she was not going to remove her hijab so walked out of surgery and went on the wards.

'I bring a headscarf in for my hospital placements that has not been wore outside and I place the surgical cap on top of it. The nurse confronted me and said the surgeon might tell you off for having your neck covered, despite other staff members wearing polo necks and scarfs. I was taken aback by this remark very frustrated and withdrew from that day by leaving the theatre. Another experience I had earlier on in the rotation, after scrubbing up a nurse gave me an alternative to the cap, it was a piece of material that barely covered my neck. For a lot of Muslim women this is a big issue'.

'After the above incident, I met a Muslim woman who was wearing a headscarf that covered her neck and she was helping out in theatre. She informed me as long as they are washed at 60 degrees for an hour or so and kept within the hospital, they should meet the safety hygiene standard. This gave me the confidence to go back to theatre'.

The women Muslim students on the whole faced many barriers to surgery, including lack of any formal advice around the wearing of hijab and the safety standards. There is clearly a lack of information and awareness of the protective factors outlined under The Equality Act 2010 and alignment with good practice inclusive strategies within healthcare Trusts.

The experience of being in the focus group, reflecting and discussing these experiences of racism had a profound impact upon the Muslim women. One woman, expressed her realisation of the depth of her anxiety in relation to the constant negotiation and justification of her identity as a Muslim woman in medical practice. The micro aggressions of subtle day to day comments and questioning that are very difficult to challenge or raise formally build a sense of insecurity and minimisation of the racist experience.

'These experiences have left me very anxious and wary of male surgeons in particular and nurses in the theatre, the day-to-day comments come across as subtle many Muslim students have the similar experience. It's very difficult to bring these comments up as once you get the details of them, they seem not big enough'.

'In Muslim Medics group chat, we often find that year on year concerns are raised from Muslim women regarding hijab, just before the surgical rotation'.

Recommendations:

(1) The implementation and inclusion of the NHS National Uniforms and Workwear guidelines by NHS England within the practice standards between Imperial College and clinical placements. These guidelines state that NHS staff may wear full cloth head coverings in surgical theatres- including hijabs, turbans and Kippah. It also states there is no need to wear and overlying surgical cap.

(2) Students need to be made aware of the NHS National Uniforms and Workwear guidelines as part of the preparation for the surgical rotation. Alongside ensuring that NHS Trusts are complying to such guidelines and complaints made by Muslim women are followed up in a robust fashion. Imperial Medical School may consider undertaking a consultation and partnership working with Derby and Burton NHS Trust who have commissioned disposal hijabs in theatres as standard practice.

(3) Muslim women students suggested holding a focus group to ensure appropriate surgical disposable hijab are identified and implemented.

'The guidelines say exactly what is supposed to be provided with disposable hijabs. But I know only one of my friends who has ever seen that on placement'.

There is scant evidence this is being followed in any of the theatres the medical students attended, however, when they are provided, they need to be suitable.

'My friend goes to Liverpool medical school, and they have the disposable hijabs, she was saying that they have a different problem in that they look really odd as they basically cut up drapes'.

(4) Robust reporting structures for Muslim students who are compromised and negatively impacted upon during the surgical rotation.

5. Curriculum

A number of concerns were raised with regards to gaps within the curriculum in particular stereotypes of black and racial minoritized people and communities. Students felt there was no regard or reference to a proactive review, development or understanding of the context and relevant differences of patients within the medical School.

'I guess we're taught that, you know, certain diseases are more prevalent in different ethnic minorities, but not really about like cultural differences and any kind of explanation of why that might be right. So, you'll say, for example, you might be taught that in South Asian communities that diabetes has a stronger prevalence than might be within some of the white population. But then no further exploration about why?'.

One example was given in a course work question regarding the contextual stereotypes and requirement to jump in thinking based upon this.

'So much of what we learn is based on stereotypes and 'jumps' in thinking we are expected to make, so for example like a woman in obstetrics and gynaecology who's is black, (this was a mock question I had) she was raised in Nigeria. She now has like urinary incontinence.
What is her medical condition? And the answer was a vaseco vaginal fistula. And the reason you're supposed to know that is because they have poor maternal care in Nigeria. So, I was supposed to make that jump that she obviously comes from Nigeria had terrible care there and that was that-I don't want to make those jumps from this just because a patient was black and from Nigeria'.

Student raised other examples of asking the question about infectious diseases in particular tuberculosis, which was used as a descriptor for many Asian patients and when students challenged this view, they felt dismissed.

'When it comes to exams, we have lots of multiple-choice questions. These are exams, right, based on clinical knowledge. What's really interesting is every time someone says, oh, a South Asian man in his 30's comes in, you're made to think TB, you're immediately typecasting them in your head in order to get your marks, which is wrong, and I know I catch myself doing that. But then I hope that in the future, when I'm a doctor and someone comes in with something that a white person might have as well just as much as a brown person that I don't miss out on an important diagnosis because of the teaching that I've been given'.

Being on placement was a catalyst for students to reflect on their concerns about the curriculum and how ill prepared they felt:

- **Feeling marginalised and isolated:**

'Everybody in that theatre room was white, all white, all clearly upper middle class. I mean, where do I fit into this? And, you know, you can very much push yourself, like, yeah, I can do this. I'm going to be the first. But why do I need this? So, it's all these little things you constantly think of going through your medical school career.

- **Support from the medical school with placements and rotations:**

'When it comes to the support you get from the medical school, we did a critical communication skills session where they barely touched upon the topic of racism and which also led by people who have most likely not experienced some of these things. I remembered we had this little e-module thing with a question saying 'this person said women shouldn't be allowed to be doctors', And then you click something. It was the most basic introduction to this concept of equality, diversity, whatever you want to call it, and then on top of that, the software, the website they were using meant any answer you made always came out as incorrect, so everybody thought it was funny,

- **Priority to Equality and diversity teaching and responding to issues of concern.**

There is a lack of effort and importance given to the teaching of equality and diversity, It's, just a tick box thing that you've got to do this little exercise online. When issues arise, we as minoritised students stick together as we don't identify with British whiteness. We're the others. We're the ones having to come forward and say what is wrong, the institution fails to recognise and respond appropriately, they are not doing enough'.

- **Curriculum concerns that impact on the learning and understanding**

'There's an Instagram account that's opened. I don't remember what it's called, brown skin matters or something. And it talks about dermatological issues on dark skin, because every picture, everything that we see, everything and anything is on a white patient, and it comes to the point where you don't even know how to recognize anyone anymore. You don't know how to recognize a basic rash on someone and be like, oh, that looks different on dark skin. You know, that puts patients at risk in the future, and I think that's awful'.

- **Role models and the presents of Black and racial minoritised staff**

Students shared that their staff were invariably white and they had very few teaching staff from African-Caribbean or African communities and a few South Asian teaching staff.

'It would be also nice to see more teaching fellows at Imperial, in my 5 years I have had one black teaching fellow, and I remember when this happened it was brilliant seeing a black fellow in a position of authority, I would like to see more of this'.

- **Professional standards of behaviour**

Students identified through reflecting up their own experience the need for an integrated holistic approach regarding communication skills, evidence of professional values and behaviour standards towards black and minoritised patients. The students lived experience of racism in terms of their own families and communities meant they had increasing concerns around the robustness of the curriculum.

'We need to explore how to effectively communicate with patients honouring their cultural and religious sensitivities when you're communicating medical information. This requires the curriculum to support student reflection on their own cultural bias -I think that our communities must get a very poor service from medics'.

Recommendations:

(1) The process of decolonising the curriculum reviewing stereotypes, extending and expanding the resource materials, focusing upon strengths, capacity and resilience within all resources, materials and teaching.

(2) The new curriculum has professional values and behaviour modules that need to be integrated within the whole curriculum and not just a stand-alone module. The introduction to placements sessions would benefit from input on exploring racism and professional standards, giving students information around reporting and complaints procedures.

(3) The need for student focussed preparation sessions based on experiential group work for clinical placements with a focus upon dealing with experiencing racism from NHS staff and patients.

6. Assessments

- **Practical simulation exams role-plays**

These exam role-plays prompted a number of comments and concerns.

'There is an important point to be made about assessment at the medical school and medical education more broadly. There are two main types of assessments at medical school: multiple choice written exams and practical simulation exams which often involve role plays. My focus will be on practical assessments such as role plays, which are assessed rather subjectively, and are based on the rapport you are able to build with the actors who are simulating patients. Further subjectivity is added to the equation by the biases that the assessors bring to the table. As I mentioned earlier, some assessors are bigoted and may hold unconscious biases as well. It is disheartening to think that such individuals can influence academic progression. Further the homogeneity of simulated patients i.e. actors is a concern as potential source of bias and unfairness'.

This last point was further elaborated on by this student:

'I think that the actors that are hired by the medical school, tend to be mostly white, there are a few black actors, but there are hardly any South Asian actors and in terms of the basis of the exam that we do to pass our fifth year on practical clinical skills this is important and I think that's something maybe the school need to think about'.

Given this simulation is significant in assessment, questions were raised as to whether the actor was black or Asian, whether this was then considered in assessing students who are white, for example how they build rapport? How were they (as black and minoritised students) being assessed with white actors? On relationship building there were further questions and anxieties about how overall impressions were being assessed by examiners.

'I honestly feel like I have to up my game so much more because I'm going to be perceived as quiet and shy, because I'm a girl who has a headscarf, I'm just wondering if I my peers who are white, will they consistently have the same nerves and anxiety as I do being a stereotyped Muslim woman?'.

- **Assessment period and support to students**

Students are often worried about exams, timing and understanding the process. Students have support opportunities from Tutors throughout their time in medical school. Although students felt this process has the potential to be very beneficial they also reported that some of the support responses were abrupt, dismissive and at times would disregard the person asking the question. This situation was identified to be even worse for non-English speakers.

'I'm obviously a native English speaker and I'm comfortable with these sessions. I just see students asking questions about time and I see them being disregarded. The responses are like 'if you're going to be a doctor, you're going to have to understand that', 'you're going to have to do this to time'. 'Well of course you have to do that'. 'Well, I told you these five times, I'll tell you again'.

'I think people go into exams, with such an increased anxiety, and then this puts you at a disadvantage, because I go into exams comfortable that I'm going to understand what they require of me and they understand me, I wouldn't be worried. But then I have friends, who don't and who have never felt comfortable to ask if they needed more time to read the instructions or anything like that. These drop-in sessions certainly do not engage students to get the help they need'.

'A lot of that insecurity are often question's that come from placements. I think the biggest problem I see is the support for people being able to speak out and problems whilst on placements'.

Recommendations:

- **Assessments**

(1) Students suggested a robust and wider reach in the process of recruiting actors.

'I propose that to tackle this issue, assessors be thoroughly vetted, actors be drawn from various ethnic groups and social classes and all role play assessments be video recorded and available for independent review where there is concern regarding fairness. The unfairness of role play assessments seems to have been highlighted by various medical students over recent years without change'.

(2) There was a suggestion that previous role plays are made available for revision rather than relying on student co-operation.

'There is a very 'cliquey' and hierarchical culture within the medical school student body with education resources transmitted from older years to younger years according to which clique you belong to. This is of course unfair to those who are not part of the 'in' group and importantly affects progression. To solve this, I propose the medical school be more forthcoming with past role-play stations that all students can use as a revision tool without having to rely on exclusive social networks. The system as it stands perpetuates these cliques to the detriment of marginalised groups who may not be part of a clique'.

(3) Increased awareness of the differential impact staff communication has upon assessing and supporting black and minoritised students.

8.Systems of support for students

- Navigating the support services

The system of support for financial, mental health and wellbeing needs is difficult to navigate regardless of the problems students are having and it was reported that for those from black and minoritised groups it's even harder to navigate.

One student spoke that within the cohort in their year who had '*dropped out'* the majority were from black and minoritised groups. One student shared an example where they had failed an exam and due to personal circumstances was seeking flexibility for the retake in the summer which was denied suggesting they drop down a year despite having mitigating circumstances for the original exam failure. This student felt this lack of flexibility was applied unfairly to them as they knew of similar cases where the discretion had been applied favourably to certain white students. Some Muslim students do not to access loan or credit facilities as this is not encouraged within Islam. So, when students applied for any hardship loan or support around finance, because they had never accessed student loan facilities, they did not meet the criteria for such funds.

'I have always lived very close to the hospital and campus, however, when I started my GP placement it was a little further and I was struggling financially to cover the travel expenses. I tried to seek financial support and was signposted towards well-being support or financial support. As Muslims my parents have never wanted me to take out a loan, I am entirely funded by my them. When I contacted the financial support office, I was told they could not assist me, as I had not taken out a loan. They went on to say that other Muslim students take out loans, so I should take also take one out. I remember leaving the meeting feeling angry and upset. Before the meeting. I had sent details of my financial circumstances; in the meeting they didn't acknowledge or refer to them and or signpost me on to other support services. It was a blanket decision which was said very harshly of no loan no support. This made me question myself and was I justified in asking for support'.

- Prayer facilities

Support for Muslim students to access prayer facilities was raised. In one of the Library's students have been discouraged and even reprimanded for praying quietly in unused rooms when studying.

'In the library there are signs up all around and in the small study rooms effectively saying do not pray in here. These study rooms have been used by students in a study break for silent prayer which does not impact upon anyone. In fact, the Muslims praying have been subject to abuse, people entering in the room in the middle of payer and interrupting them for no reason. Some people have shouted at them in the middle of the library making a disturbing scene'.

'These signs send a message that I am not welcome in the campus and the library if I can't pray. It's awful that a room is free, not booked, empty, and we can't pray in it for a few minutes'.

'In one campus there is a prayer room, however, I have been wary about praying in their as it not sanitised and people do not follow social distancing rules and the room is not cleaned. I went into one of the rooms that had a sign, 'do not pray in this room', and a security guard said very politely that I was not allowed to pray in the room. I was left with a choice of praying outside or go back to the uncleaned, non- sanitised room'.

Recommendations:

(1) The retention of black and minoritised student's requires investigation specifically identifying the causes and reasons for leaving the programme of study.

(2) There needs to be a review to examine the systemic integration of the religious requirements for Muslim students in relation to core principles, such as loans and facilities for prayer. This approach would allow the process in particular around criteria of loans in relation to hardship fund to respond in a flexible respectful way. It could also open up further pathways of support that students could access.

Conclusion

The students who have participated in this process by sharing their painful experiences have suggested valuable recommendations that have emerged from this lived experience of racism. The insidious nature of systemic racism and its reproduction of racial inequality across all aspects of Imperial Medical School will require decisive action to interrupt it. The BME charter is a starting point, coupled with intentionality, robust examination of processes and systems in particular the complaint system.

The gap between the reporting and recording of racial harassment, reflects the inertia, passivity and complacency of the system which supports and provides fertile ground for micro-aggressions. Black and racial minortised students have clearly shown us this dynamic through their experiences in this report. The operational culture of whiteness needs to be re- examined within a process that offers challenge and supports and nurtures reflection for change. To counteract any resistance to change and build a platform of dialogue and reflection we would suggest an independent facilitative process with students and staff around achieving the BME charter targets.