Diversity in Health and Social Care 2005;2:233–45

Education paper

Cultural diversity teaching in the medical undergraduate curriculum

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ABSTRACT

In 1993, the General Medical Council recommended that cultural diversity be included in UK medical school curricula. There is evidence to suggest that the number of medical schools delivering training in cultural diversity has since increased, but uncertainty remains regarding what constitutes such training. This paper discusses various training models and their limitations, and evaluates results of a study to ascertain the views of medical education stakeholders regarding the organisation of undergraduate cultural diversity teaching for medical students. The research design of the study was flexible, allowing for modification of the semi-structured qualitative interviews with 61 stakeholders (including policymakers, teachers, students and service users). Results were analysed qualitatively to identify themes. There was strong agreement that cultural diversity needs to be a part of the core curriculum. Participants were uncertain about where in the curriculum it should be taught, but generally felt that it should be taught early. There was broad agreement, especially among teachers and curriculum heads, that integration of diversity issues throughout the curriculum would be better than modular teaching, but little clarity as to how this might be achieved. There was less consensus about the amount of time needed to deliver such teaching. There was clear consensus among stakeholders on how the subject should be taught, although little of it was based in any theoretical framework. Nevertheless, cultural diversity teachers felt that cultural diversity as a curricular subject lacked credibility with staff and students. There is a need to develop diversity education within a coherent educational framework, based on a clear rationale about where and why it is being taught.

Keywords: cultural diversity, educational models, medical undergraduate

Introduction

The publication in 1993 of *Tomorrow's Doctors* by the General Medical Council (GMC) placed cultural diversity on undergraduate medical school curricula in the UK, although the relevance of the subject to medical students had been raised some years previously. In the mid-1980s, a questionnaire postal survey of deans of English medical schools found that all of the 18 respondents (out of a possible 23) reported that their schools gave no specific teaching on the cultural aspects of ethnic minority medicine (Poulton *et al*, 1986). A decade later a survey of postgraduate and undergraduate medical education institutions conducted by the British Medical Association found that little had changed (Robins, 1995).

Another decade later and there appears to have been some progress, in that 72% of schools now report some teaching of cultural diversity (Dogra *et al*, 2005). However, the number of respondents reporting that their school is teaching the subject compares less favourably with the USA (Flores *et al*, 2000), albeit more favourably than with Canada (Azad *et al*, 2002). There appeared to be a great deal of uncertainty about what constituted cultural diversity teaching.

The use of the term *culture* in this paper is broadly consistent with the perspective on the concept of *culture* adopted by the Association of American Medical Colleges (AAMC) Task Force (1999) which stated that:

> Culture is defined by each person in relationship to the group or groups with whom he or she identifies. An individual's cultural identity may be based on heritage as well as individual circumstances and personal choice. Cultural identity may be affected by such factors as race, ethnicity, age, language, country of origin, acculturation, sexual orientation, gender, socioeconomic status, religious/spiritual beliefs, physical abilities and occupation, among others. These factors may impact behaviors such as communication styles, diet preferences, health beliefs, family roles, lifestyle, rituals and decision-making processes. All of these beliefs and practices, in turn can influence how patients and health care professionals perceive health and illness and how they interact with one another. (AAMC, 1999, p. 25)

Cultural diversity is taken to mean diversity of different cultures based on how an individual defines him/herself based on the idea that Frosh (1999, p. 413) described. He stated the view that identity draws from culture but is not simply formed by it.

Educational models

Some of the difficulties in establishing cultural diversity teaching may be related to a lack of coherent educational models for the topic (Dogra, 2004). The usefulness of considering a number of different models is that they highlight potential problems with all approaches, especially when there is a lack of coherence between educational philosophy, course design, delivery and learning outcomes. A selection of models is therefore discussed below.

The LEARN model

Berlin and Fowkes (1983) developed a teaching model that focused on a process for improving communication, which they felt is central to effective cross-cultural interactions between patients and physicians. Although their model does not emphasise dissemination of cultural information, they did perceive this to be helpful. They named their model LEARN:

- **L**isten with sympathy and understanding to the patient's perception of the problem
- **E**xplain your perceptions of the problem and strategy for treatment
- **A**cknowledge and discuss the differences and similarities between these perceptions
- **R**ecommend treatment while remembering the patient's cultural parameters
- **N**egotiate treatment.

This model does not expressly address the ways in which doctors' biases and influences may affect how they hear and respond to what their patients are telling them, or the value they place on what their patients say.

The transcultural nursing model

Leininger's (1991) transcultural nursing model is rooted in anthropology and focuses on comparing and contrasting cultural values, beliefs and practices about health and illness, with the aim of providing culturally appropriate care through culture care preservation – working within the patient's frame of reference; culture care accommodation – helping people to cope with health changes within their cultural framework; culture care repatterning – helping people cope with imposed changes (Leininger and McFarland, 2002). It is very similar to the cultural competence model in the way that culture is used and ethnicity defined (Cross *et al*, 1989). In the USA, nurses and nurse educators have begun to express dissatisfaction with Leininger's model and challenge it. One such example is Duffy (2001), who proposes a new transformative, post-modern approach to cultural education. This requires greater critical self-reflection and an acknowledgement of the self. Duffy (2001) did not comment on whether the suggested changes would be sufficient to meet the educational needs of future healthcare providers.

Cultural safety model

As described by Polaschek, culturally safe nursing practice involves 'actions which recognise, respect and nurture the unique cultural identity of the Tangata Whenua and safely meet their needs, expectations and rights' (Polaschek, 1998, p. 453). This model acknowledges the need to recognise negative attitudes towards and stereotypes of individuals because of the ethnic group to which they belong, but it contains the assumption that, while all those within the ethnic group may be diverse, their attitudes are likely to be similar. Polaschek's paper highlighted the fact that the concept of cultural safety has yet to be clearly articulated with methodological rigour by its proponents, and it is therefore difficult to present it as a viable alternative to other models.

The cultural humility model

Tervalon and Murray-Garcia (1998) sought to deliver healthcare effectively and respectfully to the increasingly diverse populations of the USA. The cultural humility model stresses the need to define educational and training outcomes consistent with this aim. The authors argue that the detached mastery of a theoretically finite body of knowledge expected by the cultural competence model may be inappropriate for multicultural medical education.

A systems-theoretic view

Kim (1992) presented a systems-theoretic view that emphasises the dynamic, interactive nature of communication between two or more individuals. Like the relationship between the mind and the reality it experiences, the relationship between an individual and the environment is viewed as mutually reinforcing. All parties involved in an encounter, and also the social context in which the encounter takes place, codetermine the communication outcome. This means that no single element in a multiperson communication system can be separated out as being solely responsible for the outcomes. Each person has his or her own reality and tokens of significance in terms of which new experiences are organised (Kim, 1992, p. 371).

The Papadopoulos, Tilki and Taylor model

Papadopoulos *et al* (2004) provided a conceptual map of a four-stage teaching process, concentrating on cultural awareness, cultural knowledge, cultural sensitivity and cultural competence. They argued that attaining cultural awareness is an essential first stage in the process of achieving cultural competence.

The study

Weber's construct of ideal types (Giddens, 1971; Morrison, 1995) was used to compare two models of teaching cultural diversity to medical undergraduates: through *cultural expertise* and through *cultural sensibility* (Dogra, 2003). The comparison was based on four major areas of course development: educational philosophy and policy; the educational process; course content; and learning outcomes. The *cultural expertise* model is founded on the belief that, through gaining knowledge about another culture, one can become an expert in it. This concept is used in programmes that try to teach cultural competence. The concept of developing *cultural sensibility* contains the notion not of acquiring expertise about others, but of recognising that we need to be aware of our perspectives and how they affect our ability to be open to other perspectives. *Sensibility* may be defined as openness to emotional impressions, susceptibility and sensitiveness. It relates to a person's moral, emotional or aesthetic ideas or standards. Cultural sensitivity is not the same as *cultural sensibility*. Sensitivity is more limited than sensibility, and does not take into account the latter's interactional nature. If one is open to outside experience, one is more likely to reflect on and change because of that experience.

Transparency and clarity about the philosophy of a teaching programme inform its organisation, content and outcomes (Dogra, 2003). However, such transparency requires that those developing a programme are aware of their own biases. It is evident that models of diversity teaching such as those outlined above do not always present a clear rationale for the organisation of cultural diversity teaching. It is not yet clear how models are being utilised and how awareness of them influences the organisation of cultural diversity teaching. This report is part of a PhD thesis (Dogra, 2004) on the views held by key stakeholders in medical education on the teaching and learning of cultural diversity. This paper reports specifically on the place of cultural diversity in the undergraduate curriculum and how the curriculum might be organised.

Method

Devising the interview schedule

A qualitative approach informed the development of a semi-structured interview schedule (Strah, 2000). This schedule drew on the literature base in sociology, medical education, education and intercultural studies (Dogra, 2004); previous research (Dogra, 2001; Dogra and Karnik, 2003); clinical, educational and personal experience; earlier interviews with members of the GMC Education Committee responsible for the first edition of *Tomorrow's Doctors*; and an internet search of all UK medical school websites. After an introduction, each interview was conducted in three parts.

- *Part 1* collected basic demographic data (age and sex), as well as roles and experience.
- *Part 2* began with four open-ended questions and respondents talked unprompted, with the interviewer clarifying if necessary. The four questions were:

  1 how do you understand the term *cultural diversity*?
  2 what do you think should be taught at undergraduate level about *cultural diversity*?
  3 what main topics do you think *cultural diversity* teaching should encompass at undergraduate level?
  4 how do you think *cultural diversity* should be taught?

- The interview then continued open-ended but focused on specific aspects of teaching such as learning outcomes, delivery methods, assessment, and influence on clinical practice and student perspectives.
- *Part 3* asked for the ways in which respondents used or understood key terms such as *race, ethnicity* and *multiculturalism*.

Each interview concluded by asking respondents about their experience and/or training in cultural diversity.

The interview was piloted with two policymakers and one diversity teacher, after which minor modifications were made to the schedule. A flexible design was used when delivering the interviews, allowing modifications as part of the research process (Strah, 2000).

The interview schedule is available from the author on request.

Sample and sample size

The samples of participants in this study were selected to represent the diversity and variety of stakeholders, within certain parameters generated from the literature, and in line with the aims of the research. Those interviewed were not representative or presumed to be representative of their group, but in most cases they were key informants within their group and often to other stakeholders outside their group. This sample was not a representative sample of various groups: demographic attributes such as race, age, sex, socioeconomic status and the like were not applied to the sample selected. The professional status, job title or role was the characteristic used to identify the sample. The sample was not random in that key individuals were targeted. Using a broad range of stakeholders with different priorities means that various perspectives were explored.

There were two stages of sampling. The first sampled different groups of stakeholders; the second sampled different individuals from these groups. In this study, units that could be sampled consisted of different groups of stakeholders. Within the main groups, there was also overlap: for example, policymakers may also be medical educationalists, be practising clinicians or work in patient forums. The sampling strategy ensured that interviews continued until saturation was achieved. Box 1 shows the groups sampled. There were no exclusion criteria.

Box 1 Sample groups

- *Policymakers*: members of organisations that decide or influence policy on medical education, e.g. General Medical Council, British Medical Association (targeted leads of diversity and equality forums and snowballing).
- *Those who implement policy*: heads of medical education and curriculum committee members.
- *Teachers*: teachers responsible for developing and delivering cultural diversity, including those responsible for communication skills training (those at medical schools identified below and also those with national profiles in the subject (identified through the literature) and snowballing.
- *Researchers in cultural diversity and associated areas*: including researchers actively teaching on ethnicity (identified through the literature and snowballing).
- *Medical students*: identified students leading diversity issues through formal student bodies and snowballing.
- *Users/patient representatives*: identified through user service forums and snowballing.

Included in the sample were medical schools in which:

- the cultural diversity programmes were more consistent with *cultural sensibility* than *cultural expertise*
- the programmes had elements of *cultural sensibility* and elements of the *cultural expertise* model
- the programmes were more consistent with *cultural expertise* but had some aspects of *cultural sensibility;* and no specified programme regarding cultural diversity was taught.

Using sampling and snowballing, a total of 61 individuals were recruited and interviewed. Table 1 provides some basic demographic information on the participants. Formal association with a medical school was defined as being employed by the medical school (including clinical NHS staff appointed as honorary teachers and external examiners), or being a student at a UK medical school. Individuals from 14 of the 26 established medical schools in the UK were involved (two schools have campuses at two sites; therefore, 12 curricula were effectively covered). Members from 11 policy-making organisations and six medical disciplines were interviewed. Other clinical perspectives included pharmacy, social work, community youth work and nursing. Non-clinical participants came from sociology, anthropology, accountancy, research and advocacy work. Table 2 shows those individuals who responded but did not participate and Table 3 provides some data on non-respondents. Policymakers were the most likely to not respond.

Procedure

Interviews lasted about an hour and were conducted face to face where possible, or alternatively by telephone. Initial contact was made in a formal introductory letter outlining the purpose of the research and inviting participation in it. The letter also stated that the interviews would be confidential and that the local research NHS ethics committee had approved the project. If there was no response, the initial letter was followed up by email or by a second letter until

Table 1 Summary demographics of participants

	Men ($n = 39$)	Women ($n = 22$)	Total (%)
Role			
Communication teachers	3	3	6 (9.8)
Curriculum heads/leads	4	3	7 (11.5)
Cultural diversity teachers	5	9	14 (23.0)
Policymakers (included individuals from the GMC, British Medical Association, Royal Colleges and Department of Health)	17	1	18 (29.5)
Researchers	2	0	2 (3.3)
Students	4	3	7 (11.5)
Service users	4	3	7 (11.5)
Age (years)			
Under 30	4	3	7 (11.5)
31–40	7	3	10 (16.4)
41–50	13	8	21 (34.4)
51–60	14	7	21 (34.4)
Over 60	1	1	2 (3.3)
Ethnic origin			
White British	30	20	50 (82.0)
Black British	0	1	1 (1.6)
British Indian	6	0	6 (9.8)
British Bangladeshi	1	0	1 (1.6)
British Pakistani	1	1	2 (3.3)
Mixed	1	0	1 (1.6)
Currently clinically active			
Yes	21	10	31 (50.8)
No	18	12	30 (49.2)
Medical school affiliation			
Yes	27	18	45 (73.8)
No	12	4	16 (26.2)

the target number was achieved. No one was contacted more than twice if they failed to respond. Most of those who agreed to take part did so by letter or email; copies of this correspondence were kept, making written consent forms unnecessary. Interviews were audiotaped and transcribed verbatim.

The researcher's part in the research and interview process

This research was undertaken by a female, of Indian origin, aged 40 years, brought up and educated in the UK, who works as a senior clinical academic in child and adolescent psychiatry at an East Midlands medical school. Having undertaken the development of a module in cultural diversity, she had some professional familiarity and experience with the topic. As Robson (2002) has highlighted, all these factors may influence the research.

Analysis

Qualitative thematic analysis was undertaken (Joffe and Yardley, 2004) and followed a series of systematic steps outlined by Miles and Huberman (1994). There was also some frequency coding of responses to enable comparison between groups (Seale, 1999). The content of the interviews was analysed to identify word and phrase frequencies and intercorrelations. Themes were identified by the author and discussed with the project supervisor to facilitate reliability. The categories were compared across scripts to develop ideas beyond description. Qualitative research provides a deeper understanding of the social processes and is data driven rather

Table 2 Characteristics of those who responded but declined to participate

Number	Role	Gender	Link with medical school	Clinical	Reason
1	Policymaker	M	No	Yes (limited)	Leaving post
2	Curriculum/phase/ year head	M	Yes	No	Felt he was inappropriate
3	Curriculum lead	M	Yes	Yes	Referred me on to someone who participated
4	Policymaker	F	No	No	No reason given for not being able to participate in interview
5	Policymaker	F	No	No	Referred me on to another person as felt was not appropriate
6	Policymaker	F	Yes	Yes	Too busy
7	Policymaker	N/A			Organisation no longer exists
8	Policymaker	M			Forwarded to others in organisation but was unsure of appropriateness
9	Policymaker	F	As clinical teacher	Yes	Off sick
10	Researcher and policymaker	M	Yes	Yes	Too busy
11	Policymaker	F	As clinical teacher	Yes	Felt was not appropriate to respond at this stage as organisation undergoing changes
12	Policymaker	F	No	No	Declined to be interviewed and unprepared to give reason. Offered to complete interview schedule as questionnaire but this was not returned

Of the 11 who did not feel they were the appropriate person to participate, 8 had been suggested by other participants as potentially suitable

Table 3 Characteristics of non-respondents

Number	Role	Organisation	Clinician	Gender
1	Diversity teacher	Medical school	No	M
2	Communications teacher	Medical school	No	F
3	Communications teacher	Medical school	Yes	F
4	Researcher	Medical school	Yes	M
5	Researcher	University research group	No	F
6	User representative	User organisation	No	F
7	Student		N/A	F
8	Policymaker	Medical organisation	Yes	M
9	Policymaker	User organisation	Unsure	M
10	Policymaker	User organisation	No	M
11	Policymaker	User organisation	No	F
12	Policymaker	User organisation	No	F
13	Policymaker	Medical organisation	No	F
14	Policymaker	User organisation	No	F
15	Policymaker	User organisation	No	M
16	Policymaker	Medical organisation	No	M
17	Policymaker	Medical organisation	No	M

As enough participants had been recruited, only one of these received a reminder

than hypothesis driven (Silverman, 2001). Consequently, further themes emerged as the data were coded. These were then combined and sorted into meaningful areas. Key themes were identified from the transcripts as a whole and from collations of responses to specific themes. Key themes were categorised under the origins, organisation, content, delivery and outcomes of the curriculum. The justification for this was the need to relate findings to existing theory. The themes for the organisation of cultural diversity teaching were organised under the headings when, where and how such teaching might take place.

Findings

The key findings for each area are summarised in Box 2.

Introducing cultural diversity teaching into the curriculum

The organisation of a curriculum is about implementing policies that relate to the subject in question, and one policymaker raised the issue of a national curriculum to ensure consistency of teaching programmes:

> 'This is one of the questions of course, why don't we have a core curriculum, nationally for undergraduate medicine?' (Policymaker)

The issue of a national curriculum is a difficult one for the GMC, because so many individuals and organisations need to be satisfied with the final document. However, the GMC may be missing a key opportunity to lead and support medical schools in an area that has proven difficult to address.

Box 2 Key findings

Introducing cultural diversity teaching into the curriculum

- Cultural diversity teaching not always welcomed
- Uncertainty about where and what to teach in cultural diversity
- Teaching often unsystematic and lacking educational coherence

Where in the curriculum should cultural diversity be taught?

- There was little consensus on where cultural diversity should be taught
- Cultural diversity should not be optional
- Enduring perceptions of the social sciences as common sense extend to cultural diversity

Modular or integrated teaching?

- Consensus that integrated teaching is preferred but few were able to specify on how to ensure that cultural diversity is taught if it is to be integrated
- Teaching staff more likely to want cultural diversity teaching to be integrated

When should cultural diversity be taught?

- Consensus that it should be early: to prepare students appropriately for clinical training, to get in early and challenge them before they became 'medicalised' and to maximise learning opportunities

How much time should be spent on cultural diversity?

- Little consensus about the amount of time but should be more than a one-off lecture, an add-on or an afterthought

While most respondents were committed to cultural diversity teaching in the curriculum, the idea that it is always welcomed was challenged:

> 'One question is how much sort of resistance is there to embracing this really, either within a medical school curriculum ... [ND: "Sorry, how much resistance is there to ... ?"] How much resistance is there, either students or staff to sort of, resistance is perhaps too strong a word, how much either hostility or negativism is there in bringing, confronting these issues [cultural diversity], bringing it into the curriculum and how much again is it viewed negatively within the wider health community itself.' (Communication teacher)

Staff not directly involved in cultural diversity teaching tended to be unaware of teaching in this area, even within their own medical school. This is perhaps not specific to cultural diversity but is highly relevant, especially if the aim of integration of diversity into clinical practice is to be achieved.

Where in the curriculum should cultural diversity be taught?

There was genuine enthusiasm among respondents for cultural diversity to be part of the curriculum for undergraduate medical education and no one felt that it should be an optional component. The widespread acceptance of the view that the social sciences are just common sense has meant that curricula merely accommodate social science topics rather than challenge this view. It is possible that senior medical staff and faculty members deliberately or inadvertently collude with students in this:

> 'I know it's quite interesting how, it started off with social class in medical education and then the psychologists felt left out ... It's interesting how often they [psychology and sociology] cover the same ground in different medical schools. Some people would argue quite strongly that you have to bring them together, that you can't just teach or use them in isolation of one another.' (Diversity teacher)

There was little consensus on where in the curriculum cultural diversity might be taught.

Modular or integrated teaching?

When asked whether cultural diversity (meaning diversity associated with ethnicity or race) should be taught separately from other aspects of diversity or with them, the majority of participants (45) felt that all aspects should be taught together. Only five thought that it should be taught separately. The students among these respondents said that this was mostly for practical reasons. The justification of one of the policymakers was that it is a current (political) agenda. Several participants said that cultural diversity needs to be addressed regularly in clinical sections of the course in a way that is consistent with preclinical teaching.

One of the justifications for teaching all aspects of diversity together was:

> 'My fear is that if you just do it discretely, which is actually what we are doing now, it kind of, it gets sort of compartmentalised. I mean people are pleased that we are doing this, I'm sure they are with you, but this is, ''Oh well, they're doing this there, so that's fine'', sort of ''been there, done that''. We are trying for it to be a core and that it goes right the way through, as far as curriculum, all the way through.' (Diversity teacher)

Three participants favoured combined teaching for practical reasons, for example:

> 'I think they should probably be taught together and I say that partly because of the very constrained time we have

got in the curriculum. I suspect it would be unlikely we would find time to teach them individually, plus the fact I think there are so many common themes running through it, because it's about how you relate to people who might not be the same as you in one of the ways.' (Curriculum lead)

Others supported it for educational reasons:

'I'm cautious about this but I think there probably is a generic attitudinal thing about diversity. I might be wrong, because we know that so many other skills like problem solving, for example, that everybody had hoped was generic is actually very context specific. You might be fantastically open minded and reflective about working with people from an ethnic minority background and whatever, but homophobia might be your particular issue and you just can't handle working with gay people. I think it has to be the individual issues, the individual 'isms, have to be addressed separately but against a foundation of being reflective about it.' (Diversity teacher)

A communication teacher felt that although cultural diversity issues should be an integral part of the curriculum there is a high risk that they would not be taught if not covered in a dedicated module:

'Within each culture there are going to be different priorities, so I think what you are going to tease out, by experience, experiential process, you are going to learn about what are the key things about each of those cultures. I think there should be, rather than just doing a practical exercise, there should be some basic lecture format to support it.' (Communication teacher)

This response indicates a cultural expertise approach, with each 'culture' being fairly homogeneous and its members sharing similar needs.

One student was in favour of integration of diversity teaching because:

'I think to create a module say of cultural diversity would be an error. A lot of universities have gone down a route like this and have had behavioural sciences. What you've got to do is fit them in where appropriate. So you could be teaching genito-urinary medicine and you could include in that a lecture on gender and sexuality issues and that wouldn't need to be taught in a module of behavioural science. It would then be very relevant. Likewise for ethnicity, like if you were doing diabetes, then you could include cultural differences in the Asian population that would be related to that.' (Student)

This is again consistent with the cultural expertise model, in that it presupposes that sexuality issues are relevant only in a single context, when they could easily feature in other contexts, such as diabetes. The consensus was that cultural diversity is not the province of any specific discipline and that it should be taught throughout the curriculum, rather than just as a separate module. It was less clear how this might happen in practice. Policymakers, students and service users were less likely than the other groups of respondents to say that the teaching should be integrated.

When should cultural diversity be taught?

The question 'At which stage of the medical student's career should the teaching take place?' elicited a fairly consistent response, although justifications varied. Fifty of the 61 respondents said that diversity teaching should begin in year one and continue throughout training. Three respondents felt that the teaching should take place before students have contact with patients, which would determine when it might begin.

Communication teachers, curriculum heads and diversity teachers talked about diversity teaching (with or without a professional and personal development component) in terms of the weave of a fabric, by running vertically throughout the years of medical education and horizontally across the modules of the curriculum. Justifications for early inclusion included:

'Certainly within the first term. Just that it's an underpinning principle really. That medicine is about people, not about bodies.' (Service user)

The point that medicine is about people is an important one. As most medical students spend a significant part of their first year of medical school in anatomy laboratories they might well feel that medicine is about inanimate objects, rather than human beings. Diversity teaching at this stage might remind them that they will be dealing with living people. One policymaker guarded against introducing diversity teaching too early without preparing students adequately:

'I just think that doing everything right at the beginning isn't always great. So I think that in a sense it should be there anyway, I mean it should be imbued in the teaching, the construction of teaching materials should be informed by an awareness of the diversity of the population that you are considering ... I think students sometimes find it very difficult to really engage with some of the ethical things that we try to teach them early on before they understand the doctor/patient contract and what medical care is all about.' (Policymaker)

Eight respondents wanted to introduce the subject early to influence students more strongly:

'I think to reinforce that, at the beginning, that those are the right values to have and to build on those and to learn from those being taught as well.' (Service user)

This and other comments indicate a belief that there is a 'right' view or value. If this is stated at the outset, it may inhibit students from exploring their own beliefs.

While there was consensus that cultural diversity should be taught early and should be integrated into the curriculum, the reasons for this were variable and there was little detail on how it might be achieved. Although the majority of respondents had a philosophy for teaching cultural diversity more consistent with the cultural expertise model, the organisation of

cultural diversity teaching by integrating it into the curriculum is more consistent with the cultural sensibility model.

There were three main reasons for supporting early learning in diversity: to prepare students appropriately for clinical training, to get in early and challenge them before they became 'medicalised', and to maximise learning opportunities. No one touched on whether or not any evidence is available to determine when such teaching is likely to have the greatest effect, although most thought that it should continue throughout the curriculum. Policymakers, students and service users did not mention integration as explicitly as respondents from the other groups, perhaps because they are less aware of different types of curricula and methods of delivering educational objectives. The GMC is certainly less clear on how the curriculum should be delivered than on what it should contain (GMC, 1993; 2002).

How much time should be spent on cultural diversity?

The question of the amount of time that needs to be spent in this area was relatively difficult for many respondents and there was no consistent response. Some drew comparisons with other parts of the curriculum to suggest the number of hours. For some respondents, the amount of time spent did not matter as long as the learning outcomes were met.

> 'I think one has to look at the rest of the curriculum and put it into proportion, as well as teaching it. What we should be [doing] is reinforcing it all the way through so that it may be that you only have a small amount of the curriculum devoted to it because if you then keep reinforcing that, you don't need to keep teaching it again as a separate subject.' (Curriculum head)

Those who had struggled to get their own clinical disciplines onto the curriculum were more forward in suggesting a specific number of hours:

> 'I suppose I find that a very difficult question to answer because I think there are so many constraints on the curriculum. When I think of stuff, for example my subject area, and how little time they have for that, I would say at least 20 to 30 hours [of formal contact teaching time].' (Communication teacher)

A respondent having difficulty in answering the question made the following response after prompting:

> 'I think cumulatively it's got to be much more than 12 hours, but then again I don't want to give the impression that somehow, we are so bad at this that somehow we have got to have this huge onslaught. But actually 12 hours in the totality of 5 years' training is a drop in the bucket still compared to what we might spend on other things.' (Policymaker)

There were also those who thought that not much time was needed, although the justification for their belief was unclear:

> 'Probably not that much time ...' (Student)

This respondent generally had a very *cultural expertise* approach, in that she thought cultural diversity teaching would largely involve learning information about groups, and she may not have considered that much time is needed to impart factual information. Another student felt that cultural diversity would be more demanding than many of the other learning experiences if it was addressed appropriately. He felt that learning time should include opportunities for reflection, demonstrating a higher-level approach to learning:

> 'I would have a week of lectures, seminars and group work, so each day would be a normal, sort of phase-one style medical school day, maybe 6 hours' teaching at the most. I actually think a lot of these issues are much more draining to deal with than a lot of the sort of bland basic science that you learn ... I think the way I'd teach it is having a lot of small-group work sessions with people coming in, and it always raises debate and debate's hard work.' (Student)

This response suggests that, in practice, course design may fit more with curriculum structure than educational theory or evidence.

> 'I think you need to have the equivalent of a module throughout the course, basically, in the same way that you would have a module on any of the other major issues.' (Policymaker)

The difficulty in using a term such as *module* is that a module is likely to consist of different amounts of time in each school. Perhaps the message to be taken from this is that diversity teaching warrants a significant block of time, rather than being an add-on or afterthought.

There were also concerns about achieving an overall balance and how this might be done:

> 'This is a hugely controversial issue at the moment. Certainly some of my colleagues think there's far too much time in the curriculum already devoted to this ... But there is criticism that *Tomorrow's Doctors* has kind of swung almost too far away from clinical knowledge.' (Diversity teacher)

There were concerns that the subject should not be 'overdone', as students would then just become bored.

> 'Formal teaching, probably it would be appropriate in every year of the course, a teaching session, just to remind them. You don't want to do it to death because the students will switch off then ... We are expecting the staff who are teaching in clinical situations to be aware of the cultural issues as well as the formal teaching.' (Curriculum head)

There was, perhaps not unsurprisingly, little consensus on the time that should be spent on cultural diversity.

Discussion

One hypothesis was that cultural diversity would be taught systematically, but this was challenged significantly by the review of the literature and the interviews. There were many individual differences in approaching cultural diversity and its introduction into the curriculum. In the interviews, few based their ideas on clear theoretical underpinnings. Many acknowledged the complexity of this area and the absence of clear definitions of the terminology involved.

Medical curricula have developed in an *ad hoc* fashion (Dennick, 1998). Anything that does not firmly belong to the physical sciences continues to be attributed to the behavioural sciences. This means that psychology and sociology may be taught as one block, without enough regard for the distinct approaches of these disciplines (Dogra and Karnik, 2004). Cultural diversity teaching is in limbo – on the one hand it is not thought simply to be part of the behavioural sciences, but on the other that is where it is mostly taught. Through this placement, cultural diversity becomes associated with the lower status of the behavioural sciences in medicine. This was certainly reflected in the responses given.

Some medical schools were clearly finding it difficult to identify exactly where and when cultural diversity should be taught in an integrated curriculum. As there was considerable confusion about where cultural diversity should be taught, it is unsurprising that the organisation of cultural diversity teaching was unsystematic. The lack of a systematic approach to the introduction of cultural diversity into the curriculum is a recurrent theme in interviewees' responses.

Before a subject can be integrated successfully into a curriculum, there needs to be clarity about what is being taught and an understanding of its relevance to the curriculum as a whole. There is no evidence to date that cultural diversity has achieved this position. No one in the interviews raised the issue that, if cultural diversity were not taught separately, students might not realise that it was being taught; nor did anyone advocating integrated teaching comment on the need to ensure that students are aware that it is being taught. This is perhaps particularly important in light of a recent finding by Wachtler and Troein (2003) that students often miss the hidden curriculum.

Whether diversity teaching is integrated or not, there may be a need to be transparent about its inclusion. Those developing problem-based programmes may assume they have addressed such issues, but deeper examination shows this is often not the case (Turbes *et al*, 2002). One teacher had reservations about whether their problem-based learning course covered cultural diversity at all, and if it did, that it was being addressed only superficially. It was clear from the interviews that, on the whole, cultural diversity teaching is not yet integrated into medical school curricula, either vertically through the years or horizontally across different modules, although there are programmes that aim to develop this, especially within professional personal development (Dogra *et al*, 2005). Many accepted that it should be an integral part of clinical practice. Pragmatically, however, participants thought that if not addressed as a separate issue, it is unlikely to be taught. Until there is a clearer educational framework, it is unlikely that the place of cultural diversity teaching can be clarified. Until that has been addressed, it is difficult to see how the teaching can become systematic and proactive rather than a reaction to political pressures. This would perhaps suggest that specific teaching on cultural diversity is required irrespective of whether it is integrated into other teaching.

Time spent on cultural diversity teaching in reported programmes ranges from as little as one 90-minute seminar (e.g. Sifri *et al*, 2001) to 20 2- or 3-hour sessions (Crandall *et al*, 2003), which reflects the widely ranging views shown above. Participants in this study felt that student attention and time might be better guaranteed by ensuring that such issues had a place in high-stake examinations. There was also the pragmatic approach that one has to work with whatever the conditions are, and it is easier to start and then improve a course rather than waiting for a perfect course to be developed before implementation. Most participants, however, believed that cultural diversity should be part of the core curriculum and that it warrants more than a one-off teaching slot or being taught as an add-on to other modules, suggesting it needs more priority than it currently has.

The findings suggest that medical schools and perhaps also other institutions may benefit from reviewing their cultural diversity teaching and reflecting on whether it is organised in an educationally coherent way. Teachers establishing new courses may want to consider how they organise their teaching.

A limitation of this study is that some staff not involved in cultural diversity but involved in medical education, who do not value diversity, were unlikely to be identified or participate. The 'right' people may not have been selected. Given that interviews rely on the relationship established between the researcher and the participants, there is always the limitation that the research can be contaminated by the characteristics of the researcher. As the policymaker group is perhaps the most influential and fairly broad, more members of this group were invited to participate than from

other groups and their views may be over-represented. However, their views were not dissimilar to the range of views of other groups.

Conclusion

Although the respondents were enthusiastic about the inclusion of cultural diversity in the curriculum, some felt that they did not necessarily reflect the views of others within medical schools. There was a consensus that cultural diversity needs to be taught early and most felt that it should incorporate more than just ethnicity. Most felt that it should be integrated into all aspects of the curriculum. There is no evidence to suggest that existing approaches to the development of cultural diversity teaching have been systematic. This has created a mismatch between what is actually happening and what respondents felt should be happening. The fact that cultural diversity teaching has been indicated by the GMC, but without implementation guidelines, has resulted in an unsystematic approach to its inclusion in medical school curricula. This means that the place and organisation of cultural diversity teaching in the medical curriculum remain unclear and variable, and the subject appears to lack credibility with faculty and students. There is clear consensus among stakeholders regarding how the subject should be taught, although methods are mostly unsupported by any theoretical framework. It is promising that cultural diversity teaching is on the educational agenda. However, there is a need to develop diversity education within a coherent educational framework that will make it clear where and why it is being taught.

ACKNOWLEDGEMENTS

ND conducted the study, analysed the data and wrote the paper. She would like to acknowledge the support of the University of Leicester through a semester's sabbatical to complete her PhD and also all those who participated in the study. Thanks are also due to her PhD supervisor Dr Nick Jewson. She would also like to acknowledge the contribution of Lynette Maddock who helped with some editorial support. The reviewer comments were also most helpful.

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CONFLICTS OF INTEREST

None.

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Received 8 July 2005
Accepted 5 September 2005