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Research papers

Opinions of medical practitioners completing a certificate in medical education with regard to 'culture' in the undergraduate medical training: a pilot project

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ABSTRACT

This study aimed to establish what and how British medical students should be taught about cultural aspects of medicine in the undergraduate medical curriculum. Twenty-four doctors attending for a Certificate in Medical Education in the UK were asked to complete a questionnaire by email. The response rate was 50%. The Delphi technique was used to obtain consensus. Cultural presentation of illness and cultural aspects of the doctor–patient relationship were ranked as being the most important themes for students to be taught. Problem-based learning and peer tutoring were considered the most appropriate ways of teaching cultural themes. There was little discussion of self-reflexivity and issues of racism in medical education.

Keywords: culture, Delphi technique, medical students, teaching

Introduction

It has long been acknowledged that a person's health beliefs and communication style play a critical role in medical care. The issues of cross-cultural communication and variations in health beliefs not only impact on patient satisfaction but can also impact on clinical outcomes. The topic of cultural competence is currently one of great interest in the area of health education. The term *cultural competence* relates to those learned skills that help us to understand cultural differences and ease communication between people who have different ways of conceptualising health, sickness and the body.

In its document *Tomorrow's Doctors* the General Medical Council has emphasised the need for student doctors to be culturally aware and to be able to communicate effectively with individuals regardless of their social, cultural or ethnic backgrounds (General Medical Council, 1993). Beagan (2003) argues that medical schools need to produce doctors who are sensitive to, and competent in working with, members of diverse communities. Such sensitivity and competence require a balance between attention to differences, to the self, and to power relations. The American Association of Medical Colleges considers skills in cultural competence to be essential for the provision of quality healthcare to a diverse patient population, and call for integration of cultural competence programmes into medical school curricula (Masters, 1998).

In the UK, Prideaux and Edmondson (1999) argue that the teaching of cultural diversity, development and cultural awareness is an 'ubiquitous priority' in medical education and that students need to be able to understand the strengths and weaknesses of their own cultures and cultural identity. In a similar way Kai *et al* (1999) point out:

> Valuing ethnic (cultural) diversity embraces acknowledging an individual's culture in its broadest dynamic sense, for example a patient's ethnicity, education, socio-economic background, religion, prior health experiences and values. It requires a heightened awareness of our own cultural attitudes and sensitivity to issues of stereotyping, prejudice and racism.

Knowledge of cultural issues is essential for medical students and should have a place in the curriculum. However, there is evidence from the USA (Lum and Korenman 1994; Zweifler and Gonzalez, 1998; Louden *et al*, 1999; Flores *et al*, 2000), Holland (Van Wieringen *et al*, 2003) and the UK (Poulton *et al*, 1986) that suggests that courses addressing this issue are rare in the undergraduate medical curricula in those three countries. A recent survey in the UK showed a different picture. Dogra *et al* (2005) aimed to identify the extent to which cultural diversity was being taught in medical schools in the UK and the Republic of Ireland. The study found that 72% of medical schools reported some teaching in cultural diversity, although there was marked variability between the amount and types of this teaching. The authors emphasise the fact that some progress has been made since the publication of a survey by Robins (1995), which pointed to the fact that little attention was given to cultural issues in the medical curriculum.

Given Dogra *et al*'s (2005) findings, the question then arises as to how cultural competence skills can best be learned. To date there is a relative dearth of literature on this topic with regard to medicine. Ochoa *et al* (2003) argue that it is impossible to learn the subtleties of each of the world's cultures and therefore physicians must be equipped with a set of skills with which they can approach a patient from any culture. Kai *et al* (2001), using a focus group design, examined the views of medical students and general practitioner (GP) registrars about training to work in an ethnically diverse society. Participants were found to have a broad but superficial awareness of multicultural issues and generally focused upon the need to learn about '*difference*', such as differences in cultural beliefs, expectations and different patterns of disease and prejudice, but rarely identified the need to examine their own attitudes or issues of racism. Informants generally emphasised a '*recipe*' approach, that is to say the passive acquisition of knowledge about how a disease or behaviour might differ across different cultural groups, rather than one emphasising self-reflection and the generic skills to respond flexibly to individuals of any background, which the authors term a '*person centred approach*'.

Kai *et al* (2001) go on to point out the importance of self-reflection in examining attitudes towards other cultures, and particularly in relation to overcoming racism and stereotyping. Dogra (2001) presents some ideas about how this process of self-reflection might be achieved, using a human diversity module in which students can examine their attitudes about other cultures. This module included several exercises relating to cultural stereotyping, defining one's own culture, and interviewing individuals from different cultural backgrounds

To date there have been no studies specifically examining the opinions of medical teachers about how cultural diversity issues should be taught to medical students. The study reported here focused on a group of doctors who are also medical student teachers attending a course in medical education in London.

The aims were to:

- establish the opinions of a group of doctors with an interest in medical education about the needs of medical students with regard to learning about culture
- gain consensus within the group about:
  - the key areas/tasks in which students need to know about culture
  - how best the topic could be taught in the curriculum.

Methodology

The study was based on the Delphi technique, a form of consensus methodology (see Jones and Hunter, 1995). Consensus methods aim to determine the extent to which experts or lay people agree about a given issue, and are useful when there is a lack of consensus about a given topic. In the Delphi technique, informants are contacted by a postal questionnaire or by email, and are asked to provide ideas or opinions about a particular subject area. The data are anonymised and the method has the advantage of avoiding the need to organise expensive meetings. In this study the Delphi technique was applied in two stages. In stage 1, a questionnaire was devised following discussion with two class members and a course tutor (see Box 1). This was then emailed to participants who were asked to give their opinions about the teaching of culture to medical students. Participants were asked to include as much detail as possible and to provide concrete examples. Using content analysis, the participants' opinions were grouped together into a number

Box 1 Questionnaire

Please answer as fully as possible

1 Is there a need for doctors to understand a patient's culture?
2 If you agree, why?
3 What particular aspects of a patient's culture do doctors need to understand?
4 How can medical students be taught about culture?

of themes. In stage 2, these themes were sent to all participants with a request to rank their agreement with a number of statements. Agreement with the statements was summarised by using the median score, and consensus assessed by using interquartile ranges for continuous numerical scales (see Moscovice *et al*, 1988 for a further discussion of the Delphi technique).

Sampling

Twenty-four doctors studying for a Certificate in Medical Education in London were sent an email questionnaire asking about the teaching of culture to medical students. The age of the doctors ranged from 29 to 63 years. The sample comprised 21 men and three women. All the participants were hospital specialists, varying between senior house officer (SHO) and consultant level, apart from one who was a GP. Their specialties ranged from surgery (two) to various medical specialties including gastroenterology, sexually transmitted diseases, cardiology, respiratory medicine, genetics and psychiatry. In terms of ethnicity (ascribed by the author) four were South Asian, 19 were white British, and one was North African. All the doctors had some experience of working with ethnic minority patients in the UK.

Findings

Twelve participants (50%) responded to the questionnaire. All 12 participated in stage 2. Analysis showed two major themes emerging from the data: what students should be taught about culture and how they should be taught. Each theme contained several subthemes. Each theme is presented and discussed below. Table 1 highlights the various themes and their rankings.

Theme 1: what students should be taught about culture

Statement A: there is a need for medical students to understand a patient's cultural background

All the doctors agreed that there was a need to understand the patient's cultural background for reasons that ranged from issues related to consent, the doctor–patient relationship, making a diagnosis to compliance with treatment (see Table 1). For example:

> 'Any patient's response to medical care will be profoundly affected by their culture, so a doctor cannot be fully effective unless he/she has at least a reasonable understanding of that culture.' (South Asian physician)

Table 1 Rankings

	Median	Interquartile range
Theme 1: what students should be taught about culture		
Cultural aspects of doctor–patient relationships	2	1.0–3.5
Cultural aspects of presentation of illness	2	1.5–3.0
Cultural aspects of death and dying	4	3.0–5.5
Cultural aspects of the body	4	3.5–4.5
Cultural aspects of pain	6	5.0–10.0
Cultural aspects of birth	6	5.0–9.0
Cultural aspects of the family	7	5.5–8.0
Cultural aspects of diet and dietary taboo	8	7.0–9.5
General overview	9	5.0–9.0
Social structure	9	8.5–10.0
Sex	10	8.0–11.0
Theme 2: how students should be taught about culture		
Problem based teaching	1	1.0–1.5
Medical student teaching	2	1.0–3.5
Videos	4	3–5
Structured lectures	4	3.0–6.0
Community visits	4	3.0–4.0
Ward round teaching	5	5.0–6.0

'[It is important] to put the hopes/fears into perspective and gain an understanding of what the patient believes is important.' (South Asian physician)

'Because if ignorant of cultural nuances and the different ways that illnesses are presented depending on the patient's background, incorrect diagnoses may be made or diagnosis may be delayed leading to wasted resources and patient dissatisfaction. Also doctors may offend patients leading to embarrassment and potentially causing the patient to avoid follow-up.' (White British physician)

'[It is important] to maintain communication essential for the maintenance of a good doctor relationship, to ensure informed consent and to maximise compliance with treatment.' (White British surgeon).

Statement B: students cannot learn everything about every culture

Six doctors pointed out that it was impossible to teach students everything they might need to know about all the different cultures encountered in clinical work (see Table 1). For example:

'The probability is that a recognition of cultural differences, rather than knowledge of, is the important factor. In fact it is very difficult to have a pluripotential knowledge base that can deal with everything that walks into a clinic/clinical setting, but if you recognise and are sensitive you can modify your approach and learn from the experience. Attitudes are difficult to change unless the individual has undergone reflective learning via exposure and insight challenge. This is the way to attempt change. Yes you should try it.' (South Asian physician)

Statement C: medical students should be taught about cultural issues of doctor–patient relationships

A number of aspects of a patient's culture were cited as being relevant to medical student training. Cultural aspects of doctor–patient relationships were ranked most highly (see Table 1). Informants pointed out that there were differences in authority in different cultures. For instance, in India doctors are generally respected and paternalistic, whereas in the UK patients are more likely to challenge them. Five doctors pointed to the fact that there were differences in communication styles between different cultural groups. This was especially the case for breaking bad news. In non-Western cultures, for example, it is often the family who are given a life-threatening diagnosis rather than the patient themselves. As one participant explained:

'Where I am from in India, patients are rarely told that they have a diagnosis of cancer. We generally tell the family instead who will often hide this from their relatives. Some people believe that telling patients their diagnosis might harm them in some way or make them suicidal.' (South Asian physician)

One doctor pointed out how illness is explained in different ways in different cultures and that doctors should respect these different understandings:

'Where I come from, the uneducated patients think that problems such as gastroenteritis are caused by spirits. They go along to healers who try to get rid of the spirits or give them some sort of herbal medicines. This can be dangerous. We need to teach patients about the real causes of their illnesses. But I think that doctors do need to respect other sorts of treatment which are not medical.' (South Asian doctor)

Statement D: students need to be aware that illness presentations differ between cultures

Cultural influences affected the ways in which illness was presented (see Table 1). Somatisation of illness, the expression of psychological distress in terms of physical symptoms, was cited as a frequent occurrence, and participants pointed out that it was important for doctors to be able to recognise such differences since failure to do so might mean missing emotional distress and giving excessive physical treatments. For example:

'When patients from ethnic minorities are depressed they often present with physical symptoms. This might mislead the doctor and stop them picking up a diagnosis such as depression. They may be treated inappropriately for a physical condition.' (White British physician)

Statement E: medical students need to understand how different groups of patients and their families deal with death and dying

Seven participants raised the issue of death and dying (see Table 1). They emphasised the need for patients and families to perform various rituals in relation to death and dying and the importance of religion in people's lives at such times. For instance, one Muslim doctor said:

'Religion is important for patients who are dying. Some patients derive benefit from prayer or seeing an Imam. Their families also feel this is important.'

Theme 2: how students should be taught about culture

Statement A: problem-based learning

Problem-based learning was ranked most highly (see Table 1). Participants spoke of how any clinical problem could be analysed in terms of its cultural aspects. For instance, students could be presented with a clinical scenario and asked about the role of the patient's culture in the presentation, diagnosis and

management. One informant gave the following example:

> 'We could give a clinical example. For instance, a Muslim woman presenting to a male gynaecologist. What might the cultural problems be and how could they be overcome? We could also discuss the role of her family here and their attitudes to health-seeking behaviour.' (White British doctor)

Statement B: peer teaching

Second in ranking was peer teaching (see Table 1). Here doctors held that a medical student from a specific culture might be able to teach other members of his/her firm about aspects of their culture that were relevant for medicine. However, they acknowledged that because someone derived from a particular cultural group, this need not imply that they had the skills or knowledge to teach others about their culture. One informant, a white British physician, discussed the issue of stereotyping, and pointed out that it must not be assumed that everyone from a given cultural group will necessarily behave in the same way as everyone else from that culture or indeed be an expert in that culture.

Participants ranked other forms of teaching such as videos, structured lectures and community visits as less important. However, two participants did point out that community visits could be good ways of learning about other cultures, especially about lifestyle and the home environment. For example:

> 'You can learn a lot from seeing someone's house. It gives you a good idea about their lifestyle, who lives there, and it can teach you a lot about their culture. People often behave in different ways at home compared to when they see you in the surgery.' (White British doctor)

These finding indicate a high degree of consensus among doctors in this sample concerning what should be taught about culture and how this could be taught to medical students.

Discussion

This is the first study of its kind using consensus methods to elicit agreement about the teaching of culture to medical students. All participants agreed that it was essential to teach something about culture to medical students, although there was variation in what they considered should be taught and how it should be taught.

Participants emphasised the importance of learning about cultural differences. As in Kai *et al*'s (2001) study, there was little discussion about the need for students to be self-reflexive and to examine their own attitudes towards culture and racism. Instead participants emphasised the 'recipe' approach to cultural teaching, favouring the passive acquisition of knowledge about how a disease or behaviour might differ between different cultural groups. As these authors point out, an exclusive focus on 'difference' might in itself reinforce unhelpful stereotyping and stifle the opportunity for self-reflection upon attitudes, or for developing transferable skills to respond to diversity.

The themes discussed by the informants are very similar to themes commonly addressed by medical anthropologists in relation to working with patients from non-Western cultures, including the relevance of cultural background to the presentation, diagnosis and treatment of illness. For example, Kleinman (1980) discussed in detail how cultural factors shape the illness experience. His work in China and Taiwan may be used as a paradigm to understand other medical systems across the world. In particular he pointed out how, in many non-Western cultural groups, affective states such as depressive illness present predominantly with physical symptoms. Like the informants in this study, he cautions against the over-diagnosis of physical illness at the expense of missing psychiatric problems (see Helman, 2000 for a further discussion of these issues).

There is an evolving literature on how doctor–patient relationships differ between cultures and, specifically, how patterns of illness communication may vary in different cultural groups. Much of this literature derives from the cancer field and points to the fact that, in non-Western cultures, it is commonplace for families, as opposed to individual patients, to be told a life-threatening diagnosis (Moore and Spiegel, 2004). This has clinical significance in the UK for health professionals in oncology and palliative care who work with such cultural groups. In the UK it is normal to disclose a serious diagnosis to individual patients. Ethnic minority family members may be strongly opposed to this. Thus there may be ethical dilemmas posed for healthcare professionals working with these groups.

In terms of how cultural issues should be taught, participants favoured problem-based teaching about specific patients from differing cultural groups. In their view, a general overview of various cultures may not relate directly to the working experience of different doctors whereas problem-based learning involves focusing on the examination of particular events, usually through written clinical cases. In this context, students could be provided with various clinical scenarios or vignettes and asked to examine the role of cultural factors in each one. This method is currently deployed by the author to teach cultural aspects of mental illness as part of an MSc in culture and mental health.

Teaching by peers from ethnic minority groups was ranked as the second most appropriate teaching method. There has been some interest in peer tutoring. For example, Topping (1995) provides some evidence for the effectiveness of this form of teaching in both schools and higher education. However, there is as yet no work examining the teaching about culture by this method. Discussions with students from other cultures, who hold different cultural identities, might facilitate the development of cultural awareness, foster cultural safety and enhance respect for diversity (Prideaux and Edmondson, 2001).

The importance of cultural issues in the teaching curriculum has received increasing recognition among other groups of health professionals. For instance, in nurse education, there is a growing literature on transcultural aspects of nursing (Leininger, 1991; Papadopoulos *et al*, 1998; Gerrish and Papadopoulos, 1999; Leininger and McFarland, 2002; Papadopoulos and Lees, 2003). Papadopoulos *et al* (1998) propose a model of transcultural nursing involving four stages: cultural awareness, cultural knowledge, cultural sensitivity and cultural competence. The first stage in this model, cultural awareness, begins with a critical examination of personal values, beliefs, cultural identity and their influence on people's health beliefs and practices.

The second stage, cultural knowledge, derives from a number of disciplines: anthropology, sociology, psychology, biology, nursing and medicine as well as interactions with people from different ethnic groups. Cultural sensitivity entails the development of appropriate interpersonal relationships with clients. Finally students acquire cultural competence, which the authors see as the capacity to provide effective healthcare, taking into account people's cultural beliefs, behaviours and needs. This model emphasises the development of a set of culturally generic competencies that are applicable across cultural groups, rather than the acquisition of cultural knowledge about different cultural groups. This model, which is becoming popular in undergraduate and postgraduate nurse education in the UK, awaits further evaluation (Papadopoulos *et al*, 1998).

Limitations of the study

There were several limitations to this study. The sample was small and the response rate was only 50%, despite asking participants to reply to the questionnaire on several occasions. It is possible that only those who were interested in the subject responded. Further large-scale research is needed to ascertain whether the findings presented here are an accurate reflection of the thinking of professionals. In addition, the author did the analysis alone. It would have been preferable to check the themes with a co-researcher to assess their reliability (Mays and Pope, 1996). Finally, face-to-face interviewing might have elicited more differences of opinion than using email.

Conclusion

The field of medical education has largely neglected the issue of culture. This small-scale study demonstrated that informants generally emphasised the importance of teaching about cultural difference, but few spoke about examining attitudes to diversity. There is a need to teach doctors about a person centred approach based on enabling them to examine their own attitudes and beliefs about culture, stereotyping and racism.

This study also shows that there is a need to teach medical students about cultural aspects of health, possibly as part of a social sciences module or perhaps through the inclusion of teaching by a medical anthropologist. Another possibility is that medical anthropology could be introduced as a special study module for students, or that computer-based programmes could be deployed with this aim. At present, in the UK, medical anthropology is not included in the medical school curriculum.

Finally, there is a need to repeat this investigation with a much larger sample of doctors, perhaps extending it to an examination of the views of medical students and a comparison of their views with those of doctors.

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CONFLICTS OF INTEREST

None.

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