THE LEARNING AND TEACHING OF CULTURAL DIVERSITY IN UNDERGRADUATE MEDICAL EDUCATION IN THE UK

THESIS SUBMITTED FOR THE DEGREE OF DOCTOR OF PHILOSOPHY TO THE UNIVERSITY OF LEICESTER

BY

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Declaration

I certify that this thesis represents original research carried out by me with the help of those persons outlined in the acknowledgements. It does not contain material previously submitted for a degree or diploma in any university and, to the best of my knowledge and belief, does not contain any material previously published by any other person, except where due reference is made in the text.

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Abbreviations
AMA: American Medical Association
AAMC: Association of American Medical Colleges
AAP: American Association of Paediatrics
AMRC: Academy of the Medical Royal Colleges
BMA: British Medical Association
BMA MSC: British Medical Association Medical Student Committee
CHMS: Council of Heads of Medical Schools
GMC: General Medical Council
MedSIN: Medical Students International Network
MCQ: Multiple-choice question
OSCE: Objective structured clinical examination
SAQ: Short answer question
SCHM: Sainsbury Centre for Mental Health
UK: United Kingdom
US: United States of America

Notations
The following notations are used in the quotations of the respondents in the findings.
“...” Represents the opening and closing of the quote
// Represents a pause
[] With text within these brackets has been inserted by the author to explain the meaning made by the respondent.
… Between sentences indicates the quite has been shortened and linked to appropriate relevant sentences.

Quotations from the literature are indented and non-italicised.
Single quotation marks convey terms used by medical educationalists and lay people but imply that there is inconsistent usage.
Single quotation marks plus italics show concepts developed within the analytical framework by the author; for example, ‘cultural expertise’.
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Abstract
Nisha Dogra: The learning and teaching of ‘cultural diversity’ in undergraduate medical education in the UK

The aim of this thesis is to identify and analyse the origins, organisation, contents, delivery and outcomes of the learning and teaching of ‘cultural diversity’ within undergraduate medical education in the UK. Literature reviews of the history of medical education and relevant educational theory were conducted. Two ideal type models of ‘cultural diversity’ teaching programmes, designated as the ‘cultural expertise’ model and the ‘cultural sensibility’ model, were devised. Comparisons were made between the educational philosophy, educational process, educational content and outcomes of the two models. The models were then utilised as benchmarks against which to analyse and compare approaches and programmes to the teaching of ‘cultural diversity’. The main research objective was to identify perceptions and evaluations of the teaching and learning of ‘cultural diversity’ held by a range of stakeholders in medical education including policymakers, school heads, teaching staff, researchers, students and users. Qualitative interviews of 61 respondents and documentary analysis were undertaken. The key findings are that the origins of ‘cultural diversity’ education have been driven more by political than educational agendas. As a result, the development of ‘cultural diversity’ teaching has not been systematic and has been inadequately informed by available theory or evidence. Programmes have evolved through the advocacy of individuals, many of who have not been involved in the development of education strategy. Contents and assessment processes are driven largely by ideas that are consistent with the ‘cultural expertise’ ideal type but the desired outcomes in clinical practice and for students are more in line with the ‘cultural sensibility’ model. Ambivalence towards assessment in this area, and the management of students who demonstrate inappropriate attitudes needs resolution since the current position undermines the development of the subject. Specific recommendations for each stakeholder group are included and the thesis concludes with ideas for future research.
Chapter 1: Introduction to thesis and reading guide

1.1 Aims and objectives of the thesis

The aim of this thesis is to identify and analyse the origins, organisation, contents, delivery and outcomes of the teaching and learning of ‘cultural diversity’ in undergraduate medical education in the UK. At present, ‘cultural diversity’ in medical education broadly comprises policies, pedagogic practices and educational programmes directed towards issues surrounding ethnicity. The origins of ‘cultural diversity’ will be explored through an examination of the roots and development of medical education, with particular reference to the watershed represented by the policy document published by the General Medical Council (GMC) in 1993 under the title *Tomorrow’s Doctors*. Consideration of the organisation of ‘cultural diversity’ will entail an examination of the place of ‘cultural diversity’ within the structure of the curriculum and the status given to teachers of diversity. The relevant educational theories and philosophies are also examined. The contents and delivery of ‘cultural diversity’ programmes will be explored through a review of educational programmes in existence.

In this thesis, terms used by medical educationalists but which lay people identify, are contained in single quotation marks such as ‘cultural diversity’. Concepts developed within the analytical framework by the author are italicised and within single quotation marks; for example ‘cultural sensibility’.

This thesis has nine main objectives described below with the chapter that meets the objective in brackets:

1. To describe and review the origins of ‘cultural diversity’ in medical education in the UK (Chapter Two)
2. To identify the official rationale of the policies that influence undergraduate medical education in the UK (Chapter Two)
3. To examine educational theory and its relationship to medical education as relevant to ‘cultural diversity’ teaching (Chapter Three)
4. To develop ideal type models for ‘cultural diversity’ teaching (Chapter Four)
5. To review the educational approaches programmes currently in place and relate them to current policies, educational theory and the ideal type models (Chapter Five)

6. To identify which medical school courses have explicit ‘cultural diversity’ teaching in the UK and to apply the ideal types of ‘cultural expertise’ and ‘cultural sensibility’ to these programmes (Chapters Six)

7. To identify perceptions and evaluations of ‘cultural diversity’ and its teaching held by policy makers, faculty staff, teachers, medical students and service users and advocates in the UK (Chapters Six).

8. To describe the findings and identify how the perceptions of ‘cultural diversity’ by stakeholders in medical education compare with the ideal type models of ‘cultural expertise’ and ‘cultural sensibility’ (Chapters Seven to Ten).

9. To analyse the findings in relation to the origins, organisation, contents, delivery and outcomes of the teaching of ‘cultural diversity’ (Chapters Seven to Ten).

1.2 Terms and concepts

Before considering in detail the research objectives and aims, the term ‘cultural diversity’ needs to be clarified. Medical educationalists take ‘cultural diversity’ predominantly to refer to race and/or ethnicity (e.g. Robins, 1995; Loudon et al, 2001). Therefore, the author uses the issue of ethnicity as a principle example to illustrate and analyse the concept of diversity for the purposes of developing educational models. In this thesis, there is an underlying principle, that ethnicity is only one aspect through which individuals might choose to identify themselves. Other aspects include sexuality, religion and gender. The principles that apply to ethnicity can be generalised to these other aspects. It views any difference as diversity. It does not make judgments about the difference in groups but accepts that there is diversity within society and that future doctors need to be able to deal with diversity. Therefore, in this thesis ‘cultural diversity’ is used to include diversity based on ‘race’ and ‘ethnicity’ but allows for diversity based on other criteria.

The author argues that there is great variation in the way ‘cultural diversity’ is understood and used within medical education; part of the thesis explores this variation and its impact on the types of teaching programmes developed. It is unclear how those involved in medical education in the UK conceptualise ‘cultural diversity’, whether it should be taught, and how it should be taught. The extent to which medical education utilises the work that
exists in the body of educational theories to formulate and deliver teaching is also unclear.
The main research question attempts to investigate how medical stakeholders (such as policymakers, teachers, service-users and students) conceptualise the term ‘cultural diversity’ and issues related to the learning and teaching of ‘cultural diversity’. It is imperative that the origins and current state if cultural diversity are identified to support future developments in this area. As will be demonstrated through the reviews relatively little is known about how ‘cultural diversity’ teaching has developed. It is unclear whether or not any conceptual or educational frameworks have been utilised in developing the teaching. The key research question needs to be addressed in order to identify the gaps that exist so that future work can be undertaken in a clearer context.

Campbell and Johnson (1999) argued that active debate is needed for knowledge to evolve in medical education and that a barrier to true debate in medical education is a lack of conceptual clarity. They believed that discussants did not need to be unanimous in their definition of a concept but they must be clear about how they conceptualise particular trends or fashions, so that other practitioners understand what they mean.

Within the healthcare arena, there is also considerable confusion about the use of other key terms such as ‘race’, ‘ethnicity’, ‘culture’ and ‘multiculturalism’ as highlighted by Mulholland and Dyson (2001). In response to guidelines to tackle perceived inequalities in access to healthcare, medical educators have attempted to address issues related to ‘race’, ‘ethnicity’ and or ‘culture’. However, they have not always been explicit as to how terms are being used. ‘Cultural diversity’ is often used as a synonym for ‘race’, or ‘ethnic’ differences (e.g. Robins, 1995; Loudon et al, 2001). The way the terms are used can also imply that only those with ‘ethnicity’ have cultural differences.

The use of ‘cultural diversity’ in this thesis is broadly consistent with perspective on the concept of culture adopted by the Association of American Medical Colleges (AAMC) Task Force (1999) when reporting on communication in medicine in *Spirituality, cultural issues and end of life care*. It defined culture as:

“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, occupation, among others. These factors may impact behaviours 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 healthcare professionals perceive health and illness and how they interact with one another” (AAMC, 1999: 25).

The Jordan Institute for Families (2000) is one of the few organisations that defined culture in a similar way and then set out to apply the term in the way that it is defined.

Culture is not a value free concept. There are many sociological definitions of this and when sociologists attempt to define these terms they bring with them their own history, which plays a part in understanding the way they see and use these terms. All three terms are widely used in the everyday world and the ways the terms are used varies considerably. Smith (2000: 4) summarised the dilemma concisely, “Culture is an important but can be a slippery, even a chaotic, concept. It can mean a great deal when its scope and relevance are clearly defined and yet also very little, especially when it is used as synonymous for the social.” However, whilst sociologists may choose a variety of ways in which to define culture, one cannot discount that the concept of culture, cultural identity or belonging to a cultural group involves a degree of active engagement by individuals and is a dynamic process. It is problematic to assign culturally categories externally and based only on certain characteristics. There needs to be a recognition that individuals make sense of themselves in relation to the cultural groups with which they identify themselves with or are externally ascribed to in different ways. Memberships of some groups is voluntary but for others may not be. How much an individual chooses to identify with a group to which he/she is assigned varies from person to person Concepts of culture and understanding cultural groups imply understanding the hierarchies and rules of conduct of that group.

The concept of identity is closely related to the idea of culture. Identities can be formed through the cultures and subcultures to which people belong or in which people participate. However, different theories of identity see the relationship between culture and identity in rather different ways. Frosh (1999: 413) described the view that identity draws from culture but is not simply formed by it in the following way:
“Recent sociological and psychological theory has stressed that a person’s identity is in fact something multiple and potentially fluid, constructed through experience and linguistically coded. In developing their identities (and their sense of cultural belonging) people draw upon culturally available resources in their immediate social networks in society as a whole”.

Given that the focus of this thesis is cultural diversity in the context of medical education, the definition of culture used is consistent with that of the AAMC (1999: 25). This is a patient-centred definition and can be applied to clinical situations. The AAMC definition is an application in practice of Frosh’s definition; that is, that individuals draw upon a range of resources and for themselves through the interplay of external and internal meanings construct a sense of identity and unique culture. Patients will themselves define which aspect of their cultural belonging is relevant at any particular point. This may change in different clinical contexts, at different stages of an individual’s life and may also depend on the clinical presentation itself. For example, the issue of gender may be more relevant to a woman where she is faced with the possibility of a mastectomy because of breast cancer, than in the case where abdominal surgery may be required (although of course this may raise other issues). This is not to underplay the complexity of the term but to use it in a way that it is suitable for the context. There is a vast sociological literature relating to culture. This is not included in this thesis because the academic debates about the meaning of culture are less relevant here than the interplay between culture and identity, which involves the individual’s perception. The latter is more relevant in medical education and clinical contexts.

In a review of the relationship between mental health services and African and Caribbean communities, the Sainsbury Centre for Mental Health (SCMH, 2002), considered the usage of terms and their potential impact on the training provided. This report explicitly considered the effect of the confusion that exists in healthcare arenas and of group-based approaches to dealing with ‘cultural diversity’. It recognised that political rather than educational agendas have often influenced the educational programmes developed. The document has a clarity, which is often lacking in other documents. The report stated that the centrality of issues of ‘race’ and ‘culture’ for mental health services should not be underestimated but nor should they be used to reinforce stereotypical views about minority
ethnic communities. The report stated that in some circumstances, the term 'culture' is used in a similar way to 'race', i.e. immutable and fixed physical attributes and/or behaviours. Elsewhere, the term seems to denote a set of shared beliefs or a system of kinship. In the context of mental health this approach was perceived as problematic, as the individual's culture needs to be understood for that individual, rather than extrapolated from given generalities. They felt this is particularly relevant as many 'cultural awareness' courses aim to define or predict the characteristics of certain ethnic groups, along with a set of standard responses by professional workers, by means of overarching generalisations.

SCHM believed that service users were demanding a positive attitude and a person-centred approach, irrespective of the background of the staff member. Ethnic matching between user and provider assumes that there is a shared culture between the two, which is not necessarily true. The notion of staff from ‘similar cultural backgrounds’ rests upon the assumption that people who originate from similar geographical regions, or have similar skin colours, are likely to share views or understand one another on a complex range of elements that comprise ‘culture’ and ‘race’. They concluded that staff need to adopt a more open position of questioning and learning rather than taking refuge in the false security of predictive information. Staff also need to recognise similarities rather than concentrate on differences. SCHM argued that ‘cultural’ approaches have a tendency to homogenise communities and stereotype individuals; inappropriate use can hinder a clinical approach that is sensitive to an individual client’s needs. There was also concern on reliance on specialist agencies as the sole engines of ‘cultural’ change.

SCMH (2002) also commented on staff concerns that race and culture issues cannot be freely discussed and ‘political correctness’ is implicitly blamed. The report acknowledged that, at times, attempts to address racism and sexism have focused on the ridiculous. ‘Political correctness’ can also be viewed as a tool used by the American political right to discredit the whole political project. The SCHM review stated that any initiative against racism or sexism is likely to be met with the charge of political correctness by those opposed to changes. They felt it is necessary to achieve a rational balance between outlandish prohibitions on behaviour or language (e.g. black coffee) and reasonable criticism of racism.
In the UK, there has been little consistency in the way concepts of ‘cultural diversity’ are addressed. In the US, the notion of ‘cultural competence’ has been developed to address such issues. A widely used definition of this provided by Cross et al (1989) stated:

“The model called “cultural competence” ... involves systems, agencies and practitioners with the capacity to respond to the unique needs of populations whose cultures are different than that which might be called “dominant” or “mainstream” American. The word culture is used because it implies the integrated pattern of human behaviour that includes communications, actions, customs, beliefs, values and institutions of a racial, ethnic, religious or social group. The word competence is used because it implies having the capacity to function in a particular way: the capacity to function within the context of culturally integrated patterns of human behaviour as defined by the group. While this publication focuses on ethnic minorities of colour, the terminology and thinking behind this model applies to each person – everyone has or is part of a culture” (1989: 3).

However, it is striking that this definition does not emphasise working towards services that are sensitive to a patient’s individual needs but highlights the needs of groups, which may or may not be as homogenous as implied. The implication is that individuals belong to a single unitary cultural group and precludes identification through any criteria other than ethnicity. In addition, there is an emphasis on difference based on being outside of white, mainstream America. This contrasts with the SCNIH approach. In discussing the use of ‘cultural competence’, Cross et al (1989) cautioned against stereotyping but still offered examples applicable to groups of people.

1.2.1 ‘Cultural competence’

In the North American medical system, many educational programmes endeavoured to teach ‘cultural competence’ (for example: Deloney et al, 2000; Kamaka, 2001). However, although the term is widely used, it often has different meanings (Henry J Kaiser Family Foundation 2003). A few definitions are now considered to demonstrate the different perspectives that are present in the US even when using the same terminology. These have provided an important background to developments in the UK.
In a report on culture and family-centred practice, the Family Resource Coalition (FRC, 1996:1) defined culture as:

“the combination of thoughts, feelings, attitudes, material traits and behaviours of a group of people. Each of these characteristics is manifested and shared by the group through symbols, communication and social patterns” (FRC, 1996:1).

This definition does not seem to recognise that people can simultaneously belong to several cultural groups that are not mutually exclusive but dictated by the time and place in which someone finds themselves: for example in a basketball team comprised of individuals of different skin colours, a white American may find that when he is with the team, they take on different values than when he is with an all white group. Culture appears to be viewed as a fixed tangible reality, which is static and uniform. This way of defining cultures appears not to recognise that there are considerable ambiguities and contradictions within and between cultures. Different individuals within the cultural group may be participating in different discourses that impact on the culture itself.

The FRC (1996:1) definition is very similar in its wording and meaning to that given by Cross et al (1989). Rodriguez (1996) offered a more subtle approach. She argued that being culturally competent or aware does not mean knowing everything about every culture. It refers instead to respect for difference, eagerness to learn, and a willingness to accept that there are many ways of viewing the world. She stated that in her own delivery of cultural training that she cautioned against over generalising or characterising cultural groups in a rigid, one-dimensional and static way. She further warned against regarding culture merely as a set of artefacts or materials used by people, a laundry list of behaviours, values and facts or stereotypic depictions of groups as seen in television, movies, newspapers and other media.

Blue (2001) stated:

“Culture consists of a body of learned beliefs, traditions, and guides for behaving and interpreting behaviour that are shared among members of a particular group. It includes values, beliefs, customs, communication styles, behaviours, practices, and institutions.
The visible aspects of a culture include clothing, art, buildings, food; the less visible aspects of culture include values, norms, worldviews and expectations” (Blue, 2001: 1).

Culture influences an individual’s health beliefs, behaviours, activities and medical treatment outcomes. Because of the significant influence of culture upon health and related outcomes, Blue (2001) argued that health care professionals should be culturally competent to provide optimum health care to patients. She stated that cultural competency in the context of health care provision consists of:

- Awareness and acceptance of cultural differences
- Awareness of one’s own cultural values
- Recognition that people of different culture have different ways of communicating, behaving, interpreting, and problem-solving
- Recognition that cultural beliefs impact patient’s health beliefs, help-seeking activities, interactions with health care professionals, health care practices and health care outcomes, including adherence to prescribed regimens
- An ability and willingness to adapt the way one works to fit the patient’s cultural or ethnic background in order to provide optimal care for the patient

This list assumes that individuals define themselves as belonging to a one culture and that this is immediately obvious to the professional when they meet a patient belonging to another culture. However, this framework openly suggested that there is a need for some level of self-awareness. There is also clarity regarding what it means in practice to value diversity. However, diversity is narrowly used in that it appears to reflect diversity of ethnicity and culture is used to imply ethnicity.

There are many more definitions of ‘cultural competence’ in use (American Academy of Nursing, 1995; Blue 2001; Cross Cultural Health Care Program, 2001; North Carolina Division of Social Services 2002). There is consistency in that most of the definitions appear to be based on the premise that the majority needs to gain knowledge about the minorities. There is an emphasis on acquiring knowledge of others and then applying it into appropriate clinical skills and professional attitudes. This assumption is likely to inform particular kinds of teaching programmes and has influenced the policies that have shaped
medical education in this field in the US. It is less clear how ‘cultural diversity’ and concepts related to it have been utilised in the UK.

Whilst definitions for culture are offered as illustrated above, less has been written about diversity. It would appear that diversity should perhaps be a more straightforward term. However, again this term is used imprecisely. In some cases, it means diversity of ethnicity for which the term ‘multiculturalism’ is often used (e.g. Culhane-Pera et al 1997, Loudon et al, 2001). There is also a perspective that diversity covers the range of groups within society and so includes groups identified with characteristics other than ethnicity, such as sexual orientation. In other cases, it covers a much broader range of difference relating to individual characteristics beyond ethnicity. Policies relating to equality within institutions suggest that diversity and acceptance relates to diversity of individuals (Good Business Network, 2003). In this thesis, diversity not only includes race, ethnicity and gender but also ability/disability, education, class and many other differences.

The difficulty with the terms discussed is that they are often used interchangeably and imprecisely. Additionally, they are subject to constant change as their use is often determined by what is politically and socially acceptable at any given time. Despite this, they are often used without any attempt made to clarify how they are used. This has become more relevant now, in that there is an expectation that medical schools address issues of ‘cultural diversity’.

1.3 ‘Cultural diversity’ teaching in the UK

Teaching ‘cultural diversity’ to medical students so that they are able to meet the needs of a diverse population as future doctors became a priority following the publication of Tomorrow’s Doctors (General Medical Council, [GMC], 1993). Previously, medical schools included ethnicity more in the context of teaching about health inequalities rather than about how health practitioners, including doctors, could meet the needs of ethnic patients (University of Leicester, 1993). Tomorrow’s Doctors (GMC, 1993) comprised the recommendations for undergraduate medical education issued by the Education Committee of the GMC. In developing their recommendations, the Education Committee had consulted widely and concluded that the time for change had come (GMC, 1993:4-6). The publication
of *Tomorrow’s Doctors* with the inclusion of the issue of ‘diversity’ implies that the GMC view this as an important issue.

In a survey of medical education, Loudon *et al* (1999) found that little was published on ‘cultural diversity’ programmes taking place in the UK. Most publications came from the US; of 17 identified programmes, 13 were in North America. The limitation of this study is that it based its assessment on published literature and as such may not be an accurate reflection. Flores *et al* (2000) surveyed Deans of Students and/or course directors in the US and Canada and found that 87% of the 126 US and 67% of the 16 Canadian medical schools incorporated multicultural issues in some way. Only 8% did not address the issue in any forum. Since Loudon *et al*’s paper (1999) there has been evidence of programmes being developed in the UK (e.g. Dogra, 2001, Conning *et al*, 2001). To date, however, there has not been a published survey such as that carried out by Flores *et al* (2000) of UK medical schools since the publication of *Tomorrow’s Doctors* (GMC, 1993). How isolated these programmes are and the status of such teaching in British medical schools is unclear. These are particularly interesting questions given that *Tomorrow’s Doctors* was intended by the GMC to initiate a decisive shift in the content and tone of medical education. *Tomorrow’s Doctors* (GMC, 1993) laid out a clear agenda for change. However statements such as:

> “In *Tomorrow’s Doctors*, the GMC reduced the emphasis on factual knowledge and more stress placed upon self-learning, communication skills and sociological understanding and that the revised 2002 version continued to stress ‘touch-feely’ qualities as well as a need for a knowledge base and keeping up to date. Older professionals and some patients were worried lest excellent interpersonal communications masked ignorance of basics, such as the ability to name the main bones or know the anatomical positions of nerves” (Rivett, 2003:1).

bring into question, how widely supported the GMC perspective was, and how the principles of *Tomorrow’s Doctors* (GMC, 1993) have been translated into practice in the areas of ‘cultural diversity’.
1.4 Reading guide

To meet the aim of the thesis and answer the main research question, the literature review in Chapter Two begins with a brief overview of the history of medical education in the UK and the relationship between the different organisations that have influenced its development. This process begins to demonstrate how the development of medical education has been linked inextricably to the development of the medical profession. Therefore, a discussion of the formation of key organisations and their roles is relevant in this thesis. The chapter then moves on to discuss why the issue of ‘cultural diversity’ is relevant to medical students as future service providers to ensure equitable service delivery. The research questions that arise are how widely these terms are understood? Does the understanding of these terms impact on the educational programmes devised and delivered in medical schools? This leads to consideration of the policies driving undergraduate medical education frameworks. It explores the rationale that the medical governing bodies in the UK have used to set the agenda or take the lead from agendas set elsewhere. It considers the development and context of Tomorrow’s Doctors (General Medical Council, 1993), which has significantly shaped the current curricula in most medical schools. Whilst the aim is to review the UK situation, reference is given to the American perspective as the American experience has highlighted examples of different approaches and has led this field. There is then an exploration of US policies, including an important resource produced by the American Medical Association (AMA) (1999). In this context, comparisons are made between the UK and US perspectives.

Chapter Three considers educational issues and begins by considering the increasing emphasis by the Higher Education Funding Council for England (National Committee of Inquiry Into Higher Education, 1997) and the GMC (1999) on teaching teachers how to teach. These issues were highlighted in the second edition of Tomorrow’s Doctors (GMC, 2002). The chapter then moves to discuss the relevant learning theories with respect to the teaching of ‘cultural diversity’. These provide a framework for those charged with the responsibility of implementing and delivering the GMC’s guidelines. The relationship between educational theory and practice in medical education is explored. This raises questions, such as, how much educational theory is applied to the practice of teaching ‘cultural diversity’? It is argued that the fundamental understanding and beliefs of teachers who teach ‘cultural diversity’ drive the curriculum as opposed to evidence-based practice, although few of those in medical education may have critically reflected on their own
positions. How many teachers in medicine have actually been trained in this themselves? Issues of evidence-based educational practice are also considered given the increasing emphasis by the medical professional and government (Sackett et al, 1996), on evidence-based practice in medicine. The educational theory discussed in this chapter also informs the development of the ideal type models which follows in Chapter Four.

Chapter Four presents the core of the thesis, in which the author develops, two ideal type models of ‘cultural diversity’ educational programmes, referred to in this thesis as ‘cultural expertise’ and ‘cultural sensibility’. Expertise entails esoteric expert skill, knowledge or judgement with the expert being defined as having special skill at a task or knowledge in a subject. Sensibility comprises an openness to emotional impressions, susceptibility, and sensitiveness. It relates to a person’s moral, emotional or aesthetic ideas or standards. The ideal type compares four major aspects of the teaching of ‘cultural diversity’ in medical education: educational philosophy and policy, educational process, educational contents and outcomes. Acquisition of ‘cultural expertise’ leans towards a view that there are prescribed rights and wrongs that can be learnt. Teaching ‘cultural sensibility’ leans towards acceptance of the uncertainty of not knowing. It acknowledges that patients are not static individuals, nor completely uninfluenced by the world around them. The rationale for considering a new approach is presented, as are potential problems in applying both models. The relationship between these models and other approaches and specific programmes are discussed in the next chapter.

Culhane-Pera et al (1997) highlighted the challenges for medical educators to develop appropriate teaching in ‘cultural diversity’ given the variable definitions of ‘cultural competency’, multiple teaching methodologies of unknown effectiveness, limited resources, and doctors resistant to such teaching. These issues are discussed in Chapter Five, which considers how widely cultural diversity is taught. Again, the US perspective is also presented to provide a comparison. The chapter then considers the different approaches used to teach ‘cultural diversity’ and questions whether or not policies regarding ‘cultural diversity’ and educational theories are coherently integrated to devise appropriate approaches to educational practices. The questions that arise are what are the philosophy and beliefs behind the approaches used to develop teaching in ‘cultural diversity’? How many of the approaches are consistent with existing educational theory? This then leads to a review of specific published educational programmes and evaluation of ‘cultural diversity’
teaching. As most of the information available is brief, only programmes that give detailed information are described. The rest are summarised in the form of a table presented in the appendices. This raises the issue of how specific programmes are developed and what influences their development? The programmes described are compared with the models of ‘cultural expertise’ and ‘cultural sensibility’ to establish the philosophy that underpins them. The literature suggests that this area suffers from a lack of coherent educational models that consider every stage of the educational process.

Chapter Six begins by reviewing the research questions raised through the literature review. The research objectives designed to answer these questions are stated as follows:

1. To apply the ideal types of ‘cultural expertise’ and ‘cultural sensibility’ to the review and analysis of ‘cultural diversity’ educational programmes in UK medical schools
2. To identify the process by which Tomorrow’s Doctors (GMC, 1993) came to be include aspects of diversity
3. To identify perceptions and evaluations of ‘cultural diversity’ and its teaching held by policy makers in the UK
4. To identify perceptions and evaluations of ‘cultural diversity’ and its teaching held by medical faculty staff in the UK
5. To identify perceptions and evaluations of ‘cultural diversity’ and its teaching held by teachers in the UK
6. To identify perceptions and evaluations of ‘cultural diversity’ and its teaching held by medical students in the UK
7. To identify perceptions and evaluations of ‘cultural diversity’ and its teaching held by service users and advocates in the UK
8. To identify how the perceptions of ‘cultural diversity’ identified in objectives 3-7 align with the models of ‘cultural expertise’ and ‘cultural sensibility’
9. To analyse the literature and findings to identify the origins, organisation, contents and outcomes of ‘cultural diversity’ teaching in UK undergraduate medical education

Chapter Six goes on to explore the methodology of this study. It outlines the rationale for the method and discusses reasons for the use of individual interviews rather than questionnaires or focus groups as a means of data collection. The sampling strategy, and
justification for this, is explored. The sample studied is included as is data on those who responded but declined to participate and those who did not respond to the invitation. A description of how the sample was selected and interviews were administered is given. More generally, the role of the researcher, who is herself a medical educator and doctor, is considered in some detail. Ethical issues are also reviewed. A description of how the data were analysed is provided with the supporting arguments in the conclusion to Chapter Six.

Chapters Seven to Ten report on the findings, which are discussed in relation to the theory, and conceptual models discussed in Chapters Two to Five. Analysis led to findings being themed into broad categories that reflect different aspects of medical education. Although presented as though it is a linear process, it is acknowledged that there is interchange between the issues raised under different headings. For each findings chapter, there is a descriptive overview of the quantitative data and discussion of the findings in relation to the models of ‘cultural expertise’ and ‘cultural sensibility’ developed in Chapter Four. Quantitative data are included in the text and presented before the qualitative data and discussion. The direct quotes have not been changed in any way and represent the transcription. There is then an analysis of the findings and identification of key issues. A loose-leaf copy of the table of participants is attached for ease of reference for the reader.

Chapter Seven focuses on the origins of ‘cultural diversity’, which encompasses the educational philosophy and policies that have shaped the teaching, developed. It begins by reporting on the interviewees’ perspectives of the role of Tomorrow’s Doctors (GMC, 1993) on the origins of ‘cultural diversity’ teaching. The origins of specific programmes are also reported. The chapter then reports on how the interviewees understood key terms and the ways they considered their understanding influenced programme developments. The evidence-base used to develop ‘cultural diversity is also discussed. In effect this chapter reviews the origins of ‘cultural diversity’ in policies and practice. Chapter Seven presents the argument that the origins of ‘cultural diversity’ teaching lie in political, rather than educational agendas. There appears to be no clear educational agenda giving rise to anxieties by medical schools about making mistakes.

Chapter Eight addresses the organisation of ‘cultural diversity’ teaching including aspects of the educational process and begins by considering the place of ‘cultural diversity’ in the medical curriculum. It continues by considering when in the curriculum it should be taught.
There is also a discussion of the principles that underlie the teaching. All these issues help identify the way that teaching is organised. The status of ‘cultural diversity’ teachers in medical schools is considered. Respondents’ views about the place of potential future guidelines are also reported and discussed in order to clarify how the organisation might be developed. Chapter Eight argues that the political agenda discussed in Chapter Seven has influenced the organisation of the teaching of ‘cultural diversity’. It argues that there is a lack of a systematic approach in the way in which ‘cultural diversity’ is approached and that the organisation of ‘cultural diversity’ teaching in medical schools relates closely to the issues surrounding the teaching of ‘behavioural sciences’. It is argued that whilst there are clear ideas about the principles that organise ‘cultural diversity’ teaching, the rationale about why this should be so and how it could effectively be done is less clear. The evidence on which these principles are based is unclear.

Chapter Nine relates to the contents and delivery of ‘cultural diversity’ programmes and reports on findings about what should be taught in ‘cultural diversity’ programmes. The issues of teaching strategies, including the involvement of the community, are addressed. Chapter Nine argues that the contents of ‘cultural diversity’ programmes may focus more on process rather contents which is inconsistent with the philosophies identified. There is a discussion about the possible reasons why a coherent approach has been difficult to develop.

Chapter Ten presents the findings on the outcomes of ‘cultural diversity’ learning and teaching. This includes assessments, student perspectives, evaluation of programmes and their potential impact on clinical practice. Students’ perspectives are discussed, as are views on how to manage situations when students do not recognise ‘cultural diversity’ as relevant to their future practice. The chapter also considers the issues surrounding the impact on clinical services of ‘cultural diversity’ teaching. The penultimate section of Chapter Ten considers the outcomes of ‘cultural diversity’ teaching and argues that concerns about student feedback may override a coherent educational approach. There is also an argument made that ambivalence about what should happen to students who ‘fail’ assessments related to ‘cultural diversity’ gives mixed messages and serves to undermine those trying to teach the subject.
Chapter Eleven provides conclusions and an agenda for future studies. It does so by reviewing the research questions, reiterating the main findings and relating the findings to what was previously known. The lessons to be learned from this study’s method and methodology are discussed before the implications for practice and policy are considered. Suggestions for future developments in the teaching of ‘cultural diversity’ and the way that organisation of ‘cultural diversity’ could be improved are discussed. Suggestions to support coherent developments are presented. Specific recommendations for each stakeholder group are given. This chapter concludes with specific suggestions for further research.
Chapter 2: The origins of ‘cultural diversity’ teaching

This chapter begins with a brief overview of the history of medical education in the UK and the relationship between the organisations that have influenced its development. This process begins to demonstrate how the development of medical education has been inextricably linked to the development of the medical profession making a discussion of the formation of key organisations and their roles relevant to this thesis. These issues set the context for considering the origins of ‘cultural diversity’ in medical education in the UK. This chapter then considers why the issue of ‘cultural diversity’ is relevant in the medical school curriculum, before considering the policies that have influenced medical education in this field. The author argues that the history of medical education as a whole and the responses to Tomorrow’s Doctors (GMC, 1993 and 2002) have shaped the current status of ‘cultural diversity’ education in the UK. This is followed by a comment on the US context, which is relevant as there has been considerable work in the US on the teaching of ‘cultural diversity’. There is a brief comparison of the UK and US situations.

2.1 The history of medical education in the UK

Historically, there were three separate categories of qualified medical practitioner in England. Physicians were considered to be the learned profession, surgeons were the craft and apothecaries made up the trade. Each group had its own corporation based in London. The Royal College of Physicians was incorporated in 1518. The surgeons initially joined with the barbers to form a guild in 1540 but broke the association in 1745, and the Royal College of Surgeons of London was incorporated in 1800. Apothecaries as general shopkeepers were initially part of the Mystery of Grocers but in 1627 were granted a royal charter to become the Society of Apothecaries of London (Sinclair, 1997: 39).

Entry into these separate all male corporations was different. The practice of physic was restricted to men with university degrees and only graduates of Oxford or Cambridge (and therefore Anglicans) could become Fellows of the Royal College of Physicians. Physicians with Scottish or Irish medical school degrees could hold a licence. Surgeons and apothecaries as such were not ‘learned’ men but obtained their skills through apprenticeship, which was essentially practical. The corporations had little influence over
their members outside London where the majority of practitioners combined surgery and apothecary (Sinclair, 1997: 40).

The basic principles of any kind of apprenticeship involved binding written contractual arrangements made by the parents about sending their child to serve with an apprentice-master (Sinclair, 1997: 40). The term of apprenticeship to surgeon-apothecary was the usual seven years for most occupations throughout the eighteenth century but the premium to undertake the apprenticeship higher than most. The apprentice learned how his master conducted his practice and at the end of his term became legally entitled to practice as a surgeon-apothecary with the possibility of himself becoming a master, and, in turn, benefiting from the indentured services of an apprentice. The system of apprenticeship guaranteed a level of competence in the qualified adult (as demanded by parental, community and cultural expectations as well as the master’s concern for his own reputation). Entry of new recruits was also controlled and prevented overstocking of too many skilled men. However, the high increase in population with increasing industrialisation of Britain led to the weakening of the guilds as the one-to-one master-to-apprentice relationship became untenable. Much of the care of the sick, at this time, took place in the community with patients choosing whether or not they went to a licensed or unlicensed practitioner. Much of the care was also delivered by women in domestic and communal settings and was largely unpaid (Witz as cited by Sinclair. 1997: 41). Towards the end of the eighteenth century, increasing emphasis was placed on anatomy as a means of classifying disease and the Anatomical Method influenced a shift to hospital medicine. The inference of the Anatomical Method was that the more one knew of the structure of the body (i.e. the anatomy) the better one understood the function (i.e. physiology) (Sinclair: 1997: 51).

During the eighteenth century the number of hospitals grew especially in London. The medical attendants (or honorary doctors) to hospital patients were volunteers and received little or no payment. Surgeons were allowed to take pupils or ‘dressers’ (who had served some level of apprenticeship). As students directly paid their teachers, for surgeon the fees arising from teaching were substantial. At this time, there were also an increasing number of learning opportunities with the formation of medical and scientific societies. Lectures and demonstrations by eminent surgeons were established. Attendance at lectures was subject to payment. Links between hospitals and ‘medical’ schools were initially informal
but these became official as hospitals started to build their own medical schools for lecture courses and demonstrations. The expansion was largely focused on surgical students (Sinclair, 1997:54).

The important point in the context of this thesis is that, Sinclair (1997:56) argued that in the 18th century, hospitals cornered the market in medical training. This occurred as a result of both the increasing prestige of individual teachers appointed there (based on their connections with the three corporations) and of restrictive measures favouring the hospitals, passed by the licensing authorities whose members were usually holders of hospital appointments.

Dead bodies were crucial to the teaching of anatomy and grave robbing became commonplace. In 1832, the Anatomy Act was passed to establish a secure supply of corpses. The Anatomy Act, once again, favoured hospital anatomy schools and the private schools soon went out of business. The ‘honoraries’ were now called ‘consultants’ and increasingly gained control over admissions to hospitals. There was now a clear divide between hospital medical practice and general practice and the dominance of surgery was established. New hospital medical schools brought changes for the student, who no longer lived with a master but in private lodgings. To manage the students’ unruliness, affiliated collegiate residences were established and the formation of clubs and societies followed (Sinclair, 1997:56). Sinclair (1997:62) felt it was unclear how far hospital governors and teachers fostered the new collegiality within medical schools and how far it was a spontaneous creation of the students themselves.

The training at this point effectively had three parts. The first was two years preclinical (consisting largely of anatomy and physiology), with three years of clinical training followed by a ‘pre-registration house year’ consisting of six months of surgery and six months of medicine. This is still largely the case today, although more recently there have been developments such as those at Manchester and Liverpool with problem-based courses based on the McMaster model from Canada (Richards and Stockhill, 1997: 54). The house year may now include four months of psychiatry, gynaecology, paediatrics or general practice in addition to four months of surgery and four months of medicine (e.g. Leicestershire, Northamptonshire and Rutland Deanery, 2003).
The pre-eminent success of medicine as a profession was linked to the scientific basis of its knowledge, which Sinclair (1997: 63) linked to its historical origins in anatomy. The Apothecaries Act of 1815 marked the watershed between unregulated practitioners and the rise of the state’s involvement with the emerging medical profession. Specifically, the Act stipulated a course of training as a legal requirement for entering the Apothecaries examination for a license to practice, thus providing the population with the assurance that new medical practitioners had reached an approved standard of proficiency.

New associations of medical men formed to achieve professional and economic goals to prevent competition. One of these was the Provincial Medical and Surgical Association, which in 1856 became the British Medical Association (BMA). The BMA aimed to promote the medical and allied sciences and to maintain the honour and interest of the medical profession. The Association was registered as a company limited by guarantee in 1874 and became listed as a Trade Union in 1974 (BMA, 2003). Almost immediately after its foundation, the BMA became involved in medical reform and after 20 years of negotiation professional medical status was fully established by the Medical Act of 1858. The Act established the General Medical Council (GMC) and the Medical Register and for the first time distinguished between qualified and unqualified practitioners. The GMC was to be composed of medically qualified representatives of the licensing bodies and the universities, with a few bodies nominated by the Privy Council. The GMC was established to supervise the activities of the medical profession including medical training. Legally, all medical practitioners under the Act had to be registered with the GMC irrespective of how they had become licensed (GMC, 2003).

Training was left divided by the Act in that students were taught at medical schools, examined by a different organisation and the training was supervised by the GMC. The Medical Act of 1886 made it mandatory for all practitioners to qualify in medicine, surgery and midwifery and also enabled the profession to directly elect representatives onto the Council (BMA, 2003). By the end of the century most students took the new conjoint board examinations. Over the years, the Royal Colleges, many of which were formed in the mid-late nineteenth century, began to confine their emphasis on higher training for their specialities. Universities established responsibility for basic medical training, whilst being supervised by the GMC. An individual doctor simultaneously could be a member of the GMC Council, a Royal College and work within a university.
2.1.1 The GMC role

The GMC’s Education Committee is one of seven statutory GMC committees under the current Medical Act (1983:4). The Act (1983:7) stated:

“The Education Committee shall have the general function of promoting high standards of medical education and co-ordinating all stages of medical education. For the purpose of discharging that function the Education Committee shall:

(a) determine the extent of the knowledge and skill, which is to be required for the granting of primary United Kingdom qualifications and secure that the instruction given in universities in the United Kingdom to persons studying for such qualifications is sufficient to equip them with knowledge and skill of that extent;

(b) determine the standard of proficiency which is to be required from candidates at qualifying examinations and secure the maintenance of that standard; and

(c) determine patterns of experience, which may be recognised as suitable for giving to those engaging in such employment as is mentioned in section 10(2) below general clinical training for the purposes of the practice of their profession.

The requirements of that article are that any person who fulfils the conditions mentioned

(a) will have acquired:

(i) adequate knowledge of the sciences on which medicine is based and a good understanding of the scientific methods including the principles of measuring biological functions, the evaluation of scientifically established facts and the analysis of data,

(ii) sufficient understanding of the structure, functions and behaviours of healthy and sick persons, as well as relations between the state of health and physical and social surroundings of the human being,

(iii) adequate knowledge of clinical disciplines and practices, providing him with a coherent picture of mental and physical diseases, of medicine from the points of view of prophylaxis, diagnosis and therapy and of human reproduction, and

(iv) suitable clinical experience in hospitals under appropriate supervision (Medical Act, 1983:7).
In practice the Education Committee focuses on principles and does not involve itself in the details of specific curricula, although it has the powers to do so if it wishes. The Education Committee undertakes visits to medical schools to check whether its recommendations are implemented (Medical Act, 1983). To date no medical curriculum has been closed after an Education Committee visit although a few have had earlier review visits to enable the GMC to check that their recommendations have been implemented.

In 2003, the GMC underwent significant change with a reduction in Council members overall, including a reduction in the number of Council members appointed by educational bodies (GMC, 2003a). The Council is currently made up of 19 doctors elected by doctors on the GMC medical register, 14 members of the public appointed by the Privy Council and two academics appointed by the Council of Heads of Medical Schools (CHMS) and the Academy of Medical Royal Colleges (AMRC) who respectively represent the universities and the Royal Colleges. The CHMS was formally established in 1992 having up until then been an informal conference (Engel, 1995). This committee was established to be a principal source for informed opinion and advice on all matters concerning basic medical education and medical schools research in the UK (CHMS, 2003). The AMRC in its current format was established in 1976 having up until then been a standing joint committee of the Royal Colleges of the surgeons, physicians and obstetricians (ARMC, 2003). The chief objective of the ARMC is to coordinate the activities of the Royal Colleges. Table 1 shows how the composition of the Education Committee of the GMC has changed in the context of other changes.

Table 1: Composition and size of the Education Committee of the GMC as at July 2003 (compiled from data available GMC 2003a)

<table>
<thead>
<tr>
<th>Source of Education Committee Members</th>
<th>Former position</th>
<th>New position</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(Pre July 2003)</td>
<td>(Post July 2003)</td>
</tr>
<tr>
<td>Medical members, elected by Council</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td>Lay members, elected by Council</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Members appointed to Council by</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>undergraduate bodies</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Members appointed to Council by</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>postgraduate bodies</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Co-opted members, recommended by</td>
<td>Up to 3</td>
<td>Up to 8</td>
</tr>
<tr>
<td>educational bodies</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total voting members</td>
<td>Up to 19</td>
<td>17</td>
</tr>
</tbody>
</table>
The Council of the GMC (2003a) felt that the Education Committee must carry the confidence of the organisations that play a part in medical education and that the committee should be able to draw on the expertise and experience of the individual organisations. The GMC should therefore co-opt onto the Education Committee four members from educational bodies and four members from postgraduate educational bodies. Effectively this means that educational bodies have more say than perhaps previously. Members from both CHMS and AMRC are elected by their own membership and this is discussed further below.

2.2 The medical curriculum

The medical profession has been male dominated since its conception. The GMC is widely viewed as an organisation that is conservative and slow to change (e.g. Lowry, 1993: 8). As such, largely men, and moreover ‘white’ men, who have often been in privileged positions, have governed the medical profession. As discussed above, the GMC’s education committee has representation from the CHMS and the AMRC. Of the 27 members of the CHMS, on 26 June 2001, all were men from white backgrounds (CHMS, 2003a). The AMRC, which is made up of the Presidents of the Medical Royal Colleges, has two women of twenty members but again all were from white backgrounds (ARMC, 2003). Since 1991 there have been consistently more women than men entering medical school. However, women remain underrepresented at the top levels of the profession, as do other ‘minorities’ (Lowry, 1993: 15; Richards and Stockhill, 1997: 19; Unwin, 2001: 1223). In these circumstances, the GMC has perhaps struggled to review issues of equality and diversity within the profession itself. It is unclear how this then affects the teaching agendas that the organisation sets for students in diversity. This perhaps has relevance to the status of ‘non-biological’ or non-traditional parts of the curriculum.

2.2.1 Curriculum development

It has been argued that until recently the ad hoc nature of medical curricula has resulted in curricula of which the objectives bear little relation to what is delivery, how students learn and how students are assessed (Dennick, 1998). The intervention of medical educationalists has perhaps enabled the relationship between these four components to become more
coherent. The discipline of medicine has also had to ask itself what is most important for students to know and how might they best learn it rather than subjects being taught because they have always been taught. The newer medical schools curricula (for example the Peninsula Medical School and the University of East Anglia Medical School) have been in a position to develop courses with less historical baggage than perhaps the more traditional schools. They have also been in a position to engage with educationalists from the outset.

2.2.2 Natural sciences and behavioural sciences

Engel (1995), a leading medical educationalist of his time, argued that lip service is paid universally by medical schools to the biopsychosocial model as opposed to the purely biological model of health care. Whilst the profession wrote much about the importance of maintaining health and preventing illness, there is still an almost exclusive emphasis on the natural sciences early in the curriculum and on the curative aspects of medicine in the remaining years. The preclinical years are still dominated largely by anatomy, physiology and biochemistry; as other sciences have developed further subjects such as genetics and neurosciences have been added to the curriculum (Lowry, 1993). Sociology and psychology are often grouped under the ‘behavioural sciences’. Their place in the medical curriculum has been subject to debate over a considerable period of time (e.g. Straus 1965; Black, 1971; Russell et al, 2002) but most medical schools today do address these in the curriculum to some extent. Benbassat et al (2003) highlighted the difficulty in implementing courses in the behavioural and social sciences that most US medical schools now offer. They argued that medical students often fail to perceive the relevance of behavioural and social sciences in clinical practice. Secondly the behavioural and social sciences are vaguely defined and the multiplicity of topics causes confusion about priorities. Thirdly doctors may have received little, if any, instruction in this area and behavioural and social scientists lack clinical experience. Kelly (1990) suggested that the behavioural sciences frequently fail to excite medical interest because they adopt only a humanistic and/or critical approach at the expense of medical training.

A workshop held by social scientists explored the contribution social sciences might make to medical education (Russell et al, 2002). Most of the members were sociologists who worked within medical schools rather than departments of sociology. There were concerns identified that teaching in this area was often done by individuals not trained in social
sciences. No comment was made as to whether or not social scientists have any experience in the delivery of health care and if they were able to relate to students’ needs in clinical practice. Some of the topics identified included social inequalities in health and their processes/links to individual and group behaviour (e.g. smoking); the ‘community’ and social categories – gender, ethnicity, race, social class, disability – stereotyping (Goffman); prejudice. The outcome of the workshop was a report. In the preface of this report entitled, *Social and behavioural sciences in medical education*, (Russell et al, 2002), Hamilton proposed that the starting point for the learning, knowledge and application of the behavioural and social sciences has to be within society.

By focusing on theoretical sociological perspectives, the report appeared to fall into the trap against which Kelly (1990) warned. Whilst the potential use of patients to make the teaching more relevant was considered, talking to health professionals was not mentioned explicitly, although partnerships were raised. There was an acknowledgement that many clinical teachers in medical education have a keen interest in the social and behavioural sciences and may incorporate social and behavioural science elements into their teaching.

Faulkner and McCurdy (2000) discussed the place for teaching medical students social responsibility in the US but this is relevant to a wider context. They felt that medical schools often claim to value compassion, reflectiveness, social responsibility, autonomy and diversity, but reward and sustain practices based on competition, hierarchies of authority, fixed spheres of practice, bottom-line thinking and economic privilege. Faulkner and McCurdy (2000) argued that as trainers of doctors, medical schools have a social responsibility. It then follows that medical schools also have a duty to teach their students to be socially responsible. However, defining social responsibility is not an easy task as the concept is related to political and personal ideologies. The importance of evaluating teaching of social responsibility was highlighted explicitly. The authors concluded that for teaching of social responsibility to be credible and effective, programmes needed to be carefully designed and have committed staff. The value that medical schools hold in teaching in this area also needs to be demonstrated to students.

An increasing volume of literature covers the place of ‘cultural diversity’ teaching in the curriculum in the context of the social sciences and behavioural sciences. Friedman (2002)
argued that incorporating the humanities within a medical education environment emphasises medicine as a profession rather than merely a trade. Incorporating these disciplines legitimises individual questioning and collective probing which, in turn, motivate practitioners and students to confront fundamental questions about their field and their place in it. This, he believed, would help shape them to be compassionate practitioners and reflective human beings. He argued that those working in the medical humanities might have as yet failed to make a strong enough case for the field. This suggested that although responsibility lies with the dominance of ‘non humanities specialities’, responsibility also lies with those who teach these subjects in that, perhaps they have not articulated their case clearly enough.

2.3 Why teach ‘cultural diversity’?

Levinson et al, (1997) justified the teaching of ‘cultural diversity’ to medical students with several reasons. They argued that dealing effectively with diversity should improve the doctor-patient communication. Evidence shows that communication skills diminish the risk of malpractice: the doctor is better able to identify the patient’s problems with reduction in misdiagnosis and misunderstandings. Increased compliance and improved outcomes including patient satisfaction should also occur (Levinson et al, 1997).

The DiversityRx organisation (DiversityRx, 2001) is an American clearinghouse of information on ways to meet the language and cultural needs of minorities, immigrants, refugees and other diverse populations seeking health care. Lack of awareness about cultural differences was believed to make it difficult for both providers and patients to achieve the best, most appropriate care. The problems that may arise include:

- Lack of knowledge – resulting in an inability to recognise the differences
- Self-protection/denial – leading to an attitude that these differences are not significant, or that our common humanity transcends our differences
- Fear of the unknown or the new – because this is challenging and perhaps intimidating to understand something new that does not fit into one’s worldview
- Feeling of pressure due to time constraints – which can lead to feeling rushed and unable to look in depth at an individual patient’s needs

This may in turn lead to the following problems:
- Patient-provider relationships are affected when understanding of each other’s expectations is missing
- Miscommunication
- The provider may not understand why the patient is non-compliant, how decisions in the family may be made especially about health care
- The patient may reject the healthcare provider because of the non-verbal cues given by the provider

Williams (1997) argued that when culture is overlooked incorrect and even harmful decisions may be made, an example is giving Muslims pork insulin with which to treat their diabetes. There is also a limited ability to engage individuals and families and build on strengths. DiversityRx (2001) stated that providers may need to ask themselves how they react when confronted with a new patient situation that does not fit their expectations and if the situation provokes feelings of anxiety and discomfort. They also suggested that clinicians consider what is going on within themselves and within their patients. Clinicians, then, need to ask whether or not, they have useful strategies to clarify puzzling situations and enhance both theirs’ and their patients’ understanding.

2.4 The policies driving medical education frameworks

This section begins by exploring the rationale used by the major medical governing bodies in the UK to set the agenda or take the lead from agendas set elsewhere. It considers the development of Tomorrow’s Doctors (GMC, 1993), which has significantly shaped the current curricula in most medical schools. The context in which Tomorrow’s Doctors (GMC, 1993) was delivered is discussed and followed by other UK policies that may also affected medical education. The section then moves on to consider the place of ‘cultural diversity’ teaching and in the curriculum based on the literature available.

2.4.1 The development of Tomorrow’s Doctors

In 1993 the GMC published the first version of Tomorrow’s Doctors, which has had a significant effect on medical education in the United Kingdom. Tomorrow’s Doctors was designed with a modern glossy cover to maximise the impact the document would make. Lowry (1993) proposed that although the GMC is a statutory body, in reality, it has little
power to sanction medical schools that do not comply with recommendation. For the GMC to withdraw a medical school’s accreditation would have huge implications for the students in training. She suggested that *Tomorrow’s Doctors* was produced because of the GMC’s frustration at the failure of medical schools to implement reforms proposed by the council in 1980s when it called for a reduction in the factual overload and the promotion of self-education and critical thought (Lowry, 1993: 9).

*Tomorrow’s Doctors* (1993) contained broad statements referring to the knowledge, skills and attitudes expected from students at the key point of completing their undergraduate studies. One of the attitudinal objectives outlined in the first *Tomorrow’s Doctors* was that:

“At the end of the course of undergraduate medical education the student will have acquired and will demonstrate attitudes essential to the practice of medicine including respect for patients and colleagues that encompasses, without prejudice, diversity of background and opportunity, language, culture and way of life”. (GMC, 1993: 15)

However, there was no specific reference to this in the recommendations at the end of the document or in the annex on attributes of the independent practitioner (GMC, 1993: 25-27). It is unclear why the document raised the issues but then did not expand on them. It is possible there was pressure to keep the document to a reasonable length; it may also reflect a lack of clarity or certainty about exact requirements.

By publishing *Tomorrow’s Doctors*, the GMC set the framework within which it expected medical education in the UK to develop. Although the GMC and the Quality Assurance Agency (QAA) regularly visit medical schools to monitor standards of medical education, medical schools remain free to develop curricula as they see fit. The criteria used by the QAA are similar to those used for other university courses and cover six aspects: 1. curriculum design, content and organisation; 2. teaching, learning and assessment; 3. student progression and achievement; 4. student support and guidance; 5. learning resources; and 6. quality management and enhancement (QAA, 2001). The GMC chose not to develop a national curriculum, as diversity within medical education was, and is, considered important for innovation (Plomin, 2001).
The rationale for *Tomorrow’s Doctors* (GMC, 1993) followed advice from the GMC Education Committee. Unfortunately it is unclear how the GMC decided upon the final contents. In the revised version of *Tomorrow’s Doctors*, the GMC (2002: 3-12) recommends that attitudes and behaviours that are appropriate for a doctor must be developed. Students must:

- Develop qualities that are appropriate to their future responsibilities to patients, colleagues and society in general (p3)
- Be able to communicate effectively with individuals and groups (p5)
- Respect patients regardless of their lifestyle, culture, beliefs, race, colour, gender, sexuality, disability, age or sexual or economic status (p5)
- Graduates must be able to communicate effectively with individuals regardless of their social, cultural or ethnic backgrounds or their disabilities (p7)
- Communicate with individuals who cannot speak English, including working with interpreters (p7)
- Reflect on practice, be self-critical and carry out an audit of their own work and that of others (p8)
- Understand human development and areas of psychology and sociology relevant to medicine, including cultural background, gender, disability, growing old and occupation (p10)
- Understand a range of social and cultural values and differing views about health care and illness. They must recognise the need to make sure that they are not prejudiced by patients’ lifestyle, culture, beliefs, race, colour, gender, sexuality, age, mental or physical disability and social or economic status (p11)
- Have opportunities to interact with people from a range of social, cultural and ethnic backgrounds (p12)

It is difficult to identify the degree of difference between the principles behind the two documents. However, there have been criticisms that the second version was an opportunity missed and perhaps even diluted the impact of the first (Harden *et al*., 2002). It is possible that some of this may have been a response to the informal comments and responses made about the first document, some of which may have been similar to those discussed below.
The statements in both versions of *Tomorrow’s Doctors* were made without clarification (GMC, 1993 and 2002). The attributes expected of doctors are not dissimilar to those expected of anyone complying with equal opportunities legislation. The increasing concerns about racism by the GMC (Beecham, 1994), may have influenced the inclusion of such issues. The number of complaints about doctors’ communication skills in a climate of changing relationships between doctors and patients may also have been influential (Irvine, 2001; White 2002).

In 1993 when the first version of *Tomorrow’s Doctors* was published, the profession considered it to be a radical document in some ways. Nevertheless, little can be found in the literature on published responses to that version (Engel, 1995). In response to the second version, Toynbee (2002) commented that the document was written to refute the old complaints about arrogant, god-like consultants. She stated that:

> “The duties of a doctor registered with the GMC listed on the front page are in a very perverse order, where six “touchy feely” rather modish qualities are listed before the most important one, “keep your professional knowledge and skills up to date” (2002:716).

She felt that:

> “Bizarrely, we get doctors ordered to be polite and considerate, respecting their patients’ dignity and privacy, listening to patients’ views. Giving patients information and respecting their rights before we know if the doctor is any good at medicine. If asked to choose qualities, most patients would probably rather be cured by a brusque doctor with up to date skills than be listened to and respected by one who had hardly looked at new treatments in the past year” (Toynbee, 2002: 716).

Toynbee (2002) failed to comment on why patients should not get both aspects of professional practice and that much of medicine is not about cure but care (Richards and Stockhill, 1997:5). Overall Toynbee presented a positive response to the document, only commenting that it failed to mention the growing interference, demands and often perverse priorities set by politicians in the affairs of medicine. There has been criticism of the document from doctors themselves, however, especially those who share some of
Toynbee’s sentiments that the sciences and core issues have been lost while curriculum developers pander to the whims of the politically correct (Plomin, 2001; Fogarty, 2002; Rivett, 2003).

The drive behind *Tomorrow’s Doctors* was a desire to overhaul medical school curricula. There was a great emphasis on a shift from a heavily content-laden taught curriculum to teaching students key facts and other skills, which are transferable, e.g. attitudes towards lifelong learning. There was also an emphasis on moving away from formal didactic teaching and working towards self-directed student learning. This was, in part, an acknowledgement of the growing evidence that curricula could not continue to expand at the same rate as medical knowledge (Lowry, 1993: 7; Richards and Stockhill, 1997: 53; Sinclair, 1997: 3). The move towards self-directed learning was related partly to the increasing reality that once doctors were in practice, continued professional development was needed throughout their careers because new developments would continue to emerge.

Rivett (2003) agreed that in *Tomorrow’s Doctors* (1993 and 2002) the GMC reduced the emphasis on factual knowledge and placed greater stress upon self-learning, communication skills and sociological understanding. He argued that the revised 2002 version continued to stress ‘touchy-feely’ qualities as well as a need for a knowledge base and keeping up to date. Rivett commented that older professionals and some patients were worried lest excellent interpersonal communications masked ignorance of basics, such as the ability to name the main bones or know the anatomical positions of nerve. He stated that the new Peninsula medical school’s decision in 2002 to remove anatomical dissection from its medical course was not reassuring. He failed to recognise that Southampton medical school, a well-established and well-regarded medical school, never included dissection from the outset in 1971. The use of the word ‘touchy-feely’ appears to dismiss the importance of the very skills upon which the GMC has been trying to improve.

As well as a reduction in facts, *Tomorrow’s Doctors* (1993) placed increased emphasis on human skills and the ability to communicate with patients and colleagues. From the literature and the GMC website it is not evident how these shifts came to be made but it may relate to the changing nature of the doctor-patient relationship and a changing political climate and this is now discussed.
2.4.2 The timing of Tomorrow’s Doctors

The timing of Tomorrow’s Doctors (1993) is worthy of note. At the time of publication, there was considerable criticism of the GMC and the medical profession as a whole commented on in later years (Smith, 1998). There was a climate of much medical criticism of the Government and funding of the National Health Service (Irvine, 2001). Smith (1998) outlined the increasingly poor media coverage received by the GMC over a number of years in a climate of reducing status for doctors. As Toynbee (2002) commented, there has been growth in the political management of the NHS in which doctors have inevitably become entangled. There have also been changing expectations of what doctors and the health service can deliver, with rising demands by patients to become more actively involved in their own care (Lowry, 1993: 8; Irvine, 2001). Additionally, there has been an increasing challenge to doctors’ position as experts and patients as passive receivers of this expertise. The demographics of the UK population have also changed. The GMC appears to have recognised this and the need for changes towards improving equality (Irvine, 2001).

In a speech given to the Royal Society of Medicine in 2001, Irvine, the then President of the GMC, presented his perspective that there are deep seated flaws in the culture and regulation of the medical profession. Personal perspectives like this and the wider political climate may have strongly influenced the development of Tomorrow’s Doctors (GMC, 1993 and 2002). Fitzpatrick (2001) presented a critique of Irvine’s position and stated that attitudes such as Irvine’s and the constantly changing political situation may drive the profession from being arrogant to being so full of self-doubt and insecurity. The latter will undermine the profession’s capacity to care for patients. Doctors may also have been central to the processes of change within medicine as the profession was no longer prepared to tolerate idiosyncratic practice by colleagues. It could be that doctors for once were trying to be proactive and wanted ‘bad doctors’ to be recognised before they tarnished the reputation of the profession beyond repair.

For many years, there has been a concern that the process of medical education often has the effect of deadening students’ initial enthusiasm and fails to prepare them adequately for the realities of professional life (Lowry, 1993). There was also some concern that applications to medical schools were falling and medical education needed to be reworked. These, too, may in part have also led to Tomorrow’s Doctors (1993).
Medical and technological advances have made it increasingly unrealistic to anticipate that medical students can leave medical school knowing all they need to know. In practice, it is unlikely that this was ever a realistic expectation. Medical knowledge is clearly important but doctors also need to have appropriate attitudes that enable them to practice effectively and with the professional standards expected of them by their governing bodies and the public (GMC, 1993).

Although not an educational or governing organisation, the BMA has commented on ‘cultural diversity’ education. They commented on the GMC’s role and summarised that:

“Education should be learner-directed, integrated across curricula, evidence-based, and linked to clear support mechanisms. Formal education needs to be linked to “hands on” experience and doctors and medical students can learn much about cultural issues from patients and through contact with different community groups and their health initiatives” (Robins, 1995:56).

The objectives provided by Robins are more explicit than the contents of either version of Tomorrow’s Doctors (GMC, 1993 and 2002). However, the terms ethnicity and culture appear to be used interchangeably and may imply that only those with ‘ethnicity’ have culture. Robins (1995: 3) stated that ‘ethnicity’ is actually now just a preferred term for ‘race’. The report followed a resolution in 1992 at the BMA’s Annual Representative Meeting which asked: that this representation asks the Board of Science to consider investigating the variations in the incidence of disease between different cultural groups in the UK. Several experts advised the Board of Science and Education, interestingly none of who was recognised as a medical educator. There is no information on whether or not this document has influenced ‘cultural diversity’ teaching to medical students.

The GMC has argued that there are good reasons to allow diversity of curricula as this enables development of different ideas (GMC, 1993). However, it is possible that, given the complexity of this area and potential difficulties to support medical educationalists, it may be helpful for guidelines on a core curriculum in ‘cultural diversity’. Even then, depending on individual and professional perspectives, the slant of the core curriculum may be hotly contested.
2.5 The US perspective

This section briefly reviews the US perspective to enable a comparison between the US and UK as there has been considerably more work on ‘cultural diversity’ in the US. In 1847, the American Medical Association (AMA) was established to monitor medical ethical and adopt national standard for preliminary medical education and for the degree of MD (AMA, 2003). The AMA is a national association composed of state and territorial (or constituent) societies and county (or component) societies. The American Association of Medical Colleges (AAMC) was formed in 1876 to promote reform in medical education and all medical schools in the US must be accredited by this organisation. In the nineteenth century, the growth of medical schools affiliated with established institutions was paralleled by the development of proprietary schools of medicine. The latter were run for personal profit and tended to have low standards. In 1910, when Flexner exposed their inadequacies, the AMA and AAMC laid down standards for course contents, qualifications of teachers, laboratory facilities, affiliation with teaching hospitals and licensing of practitioners, which remains to this day (Braverman and Anziska, 1994). At the beginning of the twentieth century the prototype for American medical education was established with a baccalaureate preparation for the study of medicine (through a broad undergraduate degree in which the liberal arts are emphasised), a university-based medical school and direct clinical experience as part of medical education (AAMC, 2003). To be able to practice as a doctor unsupervised, students take a three-part United States Medical Licensure Examination (USMLE) of which the third part can only be taken after students have obtained their MD. The AMA controls both the quality and to an extent the quantity of physicians available to the nation. All US states require graduation from an acceptable medical school as a prerequisite to gaining a medical license. State medical examining boards define ‘acceptable’ schools as those approved by the joint committee of the AMA and the AAMC. The AMA has an AMA Council on Medical Education which liaises with the AAMC to set standards of medical education in the US. The AMA therefore has a position not dissimilar to the GMC, although the AMA does not accredit medical schools.

The AAMC is currently involved in a project designed to reach general consensus within the medical education community on the skills, attitudes and knowledge that graduating medical students should possess; this is, in effect, a national curriculum (AAMC, 1999). Clearly, the AAMC and AMA have been crucial in setting the historical and contemporary contexts in which ‘cultural diversity’ has been developed in American medical schools.
The US medical education system is not the same as in the UK although there are similarities in curricula. There are differences in the relationship between the state and the profession. The AMA and the AAMC have a strong influence on medical education. The AMA produced a detailed compendium (1999: Section X), which included a report entitled *Enhancing the Cultural Competence of Physicians* presented by the Council on Medical Education at the AMA's 1998 annual meeting. This report referred to a policy entitled *Promoting Culturally Competent Health Care* that called for the AMA to “encourage medical schools to offer electives in culturally competent health care, with the goal of increasing awareness and acceptance of cultural differences between patient and provider.” (1999: Section 10:2) The resolution that established this policy also called on the AMA to “investigate the development of a database for the AMA Homepage addressing the issues of cultural competency in health care.” The policy and the directive complement each other and action was planned for a database as an essential resource for medical schools.

The AMA (1999) stressed that academic and other medical institutions should offer educational programmes about gender and cultural issues to staff, physicians in training, and students. These policies reflected the AMA’s understanding that knowledge and tolerance of cultural diversity is integral to effective health care delivery and that physicians and health care organisations must be encouraged to respond to the social, cultural, economic, and political diversity of their communities, including serious consideration of cultural solutions to illness.

The AMA report took several actions to help ensure implementation of the policy. ‘Culture’ was used in the above report to encompass more than ethnic, racial, national, and gender designations. The authors of the report also considered the use of the term ‘culturally competent health care’ and identified the issues that led to their resolution, including cautions about stereotyping. The terms ‘cultural competence’ and ‘culturally competent health care’ therefore reflect a broad use, as indicated by several definitions, two of which, were (1998: 2-3):

1. “Complex integration of knowledge, attitudes, and skills that enhances cross-cultural communication and appropriate/effective interactions with others. It includes at least three perspectives:
   - Knowledge of the effects of culture on others’ beliefs and behaviour,
• Awareness of one’s own cultural attributes and biases and their impact on others, and
• Understanding the impact of the socio-political, environmental and economic context on the specific situation.” (American Academy of Nursing, 1995)

2. “The knowledge and interpersonal skills that allow providers to understand, appreciate, and work with individuals from cultures other than their own. It involves an awareness and acceptance of cultural differences; self-awareness; knowledge of the patient’s culture; and adaptation of skills.” (AMA, 1994)

The variety of definitions reflected a wish to be inclusive while simultaneously setting some parameters for coherent dialogue. The definitions had a common explicit or implicit component that culturally competent physicians are able to provide patient-centred care by:

1. Adjusting their attitudes and behaviours to the needs and desires of different patients
2. Accounting for the impact of emotional, cultural, social, and psychological issues on the main biomedical ailment

The AMA proposed a four-part curriculum to enhance physicians’ personal awareness that helped to define ‘cultural competence’ and the training to achieve it. It covered materials related to core beliefs, attitudes, and personal philosophy; influences from family of origin, gender, and socio-economic status; feelings and emotional response in patient care; and physician self-care.

The AMA report raised the issue of finding a better descriptive term than ‘cultural competence’ such as ‘culturally effective health care’. However, because literature searches (print and online) indicated widespread use and acceptance of ‘cultural competence’ over time, the AMA decided to retain the term for the purposes of its report.

In 1998, the AMA considered that medical schools and academic health centres throughout the US were offering a wide range of programs to promote enhanced patient outcomes through improved cross-cultural understanding. However, much of this work was restricted to one to eight hours of awareness-based training. The objective of this type of training was
to improve cross-cultural communication skills and avoid confrontation. Busy clinicians were perceived to prefer the one-shot, one-hour lecture approach because it “leaves their biomedical paradigm intact, and their personal opinions unaltered” (Chrisman and Schultz, 1997 as quoted by the AMA report, 1999: Section X: 14); this begs the question of the purpose of the teaching. The report stated that the success of these interventions depends on the extent to which an institutional approach requires attendance by all grades of medical staff. Otherwise, the message is conveyed that the most privileged groups are not required to change their behaviour.

The AMA (1999) stated that evaluation of multicultural education had begun. However, there was less evidence that sponsors of continuing medical education activities displayed any initiative with respect to programs promoting cultural competence, or that practicing physicians were convinced that the evolution of health care required them to improve their ability to provide culturally effective health care. The AMA report raised several questions that might help physicians reflect on issues of relevance to ‘cultural diversity’. The most relevant of these were: how inclusive should the definition of ‘culture’ be? Should extra attention be paid to competencies required to provide care to ‘vulnerable’ groups? The document also raised the issue of how much emphasis should be placed on the cultural self-awareness of health providers, without which it would be difficult to achieve the goal of respecting, affirming, and even celebrating differences. Also discussed was the balance between learning about groups while recognising that they are not homogenous.

The report identified the knowledge, skills/abilities, and attitudes of the culturally competent clinician as:

Knowledge of: history and culture of country of origin; pertinent psychosocial stresses, family life and intergenerational issues; culturally acceptable behaviours vs. psychopathology; role of religion; cultural beliefs about causes and treatments of disease; and differences in disease prevalence and response to medicine and other treatments.

Ability: interview and assess patients in the target language (or via translator); communicate with sensitivity to cross-cultural issues; avoid under/over diagnosing disease states; understand the patient’s perspective; formulate culturally sensitive treatment plans; effectively utilise community resources; and act as a role model and advocate for bilingual/bicultural staff and patients.
Attitudes: as evidence of understanding, acknowledge the degree of differentness between patient and physician; to demonstrate empathy, recall the patient’s history of suffering; have patience in shifting away from the Western view of time and immediacy; respect the importance of culture as a determinant of health, the existence of other world views regarding health and illness, the adaptability and survival skills of patients, the influence of religious beliefs on health, and the role of bilingual/bicultural staff; and demonstrate humour by having the ability to laugh with oneself and others (Lee as cited by AMA, 1999: Section X: 17).

The Council on Medical Education of the AMA (AMA, 1999: Section X: 19) recommended that the organisation continue to inform medical schools and residency program directors about activities and resources related to ‘culturally competent’ health care and encourage them to include the topic of ‘culturally effective’ health care in their curricula. Another major recommendation was to continue research into the need for, and effectiveness of, training in ‘cultural competence’, using existing mechanisms, such as the annual medical education surveys and focus groups. There was also a plan to work with agencies involved in working with minority groups to review progress.

The AAMC Task Force (1999) suggested that outcome goals required students to be aware of the importance of spirituality and culture beliefs and practices in the care of patients across a range of clinical contexts. It was suggested that students would need to recognise that their own cultural beliefs and practise and spirituality, might affect the ways in which they relate to, and provide care for, patients. This is consistent with the AMA policy referred to in the compendium (AMA, 1999).

2.5.1 Comparison between the UK and US

The differences between the UK and US policy and their interpretations with respect to ‘cultural diversity’ are striking. The AMA has been far more directive, clear and focused about the expectations it has of institutions regarding the issue of ‘cultural diversity’. It is arguable that there is a much more marked top down approach. The AMA appears to have taken on board much of the existing evidence to build their arguments and justify their position as policy leaders. Other organisation - such as the American Academy of Paediatrics (AAP), a postgraduate paediatric speciality organisation - then developed their
perspectives in the light of a central policy (AAP, 1999). Policy documents produced by the AMA and the AAMC have defined the way in which terms are to be used. Tomorrows Doctors does not define the way in which it has used terms and, thereby, left it to individual schools to make their own interpretations of these terms. In Britain there has been limited development of work in this area and the GMC has not followed up or monitored the situation to determine if their recommendations have been implemented appropriately. Developments that have taken place have pursued an isolationist perspective demonstrating little awareness of the evidence that is available and no links made with the GMC document (for example, Moodley, 2002).

Although in the US accreditation of institutions may soon be affected, the UK and US are similar in that neither country has stated how it will deal with medical schools that do not implement the policy in this area in any meaningful way. There has also been little discussion by either country's governing bodies about who should conduct 'cultural diversity' training and how this might best be developed. However, the AMA intended to continue supporting staff through a resources database and to encourage research into this area. The AMA was very clear in its documents that training must address self-awareness of physicians, although the extent of this is less clear than other aspects.

In contrast, the GMC is not explicit. The implication of the AMA position is that simply learning facts about 'other' groups is insufficient; the AAMC (2003) is also exploring the possibility of a national curriculum whilst the GMC has resisted this. Whilst both countries argue for the inclusion of diversity within the curriculum, they make little reference to the literature, which demonstrates the debate that exists as to the place of 'cultural diversity' in the curriculum from an educational perspective.

2.6 Conclusion

This chapter has served to outline the history of the development of medical education in the UK. Medical education is inextricably linked to the development of the medical profession itself. Whilst physicians began with the power, the emphasis on the Anatomical Method gave surgeons the opportunity to move to the fore of the profession. Surgery has heavily influenced the medical curriculum and what constituted a surgical apprenticeship transferred to generic medical training. It has been argued through the review that the way
the profession developed was with surgeons at the forefront and, perhaps, being the most advantaged has had an impact on what and how medical students are taught. It has also influenced the place of the non-biological subjects and this impacts on ‘cultural diversity’ in the curriculum. The GMC has resisted developing a ‘national undergraduate curriculum’ whilst work on this is ongoing in the US.

It is clear from the literature that, in the UK, Tomorrow’s Doctors has served to drive curricula changes. There is a broad range of policies and perspectives regarding what there should be in the curriculum regarding ‘cultural diversity’ but these are limited as they have often failed to define the way in which terms have been used. Even when policy statements exist, they are interpreted differently, so there is little scope for systematic comparisons to credibly further develop this area. Psychosocial issues appear to be viewed with some degree of hostility; there seems a need for these issues to first prove their worth, in contrast with other parts of the curriculum. Those who believe in the relevance of teaching ‘cultural diversity’ in medical education may have to plea with powerful curricula committees. The impression is that ‘cultural diversity’ as part of psychosocial issues is still a poor relation in deserving less respect compared with other curricula components. The review identifies that there is support for the inclusion of ‘cultural diversity’ within the medical curriculum but Loudon et al’s (1999) finding that most programmes are run by primary, community care or psychiatric staff is also important. These staff do not typically hold high status within medical organisations. One has to question how many medical schools pay lip service to the development of such programmes but in reality give them little support or much respect. This may be related, in part, to vagueness about the implementation of the curriculum and the lack of educational models. Whilst the evidence is limited, it does suggest that there is considerable work to be done before diversity teaching is perceived to be a mainstream activity and those who argue for its inclusion need to present a more coherent case. The next chapter considers educational perspectives and their place in the teaching of ‘cultural diversity’.
Chapter 3: Educational issues

This chapter begins by considering teachers in medical education and the professionalisation of medical education. A brief history of medical education is given to provide a context. There is then a discussion of learning theories relevant to the teaching of ‘cultural diversity’. The argument is that as much of the development of ‘cultural diversity’ programmes has come from training rather than educational contexts, there has been a lack of application of these theories. There is also a discussion of the place of ‘cultural diversity’ in the curriculum and both staff and student perspectives are explored. The issue of evidence-based medical education and the evaluation of medical education are also discussed. All these factors affect the kinds of educational programmes developed to implement policies such as Tomorrow’s Doctors (GMC, 1993 and 2002), which are reviewed in Chapter Five.

3.1 Teachers in medical education

Given the history of medical education as discussed in Chapter Two, medical school curricula in the UK have developed on an ad hoc basis. Generally, medical schools have considerable autonomy in the development and delivery of medical education (Lowry, 1993: 6). The GMC, as the regulating body, focuses more on the end result than how schools achieve the final result (Lowry, 1993: 6). Medical education, as a specialist field of medicine, has undergone considerable development over the last 15 to 20, with increasing calls for the field to develop academic rigour (Mennin and Cole McGrew, 2000). Medicine has traditionally taken a didactic approach to preclinical education and an apprenticeship model for the clinical phase. Few preclinical or clinical teachers received formal training in the theory or practice of education and were generally assumed to be competent teachers by way of being competent in their clinical area.

Following the publication of Tomorrow’s Doctors, the Department of Health offered medical schools funding over three years for ‘facilitators for curriculum change’ which helped develop the field of medical education (Engel 1995). In 1995, there was only one professor of medical education (Engel 1995). Since then, considerable expansion has meant that today most medical schools have a department or division of medical education if not a professor (evidenced by an examination of medical school websites as shown in Appendix
One, Table 8, page 272). Nineteen out of 26 (73.1%) of medical schools in June 2003 have a formal department or division of medical education and twelve of the 26 (46.2%) schools have a professor of medical education. Current reorganisations within the higher education sector in response to the Research Assessment Exercise (University of Leicester, School of Medicine 2003:1) may lead to medical education focusing merely on the delivery of teaching and undermine attempts to develop effective medical education research. This would undo some of the work that organisations of medical education have attempted to progress.

The Association for the Study of Medical Education (ASME) was established in 1956 and has become increasingly integrated into the mainstream over the past decade (ASME, 2003). The association has a highly respected journal entitled, Medical Education which is the highest-ranking medical education journal but only has an impact rating of 1.525, compared with the British Medical Journal with an impact factor of 7.585 (Institute for Scientific Information, 2003). The discipline of medical education now has several forums for conferences and networks included Association for Medical Education in Europe (AMEE, 2003), and the Ottawa Conferences (AMEE, 2003). The latter are run biannually as part of a European and North American Collaboration in medical education.

Engel (1995) felt that medical education in the UK developed later than in North America, the Antipodes and Scandinavia. Since the mid 1940s, he believed that the US had established units for medical education with clear career structures. There has also been greater support for research into medical education. Engel (1995) argued that the lack of research into medical education is related to the low status of teaching compared with research in the UK. Leinster (2000), Dean of the East Anglia Medical school, reiterated this in a letter commenting on reports on the malaise affecting academic medicine. He stated that there is a need for medical academics whose main contribution to scholarship is in the field of education rather than research. He stated:

“Medical educators will take time to review what the educational process is trying to achieve. They will, in cooperation with non-medically qualified educators and experts from other cognate disciplines, evaluate development in education from a broad field of study and will adapt then to apply to medicine. They will help disseminate good educational practice among their clinical and academic
colleagues. ... If medical academia is to flourish research and education must be
given equal weight” (Leinster, 2000: 511).

The status of teaching compared with research is not an issue for medical education alone. Organisations such as the Institute for Learning and Teaching for Higher Education were established in the late 1990s to increase the professionalisation of teaching in higher education (ILTHe, 2003). Until recently, few teachers in medical education, or the higher education sector in general, have received formal training in educational theory or practice (National Committee of Inquiry Into Higher Education, 1997). Over recent years, there has been an increasing emphasis in medical education on teaching teachers how to teach (e.g. GMC, 1999). However, many of the programmes tend to be pragmatic and because of time constraints barely skim educational theory (e.g. Dogra, 2003); some teaching staff may be more aware of these theories than others. Educators may provide teaching that reflects their personal preferred approaches and beliefs as opposed to a considered overview. Campbell and Johnson (1999) suggested that medical education must engender a culture that is more aware and critical of educational theories and principles. Teaching must challenge the professional and disciplinary tribalism, which results in the separation of bodies of knowledge, for which medicine’s positivist culture must adapt. Medical teachers do not perhaps apply the same rigour to their teaching practice as they do to other aspects of their jobs (Van der Vleuten, 1995: 53).

To improve the quality of medical education and encourage research in medical education, specialist masters courses in medical education are now offered at five UK universities. The first of these taught masters was developed in Wales (University of Wales College of Medicine, 2003) with others now offering similar courses. Dundee has over twenty-five years experience of teaching medical educators (University of Dundee, 2003). The University of Sheffield (2003) proposed that there is a need for such courses given the revolution that has taken place in medical education since Tomorrow’s Doctors (GMC, 1993). Competent educators need to go much further than simply acquiring the facts about education or the skills of teaching.

In considering educational philosophy and policy (including beliefs, ideology and values), Toohey (1999: 48) suggested that there are different approaches to teaching. Each approach has its own way of understanding or interpreting the following educational issues: the view
of knowledge, the process of learning (the roles of learners and teachers); the learning goals and how they are expressed; how content is chosen and organised; what purpose does the assessment serve and what methods are used; what kinds of resources and infrastructure are needed. When discussing the educational process, the way in which the educational philosophy is translated into practice is under consideration. The question is how values and ideologies are used to develop the course. Some course designers may, of course, not recognise that their underlying beliefs about the merits or disadvantages of certain approaches influence their choices.

Doctors and/or teachers with a sociological background may be more likely to develop educational programmes that are based in some sociological concepts, and demonstrate awareness of the debate regarding the concepts of race and ethnicity given that personal beliefs and philosophy do influence teachers (Toohey 1999). Teachers without sociological perspectives may be inclined to develop programmes that use more lay public concepts: there may be little or no differentiation between race and ethnicity. Race and ethnicity may be seen as the sole definers of cultural belonging or a sense of identity. Some people in medicine may see medicine as more of a science than do others. Those who believe there are ‘correct’ or ‘right’ answers may tend towards developing curricula that are based on helping students learn the right way of dealing with diversity and imply there is a single and correct response. Those medical educators who work in less concrete fields, such as psychiatry, may be more familiar with working with not knowing and be comfortable with uncertainty. They may be more inclined to develop or support programmes that help students manage not knowing and aim to help students learn about being willing to acknowledge when they do not know. The latter approach is less likely to produce checklists and claims that students have achieved a competence, which is then never built upon.

Essentialism refers to the belief that it is possible to discover and articulate the truth behind natural phenomena, a truth that defines their essence (Johnson, 2000). An essentialist perspective is the belief that it is possible to establish the truth of any scientific theory. Essentialism when applied to culture focuses on differences, artificially simplifying individual and group identities and interactions. Culley (2001) argued, that those who hold an essentialist concept of culture then map this perspective into an ethnic group. For them
ethnic groups are defined as cultural groups who manifest particular sets of cultural attributes or traits.

Fuller (2002) suggested the need to eradicate essentialism from programmes to teach ‘cultural competence’. She argued such programmes cannot be simply a list of traits about other groups as this may merely reinforce stereotypes. Fuller (2002) believed that the essentialist viewpoint needs to be replaced with an ethnogenetic focus, which recognises that groups, cultures, and the individuals within them are fluid and complex in their identities and relationships. An ethnogenetic approach looks beyond ‘colour’ approaches to patients and suggests a more detailed understanding of each individual’s ancestry, perhaps using an ‘ancestry form’. This highlights the complexities behind simple labels such as black or white. The ethnogenetic perspective must be integrated fully into medical education if medical students are to become physicians who are truly able to competently meet the needs of an increasingly diverse and complex society. Fuller did not comment that the ethnogenetic perspective cannot be integrated into medical education if those teaching ‘cultural diversity’ have not addressed it.

The history of medical education as outlined above may help explain the absence of any clear link between the application of education theory to the practice of medical education.

3.2 Theories of learning

This section focuses on different theories of learning that are relevant to teaching ‘cultural diversity’. Medical education has traditionally used cognitive types of learning approaches with fact-laden curricula (GMC, 1993). These types of learning may not be appropriate for ‘cultural diversity’ teaching and newer more challenging learning approaches may need to be applied.

Theories of learning differ from those of training. The former aim to elucidate the processes and principles underlying learning: the latter aim to establish what has to be done to bring about a change in a learner’s behaviour and, therefore, focus primarily on the structure of, and the procedures appropriate to behavioural interventions (Joyce et al, 1997: 25-34). This has implications for the teaching of ‘cultural diversity’ as much of the groundwork for this area has been developed in the context of training (for example Chirico, 2002). There has
been a greater emphasis on skills and ‘cultural competence’ than on principles based on educational frameworks.

Kaufman et al (2000:2) reviewed how theory can inform practice in medical education and stated that there is often a gap between the two. In this thesis, social cognitive theory, experiential learning and transformative learning theory are the most relevant. The first has generally been the most widely used model in medical education. Tomorrow’s Doctors (GMC, 1993) advocated the use of the second theory. However, arguably, the third is the most relevant for teaching ‘cultural diversity’ as will be shown through the discussion below. Kaufman also discusses the self-directed learning approach, which has some relevance for diversity education. The apprenticeship model of medical education, discussed in Chapter One, relies heavily on social cognitive theory, which developed from behaviourist learning theories, which are now discussed.

Learning theories initially tended to be behaviourist (e.g. Pavlov, Watson and Skinner). The central tenet behind all these approaches argued that behaviour can be observed. Through observation of the input (e.g. environmental stimuli) and the output (the response of an individual to the stimuli) a theory of learning can be devised. An argument was that laws of learning, identified through work with animals, could be generalised to humans. The work of Skinner has been particularly influential on educational practice and the work of all three strongly influenced behavioural therapy in the field of mental health (Peck and McGuire, 1988). Pavlov’s work established that in response to a particular stimulus (the sound of a metronome) paired regularly with something else (food), dogs would respond in a particular way (salivation). The food was termed the ‘unconditional stimulus’ in that it generated salivation with or without training. The metronome as ‘conditional stimulus’ given it produced a response after presentation with food i.e. the response was to the metronome was conditional on presentation with food and did not in itself produce a response. The salivation to food is an ‘unconditional’ response and that to the metronome a ‘conditioned’ response. The theory is that someone can be trained to produce certain behaviours given the appropriate training. In the same way behaviours can also be reduced, extinguished, generalised and discriminated through producing undesirable and desirable stimuli.
Watson (1950) built further on Pavlov's work in a social climate. Watson (1950) believed 'man' was a product of his experience and established the concepts of frequency and recency to explain learning. The former principle stated that the more frequently we have made a response to a given stimulus in the past, the more likely we are to make that response when presented with that stimulus again; the latter that the more recently we have made a particular response to a given stimulus, the more likely we are to make the same response again. Skinner (1971) further added to the field by introducing the concepts of reinforcement, i.e. the rewarding or punishing if behaviour also influences the continuance or discontinuance of behaviour. Sporadic reinforcement has been found to be more effective than constant reinforcement.

The cognitive approach focused on perception, memory, concept formation, language, symbolisation, problem-solving and reasoning as basic cognitive processes that influence learning. The emphasis in cognitive theories has been placed primarily on elucidating the processes by which people selectively attend to aspects of their external environment, how they form and evaluate mental representations of external events, either rejecting or storing them, and how they retrieve and use them in the course of their every-day activities, acting on and changing their environment in the process. The key figures in the development of cognitive theories have been Piaget (1950) and Vygotsky (1978), both of whom have had significant influences on education in schools, with the latter's work finding favour more recently.

There have been attempts to reconcile the two approaches of behavioural and cognitive through for example the work of Gagne (1971). Gagne (1971) developed a hierarchy of learning, which states that for certain kinds of learning to happen (e.g. problem-solving) other types of learning must have preceded it e.g. the learning of concepts. Gagne (1971) emphasised the importance of structuring material to be learned to break it down into its component parts by analysing the complex skill or knowledge outcome required into its components. For example, with regard to training medical students to meet the cultural needs of patients, initially the teacher would need to decide: what items of knowledge and skill are required to do this; how these items depend on one another, that is, the order in which they should be learned into which further basic components these items could be analysed and the order in which they should be learned and so on. Interestingly, the issue of attitudes was not raised.
This has led to the view that students rarely come to learning contexts with a blank slate and that most learning especially in adulthood consists of assimilating new experience into one’s existing cognitive structure (Brookfield, 1986:9). Further concepts of learning were introduced by Bandura (1969) who argued that the copying or modelling of the behaviour of others involves a cognitive process of identification that is motivated by the imitator’s desire to be the same kind of person as the model. Modelling as a concept is often referred to in medical education; students supposedly learn more through observation of the behaviour of senior medical staff than what they are taught in formal settings (Lowry, 1993:51). For example, a student might be taught about treating patients in a certain way but, in the context of medical schools, he/she is more likely to be influenced by the way that a particular doctor behaves and model themselves on this observation rather than what is taught. There may be inconsistencies between what students are taught and what they observe.

More recently there has been a development of the social contexts in which learning takes place. Psychological theories can be viewed as universalist (universal laws of behaviour or universal cognitive processes) or relativist (human behaviour and thinking situated within a cultural context). Wertsch (1995) presents a model of sociocultural research, which asserts that there is a relationship between mental processes and the sociocultural setting. There has also been the development of adult learning theories and training, which have led to some key principles that have strongly influenced education, and more especially training in the West. The experiential learning cycle of Kolb is well recognised in medical education. Kolb (1984) stated that:

- Learning is a process and not an outcome. Our concepts are derived from and modified by experience and this is a continuous process. Failure to modify ideas and habits as a result of experience is seen as maladaptive.
- Learning is perceived as a continuous process and grounded in experience. Knowledge is derived from and tested out in the experience of the learner.
- The process of learning is seen as requiring the resolution of conflicts between opposing ways of dealing with the world
- Learning is perceived as the central process of human adaptation to the social and physical environment.
• Learning is perceived as involving transactions between the person and the environment. Learning is not something, which merely goes in within the person but takes into account the situations for the learning.

• Learning is perceived as the process of creating knowledge. It is the result of the transaction between social knowledge and personal knowledge.

Unsurprisingly there has been some criticism of Kolb’s model, which argues that the model may apply better to some contexts than others (e.g. Jarvis, 1987). However, as a model it is a useful tool for teachers developing curriculum to work with in the sense that it provides a framework for considering the different processes that place in educational or learning contexts.

Kaufman et al (2000: 24) proposed that the self-directed learning approach is an utilisation of several theoretical approaches, including the cognitive, social learning, humanist and constructivist approaches. The implication for the medical curriculum is that learners must have the opportunity to develop and practice skills using this approach. This should directly enhance the learning approach, which includes competency at asking questions and at critical appraisal of new information. Learners need skills for multiple learning, including both superficial and deep learning styles and the ability to decide when each is appropriate. There also needs to be a critical reflection on one’s own learning and experience. In practice, there has been considerable confusion between directed self-learning and self-directed learning with medical schools often doing more of the former than the latter. It is difficult to see how students can undertake self-directed learning given that certain outcomes must be met before they can pass their examinations.

Freire (1970) introduced the concept that, in order to learn, one has to be willing to challenge one’s own worldview, to step outside it and look back on his/her own life. He highlighted the need for education and training practice to engage the learner in a continuous and alternating process of investigating and exploration, followed by action, which in turn is followed by reflection on this action. This concept is relevant to transformative learning.

Mezirow (1994) largely developed transformative learning. It is based on constructivism and defines learning as the social process of constructing and internalising a new or revised
interpretation of the meaning of one’s experience as a guide to action. In contrast, conventional learning elaborates the learner’s existing paradigm, systems of thinking, feeling and actions relative to the topic. Transformative learning changes the learner’s paradigm, and critical reflection and rational discourse are the primary processes used in this type of learning approach. Mezirow (1994) argued that in a discourse, a participant will:

1. Have accurate and complete information
2. Be free from coercion and distorting self-deception
3. Be able to weigh evidence and assess arguments ‘objectively’
4. Be open to alternative points of view and to care about how others think and feel
5. Be able to become critically reflective of assumptions and their consequences
6. Have equal opportunity to participate in the various roles of discourse
7. Be willing to accept informal, objective and rational consensus as a legitimate test of validity.

Successful transformative learning according to Kaufman et al (2000:21) questions the assumptions that individuals hold. The role of the educator is a co-learner and provocateur. This kind of learning is very different from the apprenticeship model that has until recently dominated medical education. To change educational methods as well as changing the curriculum itself may be too much change at once for some medical educationalists to manage.

3.2.1 Application of learning theories

Kaufman et al (2000: 34) concluded that the application of educational theory to practice has always been somewhat eclectic. Kaufman et al (2000: 35) believed that this theory could be linked to practice through medical educators acquiring and studying the relevant literature to better understand the theories. Educators can then practice applying these theories, receiving feedback and reflecting on the process to improve their practice. There is little evidence that this has been applied to the teaching of ‘cultural diversity’ or even medical education as a whole. The lack of application of educational theory may also be related to the uncertainty of the status of ‘cultural diversity’. The traditional learning approaches in medicine would suggest that if any educational theory has been applied to the teaching of ‘cultural diversity’ it would direct ‘cultural diversity’ towards acquisition of
facts. This is discussed in greater detail in the next chapter. As discussed in Chapter Two, there has been considerable debate about the place of the behavioural sciences in the curriculum. At present, this debate includes the place of ‘cultural diversity’ in the curriculum and this is now discussed.

3.3 The place of ‘cultural diversity’ in the curriculum

The evidence presented provides a range of perspectives about the place of ‘cultural diversity’ in the medical curriculum. It is proposed that, whilst there is support for ‘cultural diversity’ in the curriculum, the case is made by way of a moral plea rather than using the available evidence to support the inclusion of such teaching. The different perspectives also highlight the lack of any structure for a coherent debate about this issue; some papers assume that there is agreement about the place of ‘cultural diversity’ and what teaching in this subject actually entails. Staff perspectives are reviewed before those of students.

3.3.1 Staff perspectives

In an editorial in Medical Education, Prideaux and Edmondson (2001) asked whose responsibility is it to teach the issue of ‘cultural diversity’ and who is representing culture in medical education. They suggested that it is an individual’s cultural identity that affects interactions with the health system and influences health status. Thus, teaching ‘cultural diversity’ and developing cultural awareness means learning to respect and value differing cultural identities as a starting point to understanding health needs and delivering excellent health care. There appears to be an assumption that exposure equals automatic respect for that which is different. In a commentary on Kai et al’s (1999) paper on valuing diversity, Prideaux (1999) argued that the curriculum could be designed so that it incorporates the lived experience of cultural and ethnic groups and their interactions with the health system. These experiences should be combined with opportunities to gain and consolidate the essential knowledge, skills and attitudes for safe practice. Prideaux (1999) emphasised, that in an integrated curriculum students might place greater importance on ‘biomedically relevant’ aspects than on ‘socially and culturally relevant’ aspects. This potentially also applies to problem-based learning curricula. Prideaux (1999) proposed that new curriculum proposals need advocates to push for initial acceptance, adoption and subsequent implementation and thereby, change. He suggested that existing staff and students can act
as advocates but “medical schools should also seek to attract members of cultural and ethnic groups and recognised culturally and ethnically safe practitioners to their faculties. They should become the designers, teachers’ ongoing evaluators and innovators of the culturally and ethnically safe curriculum programmes” (Prideaux, 1999: 556). This perhaps is not an ideal way to promote the message that valuing diversity is the concern of all practitioners not just those from minority groups.

Kai et al (1999) discussed the meaning of learning to value ethnic diversity. The authors outlined the principles and content of potential training programmes. They place training in the changing context of medical education following Tomorrow’s Doctors (GMC 1993). Kai et al (1999) emphasised that teaching about diversity is not just about other cultures but that we all belong to a unique cultural group. They suggested that learners should be enabled to contextualise the health and health care experiences of individuals, and to reflect on their own personal and family experiences. The point is made that this approach is more patient-centred. The valuing diversity approach was perceived as necessary to improve access to appropriate health services for ethnic minorities.

Green et al (2002) proposed a case that caring for patients of diverse cultural backgrounds is linked inextricably to caring for patients of diverse social backgrounds. Lower socio-economic status is lower in minorities and those of lower socio-economic status are disadvantaged and have higher burden of morbidity and mortality. The authors argued that cross-cultural medical education typically fails to address social factors such as income and education but also illiteracy, immigration experiences, religion, social stressors and social support networks. Failing to address these important areas risks, inadvertently teaches doctors to view culture as the explanation for fundamentally social issues. The authors stated, that as medical students and residents frequently train in ‘safety net’ institutions, this issue is magnified and they are at particular risk of developing negative stereotypes for various cultural groups as poor and undereducated. They felt that students need to learn to integrate the social aspects of patients’ lives into their history taking and suggest focusing on social stressors and support networks, changes in environment, life control and literacy.

Durie (2003) stated that many indigenous groups have emphasised autonomy and self-determination, and have prioritised developing an indigenous health workforce with both
professional and cultural competence. Durie (2003) did not dismiss this approach but suggested that, while access to quality health care is important, socio-economic and macro political interventions may have greater potential for improving the health status of indigenous people. This then raises the question as to the benefits of investigating ‘ethnic’ group attitudes to specific illnesses/diseases.

Wear and Nixon (2001) argued that Fadiman’s book ‘The spirit catches you and you fall down’ raises questions that medical educators and students should ponder. The book was about a young Hmong girl, Lia, who had epilepsy and died because, her parents and healthcare staff did not communicate effectively (Fadiman, 1998). How do doctors achieve multicultural understandings of patients that give illness context and meaning? How should doctors honour their practices, cultural beliefs and practices that may be in opposition to standard medical practice? The case of Lia covered in the book, touches many raw nerves, partly because it has been so eloquently conveyed; it is not, however, inconceivable that there might have been a similar outcome in a white family who did not understand the explanations offered to them. Clinicians often deal with families of different ethnic backgrounds whose understanding of conditions such as epilepsy, and seizures in particular, and its management differs from the ‘medical’ perspective.

Hoffman et al (2000) argued that, while equality under the law and in economic opportunities is often best achieved in a sex and gender-neutral manner, equity in health care requires a respectful appreciation of difference. They argued that a woman-centred perspective in medicine brings equity to health care, research and education. This is akin to the ‘ethnic-centred’ perspective. Women are seen as an influence to challenge ‘norms’ set by white males. They stated that if all specialities are making changes to better serve women, then all medical graduates need to have a working knowledge of sex and gender-based differences and the skills to keep themselves informed and competent as the field of women’s health becomes more defined. They lead to the view that a patient-centred approach underscores the importance of including an appreciation of sex, gender, race and cultural variation. The authors believed that ‘a diversity lens’ needs to be added to evidence-based medicine.

Turbes et al (2002) conducted a content analysis of 983 cases presented in the first two years of the curriculum at the University of Minnesota Medical School to determine the
ways in which they might embody elements of the hidden curriculum, i.e. how they either supported or undermined explicit messages about patient diversity. The findings showed that cases featured more males than females. Sexual orientation only tended to appear in the context of a risk assessment for particular diseases such as HIV. Racial or ethnic descriptions were infrequently provided. The authors suggest that the lack of diversity in cases presented may undermine those parts of the curriculum where these issues are addressed. This study has particular relevance for problem-based learning curricula in that although these issues may be touched upon, little effective learning results.

### 3.3.2 Student perspectives

Dogra and Stretch (2001) aimed to establish whether students had an awareness of the requirement to consider cultural issues in caring for patients and identify those issues that are most difficult for students before introducing this to their curriculum. Previously validated questionnaires were modified and expanded on the study in 1998. Data were collected from 105 medical students in years two and four. Students accepted that they, as future doctors, have a responsibility to be aware of the different cultures within their practice. Their responses supported the introduction of sessions on cultural and racial awareness as part of the Human Diversity Module.

Kai et al (2001a) undertook 9 focus groups with 55 medical learners, including undergraduate students in a UK medical school and a group of postgraduate general practitioners in training. The results indicated that there is a potential predominance of a ‘difference’ perspective, which might drive a narrow focus upon learning cultural knowledge at the expense of promoting a balance with self-reflection upon attitudes and developing generic skills. This supports the notion that students want certainty that much of medical training seeks and claims to provide.

Loudon et al (2001: 38) reported on a series of discussion groups with medical groups and found that a student committee was quite negative and felt that students had little to gain from teaching about diversity and in-depth knowledge was not required. Paradoxically they wanted lecture-based information on health beliefs, cultural ‘norms’ and sensitive issues. The work suggested that students felt the issues were ‘thrown at them’. In another forum, they found students believed that teaching about ‘cultural and ethnic diversity’ should be
delivered through experiential learning in clinical settings. Pre-registration house officers (PRHOs) were interviewed and felt that formal teaching about culture and ethnicity was not required and could not recollect any specific teaching about diversity. However, despite saying they did not feel teaching was necessary, they acknowledged their levels of cultural awareness were quite low but clearly did not see this as having any relevance to their delivery of care. The same group found that students who had experienced teaching did find it was relevant and that it would lead to improved clinical care (Loudon et al, 2001: 49).

A series of reflective readings and small group discussions were run to meet curricular goals for medical student self-care and sensitivity to patients’ cultures, values, spirituality and end-of-life wishes for freshman medical students in the US (Hull et al, 2001). The sessions were designed to help students recognise their own views of other cultures, death and spirituality and to share those views. The small group discussion sessions were included in the school’s Student Wellness Program to reinforce the concept that discussion of difficult issues is a part of physicians’ care of themselves. Class attendance averaged at 42%. At the end of the year, students completed a questionnaire assessing their attitudes toward inclusion of spirituality in the medical encounter, discussion of personal or patient feelings and their perceptions, and 47 of the 72 (65%) questionnaires were returned. Women were significantly more comfortable in the area of feelings and spirituality, and those who had participated in the spirituality sessions rated themselves as being somewhat more spiritually oriented. No comment is made on whether or not spiritually oriented physicians may bring up issues of spirituality irrespective of the patient’s wishes.

In a questionnaire survey to first year medical students at four southeastern US medical schools, Elam et al (2001) found that students with the most diverse first year class placed the greatest value on the contributions of diversity to the learning environment. Women students placed more value on the inclusion of diversity issues in the curriculum than did male students, and also placed greater value on understanding diversity issues in their future medical practices. In this survey, African-American students were the least likely to think that the curriculum contained adequate information about diversity.

The papers above present a rather disjointed approach without referring to the evidence that might exist and do not discuss any potential problems. It appears enough to say diversity is important and, therefore, should be taught. This reflects the place of the ‘biomedical
sciences’ where little attempt has been made to filter out what is truly relevant to medical students as future practitioners, and what is taught as a tradition. There have been a few studies exploring student perspectives on the place of ‘cultural diversity’ within the curriculum. The fact that women and ‘minority’ students perceive this need as greater than majority males needs some consideration by medical educators because this would suggest that ‘diversity’ is largely perceived as an issue of marginal interest. Students may demonstrate an awareness of the issues raised but, to date, they have not always demonstrated a willingness to be personally challenged as shown when discussing diversity teaching to postgraduates (Culhane-Pera et al, 1997).

3.4 Implementing policy

It is unclear how educational theory is applied when educational policies are implemented through course design and delivery (this can either be a curriculum with many components or one of these components).

Bland et al (2000) undertook an extensive review of the literature on educational curricular change and organisational change to provide guidance for those directing curricular changes in medical schools in the US. From the literature they identified a consistent set of characteristics that emerged as being associated with successful curricular change. The characteristics were: the organisation’s mission and goals; history of change in the organisation, politics; organisational structure; need for change; scope and complexity of innovation; co-operative climate; participation by the organisation’s members; communication, human resource development; evaluation; performance dip; and, leadership. Four suggested stages to including new materials were:

- Planning the change after need is established
- Initiation of innovations
- Implementation
- Institutionalisation – the ‘new’ way of doing things is now established.

Politically, the issue of power and who ‘owns’ or ‘controls’ the curriculum may need resolution. Resource allocation may also heavily influence change as in some ways financial support may also reflect other support. Bland et al (2000) stated that the importance of a positive, respectful work climate to successful curricular change cannot be
overstated. The authors expressed surprise at the paucity of literature on curricular change. These issues are particularly relevant to teachers in diversity. Distlehorst and Cameron (2000), reporting on curriculum management and governance structure included curriculum goals for 2000, of which one was that students recognise that spirituality and cultural beliefs are important elements of the health and well-being of patients. The attributes of being compassionate, tolerant and respectful in caring for patients and trustworthy were commented upon. Medical teachers within medical schools may find themselves less valued when they are associated with “softer skills teaching” such as diversity which is considered to have less merit than skills in “hard sciences”. They may also find that student views make acceptance of such programmes more difficult.

3.5 Best evidence medical education and evaluation

Given the increasing emphasis by the medical professional and government on evidence-based practice in medicine (Centre for Evidence Based Medicine, 2003) issues of evidence-based educational practice are now considered. The first centre for evidence-based medicine was established in 1994 in Oxford as a joint venture of various government, clinical and academic organisations. Sackett et al (1996) defined it thus:

“Evidence-based medicine is the conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients. The practice of evidence-based medicine means integrating individual clinical expertise with the best available external clinical from systematic research” (Sackett et al, 1996: 71).

There has been support for using a similar framework in medical education as proposed by Harden et al (1999). They discussed the concept of “Best Evidence Medical Education” (BEME) (Harden et al, 1999) as a response to the rise of evidence-based approaches in medical practice (e.g. Greenhalgh, 1997). The perspective is that those principles that apply to effective clinical practice should be considered equally for effective teaching. Harden et al (1999) argued that new approaches might be introduced in medical education with much rhetoric but little real, reliable or valid evidence. They stated that education often develops and changes simply on the basis of new ideas promoted with missionary zeal, new theories with very little evidential basis and the social and political values of the moment. In practice, very often ideas, which have no evidential basis, become so ingrained by constant
repetition and reassertion that they become the evidence. Van der Vleuten (1995:S3) highlighted a paradox in medical education stating that:

“I noticed that my new colleagues - clinical and biomedical researchers - had the same academic values as I did which reassured and made me feel comfortable. However, I quickly noticed something peculiar; the academic attitudes of the researcher appeared to change when educational issues were discussed. Critical appraisal and scientific scrutiny were suddenly replaced by personal experiences and beliefs and sometimes by traditional values and dogmas” (Van der Vleuten, 1995:S3).

Gibbs (1995) proposed that much of the evidence available is not well-known or simply ignored. Campbell and Johnson (1999) suggested that the epistemological assumptions underlying evidence-based medicine are inappropriate for medical education. They described fashions in medical education and attributed this fashion-driven approach to the fact that medical education is based primarily on social influences. This is in contrast with approaches based on established educational principles and theories, critically evaluated experiences, or the results of valid research. In a fashion, educational reasoning and justification are implicit at best and at worst absent. They argued that unless medical educators are proactive in redefining what is meant by medical education and how it is justified, inappropriate measures of what constitutes evidence may be imposed.

This is a claim further supported by Greenhalgh et al (2003) who evaluated the use of an evidence-based medicine framework to improve educational quality. They concluded that evidence in education should include not only formal, research-derived knowledge but also tacit knowledge (informal knowledge; practical wisdom and shared representation of practice). It is not clear what is interpreted as formal knowledge and who decided on what is important. Randomised controlled trials are not the only method for research. Tacit knowledge perhaps is even more prone to personal bias. However, Greenhalgh et al (2003) do not appear to recognise is that medical education must seriously consider what it is trying to achieve and the extent to which medical educationalists systematically apply educational theory to their practice. Perhaps it is not that the evidence-based approach does not apply to medical education, but that it needs to be applied more critically. Questions also need to be asked about how teaching programmes are developed and the relationships
they bear to the available evidence-base. However, Cottrell (2003) argued that an evidence-based approach can be taken whilst acknowledging that most studies will not be randomised and controlled and that evaluation of education interventions is perhaps similar to evaluating multi-factorial treatment (management) approaches in clinical contexts.

Harden et al (1999) argued that the continuum is between opinion based and evidence-based teaching and teachers make decisions about their teaching practice on the best evidence that is available, at whichever point that find themselves on the continuum. They suggested a model for evaluating evidence in educational practice to help teachers develop a more evidence-based approach and conclude that the adoption of best evidence medical education does not require the teacher to be a researcher in education, but does require the teacher to be able to appraise the evidence.

Norman (2000) considered some of the difficulties in using the best evidence medical education. He viewed it as a clearing house for systematic review of educational research literature and states it may not be as straightforward as proposed by Harden et al (1999). He argued that the extent and strengths of evidence presupposes one worldview and that the need to ensure that statistical significance should not be confused with strength of evidence. However, despite the difficulties faced, Norman (2000) concluded that educational researchers need to make their research more accessible and that there are areas of good quality research, which are perhaps not accessed or utilised.

In an overview of cross-cultural medical education, Betancourt (2003) reviewed conceptual frameworks and the appropriate frameworks for evaluating them. The three conceptual approaches are those of attitude, knowledge and skills. He proposed that before deciding on an evaluation framework, the teacher needs to be clear about what is expected from the student as this governs what follows. He suggested a range of assessment techniques including objective structured, clinical examinations (OSCEs), presentation of clinical cases and other commonly used methods. In linking cross-cultural curricula to health outcomes, he asked teachers to ask if students learn what is taught, if they use what is taught and if what is taught has an impact on care. Again the techniques for the first two questions are largely assessment techniques and the third question is answered by use of patient/provider feedback and an investigation into processes of care. What is less evident
is how these might be implemented. Nevertheless, the review suggested that it is no longer acceptable not to consider evaluation.

3.6 Conclusion

Until recently teachers in medical education have not always received formal educational training, so it is unclear how they apply educational frameworks let alone consider issues such as evidence-based education. It may be that many involved in teaching ‘cultural diversity’ are unaware of the different educational approaches. This chapter also reviewed the learning theories most relevant to ‘cultural diversity’ teaching. It argued that the failure to apply these might partly relate to the ambivalence of the place of ‘cultural diversity’ in the curriculum given the lack of any clear consensus on this issue. In summary the field of medical education is aware of established educational theory. However, as Kaufman et al (2000) state, the link between educational theory and the teaching of medicine is not always clear. There is a lack of clarity about whether or not educational theories influence medical educationalists who develop or deliver curricula and whether traditional teaching methods are appropriate for the teaching of ‘cultural diversity’. It is difficult to be clear whether in practice, the teaching of ‘cultural diversity’ has utilised inappropriate learning approaches or whether any educational theory has been considered.
Chapter 4: Ideal types for ‘cultural expertise’ and ‘cultural sensibility’

This chapter begins by outlining two ideal type models of ‘cultural diversity’ teaching programmes, designated as the ‘cultural expertise’ model and the ‘cultural sensibility’ model after a brief introduction to the ideal type method. It should be emphasised that these are analytical concepts developed in this thesis, with the aim of clarifying, classifying and differentiating between the range of practices that medical educators include in ‘cultural diversity’ programmes. Thus, although ‘cultural diversity’ is a term used by medical educators to describe a somewhat eclectic mixture of practices, the terms ‘cultural expertise’ and ‘cultural sensibility’ are introduced to make systematic analytical distinctions. The rigour of ideal types is required because it brings clarity to the muddled reality of ‘cultural diversity’. ‘Cultural diversity’ programmes, which in their terms seek to achieve ‘cultural competence’ among students, exemplify ‘cultural expertise’ models. Elements of the ‘cultural sensibility’ model are less common and have different kinds of objectives. Comparisons are made between the educational philosophy, educational process, educational content and educational and clinical outcomes of the two models. The chapter concludes with potential learning outcomes for each model.

4.1 Ideal types

This section describes the ideal type as a methodology. Weber (Morrison, 1995) devised the ideal type as a methodological procedure to try to overcome some of the limitations of investigation in the social sciences. The ideal type was initially put forward in 1905. Giddens (1971) stated that the ideal type concepts and their usage in the social sciences are logically rooted in a general epistemological standpoint. Weber did not see himself as having a new sort of conceptual method but that he was making explicit what was already being done in practice (Giddens, 1971). As a methodological construction, the ideal type is neither a typology in the conventional sociological sense of the term, nor a dichotomous list of contrasting elements. Neither is it a list of comparative characteristics. The ideal type is defined as a conceptual pattern, which brings together certain relationships and events of historical life into a complex, which is conceived as an internally consistent system. The rationale is that social subject matter cannot be observed directly. The concepts that are used in the social sciences cannot be derived directly from reality without the intrusion of value-presuppositions, since the very problems, which define the objectives of interest, are
dependent upon such presuppositions. Thus the interpretation and explanation of an historical configuration demands the construction of concepts, which are specifically delineated for that purpose and which, as in the case of the objectives of the analysis itself, do not reflect universally essential properties of reality.

The ideal type is a method of discovering common properties of social phenomena; it is meant to show that social phenomena can be studied when social scientists engage in concept formation that functions to select aspects of empirical reality that are worth knowing. The ideal type is, therefore, designed to capture empirical reality by arriving at the analytical accentuation of certain aspects of society by providing a lens through which that aspect of society can be viewed. An ideal type is not ideal in a normative sense in that it does not carry the connotation that its realisation is desirable. An ideal type is a pure type in a logical and not an exemplary sense.

The main category of type formation formulated by Weber was historical ideal types. Historical ideal types form concepts by selecting phenomena on the basis of common characteristics and employ a criterion of selection of only those general concepts, which are precisely and unambiguously definable such as individualism, feudalism and capitalism. The example most widely used is that of the city economy type. The concept of a city economy can only be formulated by isolating what is essential from the non-essential. The ideal type does not serve as a description of concrete historical reality, but is a construct used to elucidate the features of historical reality. Extracting essential traits that elaborate concepts by comparing them with concrete phenomena, does this. These traits are then compared with a purified picture of social reality and, from this, a workable type is formed.

The type is created by providing a one-sided accentuation of one or more points of view and by the synthesis of many diffuse, discrete, concrete individual phenomena arranged according to a one-sided analytical construct. When applied to reality, ideal types are useful in research and exposition. Ideal types arrange certain traits, which in society are generally unclear and often confused, into a consistent ideal construct by an elucidation of their essential elements. The ideal type can then be used as a benchmark to allow comparisons.

A criterion of ideal type construction is the capacity to draw connections and interrelations between divergent condensed elements. In this respect, the ideal type is seen as a shorthand
medium of concept formation, the goal of which is to extract the essential elements and formulate the type. The purpose of the ideal type in this context is that it constructs, rather than describes historical types; such constructs are a means of explicitly and validly imputing a historical event to its real cause while eliminating those, which on the basis of present knowledge, seem irrelevant. The goal of the ideal type is to make explicit both the general and individual characteristics of empirical reality.

Morrison (1995) stated that, according to Weber, the ideal type serves several distinct investigative purposes:

1. It can discover relationships of the type referred to, in concrete reality by seeing if the types actually exist in reality and if their characteristics can be made clear and understandable
2. It is useful for heuristic and expository purposes since it helps develop an understanding of the kinds of activities that which can be assigned to different societies during research
3. Ideal types can help with the formulation of hypotheses
4. Ideal types can help reduce the ambiguity about empirical reality by providing means to foster adequate descriptions of it
5. The ideal type leads to the formulation of concepts about societies by holding ideas of historically given types of societies within its conceptual understanding of reality

For the development of ideal type models of ‘cultural diversity’ teaching programmes, the concepts behind points 1-4 are utilised.

4.2 Key concepts

‘Cultural expertise’
A dictionary definition of expertise (Thompson, 1995) is expert skill, knowledge or judgement, with expert being defined as having special skill at a task or knowledge in a subject. There is a view that through learning knowledge about ‘other’ cultures, one can develop ‘cultural expertise’ and that much of this knowledge can be learned through didactic teaching. ‘Cultural expertise’ is about having facts about other cultures. The concept of ‘cultural expertise’ encompasses the well-established model of ‘cultural competence’.
'Cultural sensibility'

'Cultural sensibility' is proposed so as to broaden the concept of 'cultural sensitivity', which in general, has been a tentative alternative to the idea of 'cultural expertise'. A dictionary definition (Thompson, 1995) of sensibility is an 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'. 'Cultural sensitivity' is the quality or degree of being sensitive, which is more limited than sensibility, and does not take into account the interactional nature of sensibility. If one is open to the outside, one might reflect and change because of that experience. This is not necessarily the case with sensitivity. The approach of 'cultural sensibility' has arisen out of the author’s work in 'cultural diversity' and medical education and an experience that the 'cultural expertise' model potentially limits the benefits of 'cultural diversity' teaching.

4.3 Ideal types of 'cultural expertise' and 'cultural sensibility'

Using Weber’s construct of ideal types (Giddens, 1971, Morrison, 1995) the concepts of 'cultural expertise' and 'cultural sensibility' are compared with regard to several characteristics. The characteristics are grouped into four major areas of course development:

- Educational philosophy and policy
- Educational process
- Educational contents
- Educational and clinical outcomes

Educational philosophy and policy usually inform all stages of course development and also affect the educational process, educational contents and outcomes. When discussing the educational process, the way that the educational philosophy is translated into practice is an important guiding principle. The question is how the values and ideologies of those developing the course are used to develop the course. Some course designers may, of course, not recognise that their underlying beliefs about the merits or disadvantages of certain approaches influence their choices. In considering educational contents, the very nature of the material is under review. This stage involves identifying the key areas that the teaching will emphasise and whether or not the programmes will focus on the attainment of knowledge, skills and/or attitudinal outcomes. Assessment is often perceived to be the
major educational outcome measure but there will also be other outcomes, albeit that some are more explicit than others.

4.4 Educational philosophy

This section compares the educational philosophy embedded within the 'cultural expertise' and 'cultural sensibility' models as summarised in Table 2 (page 68). For each model the issues of epistemology, categorisation of knowledge, use of categorisation, ontology, conception of reality, analytical perspective, historical connection, politics of institutions and relation to inequalities are considered. This section also considers the conception of culture, the perception of the individual’s relationship to society as well as the role of teachers and learners in the education.

For the 'cultural expertise' ideal type the educational philosophy is based on the epistemological position that knowledge exists independently of a context. Not only can knowledge be categorised, but also it is helpful to do this. In its most limited form, the philosophy is compatible with the “biomedical model” (a term that is possibly more used in sociology than in medicine), in that core competency can be learned in the same way as medical disorders. That is, culture can be categorised into items in the same way that medical disorders are categorised into underlying lesions that are indicated by signs and symptoms. In an uncritical medical model, the signs of medical illness (i.e. those that the doctor identifies through history taking and examination) and the symptoms (of which the patient complains) are categorised. The principle is that a constellation of particular signs and symptoms lead to the diagnosis of a disorder, although this may not necessarily be the case in practice. The 'cultural expertise' model in the extreme, treats culture in the same way in that particular signs of how people behave (e.g. the food they eat) or particular characteristics or beliefs such as skin colour, or views about alternative medicine, are used to categorise people into cultural groups (e.g. Deloney et al, 2000).

The 'cultural expertise' educational philosophy has a positivist view of science, is reductionist and structuralist in nature. Structuralism sees the truth as behind or within a text; in contrast post-structuralism stresses the interaction of the reader and text (Sarup, 1988). In practice the 'cultural expertise' model translates this into the belief that there are objective fixed truths about cultural groups that can be learned. In this model, the education
that students receive reveals to them the truth about other cultures in a non-critical sense. There is also an emphasis on the difference from *us* (a majority) and *them* (the others) (Culhane-Pera *et al.*, 1997).

In social sciences, the positivist approach places particular emphasis on behaviour that can be observed directly, and argues that factors that cannot be observed directly (such as meanings, feelings and purposes) are not particularly important. Culture is reduced to specific traits and people's culture simplified into items that can be observed. This approach does not recognise the meanings that individuals may assign to their sense of self and culture. In the context of ‘cultural diversity’, ‘cultural expertise’ model explains the way people behave as a product of their membership of certain groups. These behaviours can be learned by outsiders in the form of lists (e.g. McGarry *et al.*, 2000; Chirico, 2002). Culhane-Pera *et al.* (1997) discuss the wish of doctors in training to receive concrete pieces of information from which they can generate ‘do and don’t’ lists for use in clinical practice and the need for teachers to resist providing students with such lists.

The ‘cultural expertise’ model appears to be rooted in the historical context of white domination of disadvantaged minorities. Much of the drive for ‘cultural expertise’ in healthcare has arisen from the growing awareness of inequalities that exist in the prevalence of health problems and health care uptake (Dyson and Smaje, 2001). The rationale, in part, is that healthcare provision is planned and delivered without taking into account that different cultural groups may have different needs. There appears to be the view that, if the providers were trained to be culturally competent, some of the health inequalities would be diminished. For example, Cooley and Jennings-Dozier (1998) suggested that a lack of knowledge about cultural influences on care may account for the disparity in the incidence and mortality rates of cancer, especially lung cancer, between African Americans and white Americans. Green *et al.* (2002) also argued that ‘cultural diversity’ as a field has blossomed in an environment of increasing awareness of the effect of race and ethnicity on health outcomes.

In the ‘cultural sensibility’ model, educational philosophy is rooted in a wider social context and is located within a social constructionist perspective. Knowledge is seen as contextual to one’s environment and does not necessarily need to be categorised. ‘Cultural sensibility’ does not use the medical model as a metaphor and does not attempt to look for
signs and symptoms, which can lead to a classification of an ethnic group or other social category. Indeed, in this model it can be unhelpful for knowledge to be categorised as this leads to a view that cultures can be reduced to lists of characteristics. It also implies that the meanings individuals have of their own sense of culture are lost because the categorisation process is about groups rather than individuals. ‘Cultural sensibility’ recognises that different people interpret the world differently, so that even two individuals in the same group, who experience the same event, may take very different meanings from it. The philosophy behind this model is that there is no single objective reality to be discovered. It acknowledges that individuals construct their own version of their culture dependent on the various social discourses of which they are aware or in which they participate.

‘Cultural sensibility’ avoids being reductionist, in that it takes an overview of the concept of culture and tries to avoid listing characteristics of groups. This model is more interested in the relationship between different components of culture and their meanings to individuals. A post-structuralist approach argues that, the way in which people understand society and the way that society works, are shaped by language, which creates reality rather than reflecting it. Language is not just the spoken word but the meanings also conveyed by it. For example Derrida, (1978) argued that the meaning of a text depends upon how a particular reader interprets it and that language is constantly shifting. ‘Cultural sensibility’ recognises that there are many different viewpoints on society, that one should refrain from passing judgements, and that all are equally valid with none being superior to another. With respect to ‘cultural sensibility’, there is emphasis on acknowledging that, unless we ask others, we cannot know about them. This is why students need to learn how to ask patients about themselves, rather than teaching them how to pre-know patients by listening to experts.
Table 2: Comparison of educational philosophy

<table>
<thead>
<tr>
<th>Item</th>
<th>‘Cultural expertise’</th>
<th>‘Cultural sensibility’</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Educational philosophy</strong> (i.e. the theory of knowledge)</td>
<td>Knowledge exists independently</td>
<td>Knowledge is contextual to one’s environment</td>
</tr>
<tr>
<td>Categorisation of knowledge</td>
<td>Core competency is about categorising groups of people and that these categories can be learned i.e. knowledge can be categorised</td>
<td>Knowledge does not need to be categorised</td>
</tr>
<tr>
<td>Use of categorisation</td>
<td>Categorisation is helpful</td>
<td>Categorisation may be unhelpful</td>
</tr>
<tr>
<td>Ontology (the nature of being)</td>
<td>Positivist</td>
<td>Non-positivist</td>
</tr>
<tr>
<td>Conception of reality</td>
<td>Objective reality to be revealed or discovered</td>
<td>No single objective reality to be discovered</td>
</tr>
<tr>
<td>Structuralist</td>
<td>Non-structuralist</td>
<td></td>
</tr>
<tr>
<td>Modern</td>
<td>Post-modern</td>
<td></td>
</tr>
<tr>
<td>Not social constructionism</td>
<td>Social constructionism</td>
<td></td>
</tr>
<tr>
<td>Analytical perspective</td>
<td>Reductionist</td>
<td>Holistic</td>
</tr>
<tr>
<td>Historical connection</td>
<td>Rooted in historical context of minority disadvantage and white domination</td>
<td>Steps outside of the historical context of race</td>
</tr>
<tr>
<td>Politics of institutions</td>
<td>Improve competence of providers and/or users to improve access to care/services</td>
<td>Does not work on a competence level</td>
</tr>
<tr>
<td>Relation to inequalities</td>
<td>Attempts to change and reduce health care inequalities</td>
<td>Acknowledges inequalities but as such does not directly attempt to change them</td>
</tr>
<tr>
<td>Role of teacher</td>
<td>Teacher sets the agenda</td>
<td>Teacher introduces the agenda</td>
</tr>
<tr>
<td>Role of learner</td>
<td>Primarily as receiver</td>
<td>Student contribute to the dialogue as well as receiving</td>
</tr>
</tbody>
</table>
4.4.1 The conception of culture

The two models also view culture very differently, as shown in Table 3 (page 70). In the expertise model, culture is perceived as an external characteristic, something that others can see in what people do and how they behave. Culture is perceived as essentially static and individuals viewed static in their cultural belonging. Race and ethnicity are often used interchangeably (e.g. Sue, 1991; Deloney et al, 2000) and disproportionately emphasised in comparison with other aspects such as gender and social class. In considering the individual’s relationship with society, in the ‘cultural expertise’ model the individual is shaped by their social world and their individual identity is defined by their culture. Differences between individuals are generalised and relationships in society perceived to be between different groups. This is exemplified by ‘cultural immersion’ programmes which imply that learning about one ethnic family in depth somehow is a generalisable experience when encountering others from the same ethnic group (e.g. Loudon and Greenfield, 1998; Godkin and Weinreb, 2001). In the ‘cultural expertise’ perspective, dialogue regarding culture takes place at a group level and the individual’s identity is fixed irrespective of the context. For example, using this model, an Indian woman is an Indian first and foremost, irrespective of the context. If she is seeing a gynaecologist she might identify her gender as being the more pertinent issue. Learning outcomes such as “to describe a local service to meet the needs of a specific minority ethnic group” (Guys, Kings and St Thomas’ Medical School, 2001: 58) do not allow individuals to comment on the way they are characterised.

The ‘cultural sensibility’ model acknowledges the historical context. However, it does not allow the historical context to dominate the discourse and to deviate from the philosophy that all individuals have to learn about others. The drive behind this model is not so much that healthcare inequalities can be addressed by ‘cultural sensibility’, but that an understanding of how individuals see and understand themselves may help practitioners improve individuals’ access to healthcare. This model would not define the prevalence of health problems or access to healthcare in terms of culture, and recognises that a range of factors, such as poverty and age, may more significantly affect health than culture (Logan and Spencer, 2000). It also does not set out to directly change health inequalities.
Table 3: Comparison of conceptions of culture

<table>
<thead>
<tr>
<th>Conceptions of culture</th>
<th>‘Cultural expertise’</th>
<th>‘Cultural sensibility’</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conceptions of culture</td>
<td>Culture is an externally recognised characteristic</td>
<td>Culture is an internally constructed sense of self</td>
</tr>
<tr>
<td>Conceptions of culture</td>
<td>Static</td>
<td>Dynamic/fluid</td>
</tr>
<tr>
<td></td>
<td>One-dimensional</td>
<td>Multidimensional</td>
</tr>
<tr>
<td></td>
<td>Race/ethnicity</td>
<td>Race is one aspect</td>
</tr>
<tr>
<td></td>
<td>emphasised</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Unitary</td>
<td>Diverse/differentiated</td>
</tr>
</tbody>
</table>

**Perception of individual’s relationship to society**

<table>
<thead>
<tr>
<th>Conception of difference</th>
<th>Generalise the differences between individuals</th>
<th>Sensitive to difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Identity formation</td>
<td>Individuals are shaped by their social world</td>
<td>Individuals construct and accomplish their own social world</td>
</tr>
<tr>
<td>Conception of individual identity</td>
<td>An individual is defined by their culture</td>
<td>An individual defines their culture</td>
</tr>
<tr>
<td>Individual’s relationship with society (relationship of self with society)</td>
<td>In defining culture relationship is between groups</td>
<td>In defining culture relationship is between an individual and others</td>
</tr>
<tr>
<td></td>
<td>Dialogue re culture takes place between groups</td>
<td>Dialogue re culture takes place between individuals</td>
</tr>
<tr>
<td></td>
<td>Individuals remain as defined by their culture irrespective of the context</td>
<td>Individuals bring their own meanings and histories to different contexts i.e. the meanings may change dependent on the context</td>
</tr>
</tbody>
</table>

In the ‘cultural sensibility’ model, culture is perceived to be an internal process as an ongoing dialogue that an individual has with other individuals with whom there may be both similarities and differences. Individuals relate to the world, internally make sense of what they have experienced, and then use this to relate to the outside world. This is conceived as an ongoing cyclical process. Culture is perceived as the meaning that an individual has or gives to certain aspects of themselves and is, therefore, sensitive to differences between individuals. Thus, the ‘cultural sensibility’ model perceives cultures as fluid and dynamic. Culture is viewed as being a multidimensional construct and ethnicity as one component among many that make up an individual’s sense of self. It acknowledges that individuals may identify their cultural belonging differently from how others might
define them, e.g. an institution may define a gay man brought up in the UK by Indian parents as being an ethnic minority. He, himself, however, may define himself more by his sexuality. His clinical needs may be unmet if healthcare professionals persist in only identifying his ethnicity as relevant. Also in different contexts the definition and emphasis will shift; there are many fractured and fragmented selves depending on contexts in which individuals find themselves. The philosophy in this model is that individuals construct and accomplish their own social worlds and the meanings they give are contextual. In defining culture, the relationship is between individuals rather than groups.

4.5 Educational process

The educational process also offers contrasts between the two models. This section considers the learning process, learning outcomes, expression of learning outcomes, content, cultural focus, systems theory, pedagogical approach and the role of experts as shown in Table 4 (page 73).

The ‘cultural expertise’ model is knowledge driven. Learning outcomes are presented as the acquisition of facts. The educational approach is largely cognitive: for example, students should know what the views of Native American Indians are towards homeopathic remedies (Blue, 2001) and, more generally, have at their fingertips a command of a body of facts relating to different cultural groups. The learning outcomes are expressed in terms of skill and competence (e.g. Culhane-Pera et al, 1997). The ‘cultural expertise’ model is dichotomous and implies that there is wrong or right way about addressing issues. The structure of the observed learning outcome (SOLO taxonomy) developed by Biggs and Collis (1982) is a system that classifies student work according to its quality and attempts to identify the depth of learning achieved. Using the SOLO taxonomy, the ‘cultural expertise’ model is multistructural, in that the student may grasp a number of ideas about the topic, but does not relate them to each other or to the central question; the information is presented as a list or description. ‘Cultural expertise’ is also a first-order pedagogical approach in that the teacher (and this may be teachers from minority groups) teaches students and there are certainties that can be learned, thereby creating a place for ‘cultural experts’ and the educational teaching strategies can become didactic. There is also a view that individuals might be experts about groups: i.e., individuals carry a body of knowledge that qualifies them to profess expertise in a particular culture (Deloney et al, 2000).
certainty of the outcomes of the ‘cultural expertise’ model seeks to leave students feeling comfortable and sure of the knowledge they have learned, as it does not challenge students themselves. Culhane-Pera et al (1997) commented on students’ reluctance to self-exploration and their preference to focus on knowledge acquisition. The giving of facts may increase student ambivalence towards challenging their own views. Perhaps, programmes cannot achieve course aims successfully if information is presented about groups and students are simultaneously asked to recognise heterogeneity.

In the ‘cultural expertise’ model the educational process weights the teaching emphasis on groups of people rather than individuals and asks students to consider the health needs of minorities. The teaching is practical and skill-based. If the knowledge focus is not on cultural groups it may be on sociological theories (Moodley, 2002). The ‘cultural expertise’ model increases the likelihood of individuals disassociating themselves from the issues related to cultural and other aspects of diversity. It can be a way of externalising difference and relate it to external characteristics of others, rather than considering how the way we think and feel about issues may impact on our behaviour.

In contrast, ‘cultural sensibility’ is attitudes-driven; it asks students to evaluate their attitudes and consider the effect these might have on the care they deliver. It focuses on student acquisition of principles and concepts. The process focuses on students acquiring the means of demonstrating ‘cultural sensibility’ - the focus is on teaching the broad skills to consider a range of issues with a transferable skill. The process is recursive and reflective. Learning goals are framed in terms of attitudes and self-reflection. Emphasis is on a transformative approach to learning. Using the SOLO taxonomy, the aim of the ‘cultural sensibility’ model is an extension of the abstract - all the aspects of the learning have been brought together. However, the learning enables the student to reason about applications beyond the scope of the immediate question, theorise about related issues or reflect on his or her own actions and understanding.
Table 4: Educational process

<table>
<thead>
<tr>
<th>Educational process</th>
<th>‘Cultural expertise’</th>
<th>‘Cultural sensibility’</th>
</tr>
</thead>
<tbody>
<tr>
<td>Learning process</td>
<td>Acquisition of knowledge</td>
<td>Acquisition of principles (method)</td>
</tr>
<tr>
<td>Learning outcomes</td>
<td>Command of body of information and facts</td>
<td>Command of mode of respectful questioning</td>
</tr>
<tr>
<td>Expression of learning goals</td>
<td>In terms of skill and competence</td>
<td>In terms of attitudes and self-reflection</td>
</tr>
<tr>
<td>SOLO taxonomy</td>
<td>Multistructural</td>
<td>Extended abstract</td>
</tr>
<tr>
<td>Content</td>
<td>Certain</td>
<td>Acknowledge uncertainty</td>
</tr>
<tr>
<td></td>
<td>Dichotomous</td>
<td>Mostly grey areas</td>
</tr>
<tr>
<td></td>
<td>Right or wrong</td>
<td>Not always right or wrong</td>
</tr>
<tr>
<td>Cultural focus</td>
<td>Majority view of other cultures dominant</td>
<td>No focus on particular groups – all individuals need to consider needs of others</td>
</tr>
<tr>
<td></td>
<td>Majority whites need to consider needs of minorities</td>
<td></td>
</tr>
<tr>
<td>Cybernetics theory</td>
<td>First order i.e. the teacher teaches the student</td>
<td>Second order i.e. the student and teacher learn together</td>
</tr>
<tr>
<td>Pedagogical approach</td>
<td>Didactic</td>
<td>Directed self-learning</td>
</tr>
<tr>
<td>Role of experts</td>
<td>There are those who are experts on understanding cultural perspectives of certain groups</td>
<td>No one individual has ownership of expertise of others with respect to identification of cultural belonging</td>
</tr>
</tbody>
</table>

‘Cultural sensibility’ is a second-order pedagogical approach in that learning is a more active process and the relationship between students, teachers and the material is also considered important. The ‘cultural sensibility’ agenda is, at its best, a dialogue between learners and teachers. Teachers are seen as facilitators in the student learning process, more consistent with Vygotsky’s zone of proximal development concept (Wertsch, 1991). The zone of proximal development is the range of potential each person has for learning, and the learning is shaped by the social environment in which it takes place. When someone with greater expertise or in collaboration facilitates the learning with more capable peers, the potential ability is greater than the actual ability of an individual. This model refutes the concept that an individual can be an expert in the culture of others. Expertise is about
understanding the influence of culture and the meaning of culture to individuals. ‘Cultural sensibility’ acknowledges uncertainty, tries to ensure learners become comfortable with not knowing, and prompts the realisation that there are few wrongs or rights. Students are expected to feel uncomfortable about some of the issues raised and find the learning personally challenging. The approach seeks to support students through this rather than avoiding raising difficult issues. It emphasises that culture is complex and that there are many grey areas. This enables students to move towards directed self-learning. The focus also tends to be on the individual and the meanings the individual has about their sense of culture and cultural belonging. Cohen (1998: 6) believes that few people are willing to search out and examine the assumptions that underpin our everyday lives and most are reluctant to recognise that they exist. He proposed that as most of our assumptions are held subconsciously, we do not often even realise the extent to which they guide our thinking nor do we realise that many of the ideas we hold as ‘truth’ are themselves based on assumptions.

4.6 Educational content

With respect to educational content, the nature and organisation of the content are compared and summarised in Table 5 (page 76). The ‘cultural expertise’ model reflects what Bernstein (1973) described as a ‘collection’ type curriculum; that the contents of the curriculum are clearly bounded and insulated from each other. The learner has to collect a group of favoured contents to satisfy some criteria of evaluation. ‘Cultural expertise’ tends to start usually from the white dominant perspective and be about how this group understands minorities (e.g. American Medical Students Association, 2001). Minorities’ views of other minorities are usually not considered. Whilst there is some emphasis on considering one’s own views, this is not predominant. There is also a greater emphasis on whites having to take greater responsibility for learning about others and, therefore, the learning appears to be one-sided. The teaching of ‘cultural expertise’ may focus on local ethnic groups, so that in the US the focus may be on Hispanics and African-Americans; in the UK it may be on Asians from the Indian subcontinent; in Australia on Aborigines, Asians (from South-East Asia) and sometimes Greeks; in New Zealand it may be on Maoris and other Polynesian groups; in Norway it may be the Sami and so on. There is a perception that teaching ‘facts’ about these groups is a way of acquiring competence in
dealing with these groups. This model may generate discussion, but it will focus more on the ‘accuracy’ of the contents presented, and interpretations of them, than on self-reflection.

The ‘cultural sensibility’ model reflects more closely what Bernstein (1973) described as ‘an integrated’ type curriculum where the various contents stand in open relation to each other. The idea behind ‘cultural sensibility’, is that students need to understand their own perspectives and then relate these to their clinical experiences. The model acknowledges that the two aspects of learning are linked to each other. Another key difference between the two approaches is that ‘cultural sensibility’ attempts to teach a method of inquiry rather than the acquisition of facts about other cultures. ‘Cultural sensibility’ views everyone as different and does not focus on particular groups; it asks students to consider what they think of others and also what others think of them as individuals. It places equal responsibility on all to learn about others, even those they may believe are similar to themselves. It challenges students to consider their own attitudes (e.g. Sifri et al, 2001) and is much less skill focused than ‘cultural expertise’ tends to be. ‘Cultural sensibility’ acknowledges that student understanding of other cultures is linked to their understanding of the wider sociological debates, and their own meaning of culture and cultural belonging.

Before students can, most effectively, make sense of the struggles that people have experienced to assign certain meanings to their lives, they need to be aware of this for themselves (e.g. Goldstone and Drake, 2000). There is reduced need to focus on definitions and theories but a greater need to explore them and the processes through which they may have arisen. Students need to be aware of themselves, since it is this awareness (or the lack of it) that they take to a clinical consultation (and indeed to whatever the work context).

Whether or not, they are aware of it, what they take and what the patient brings to the consultation are influenced by each other: the ‘cultural sensibility’ model emphasises that if a doctor has had exposure to difference, when he/she comes across this in practice, he/she may feel uncomfortable. In turn, the patient may pick this up and interpret it in many ways, some of which may be negative and lead to a less effective dialogue between the two. If the doctor is aware of his/her own discomfort, he/she can be more attuned to the possibility that the patient’s response may be equally related to the doctor’s behaviour and to the patient’s ‘culture’. For example, if for whatever reason, the doctor is uncomfortable about the issue of domestic violence, the doctor may either not raise the issue, or raise it in such a way that tells the patients that the subject is taboo. The patient may leave with their story unheard, whatever their ‘ethnic’ background. A strong focus on attitudes means that there is less
factual content to cover; the teaching of 'cultural sensibility' should generate student discussion and constantly ask students to reflect on their experience and consider how this might affect future encounters.

Table 5: Comparison of educational content

<table>
<thead>
<tr>
<th>Educational content</th>
<th>'Cultural expertise'</th>
<th>'Cultural sensibility'</th>
</tr>
</thead>
<tbody>
<tr>
<td>Curriculum type (as relating to Bernstein, 1973)</td>
<td>Collection type</td>
<td>Integrated type</td>
</tr>
<tr>
<td>Nature of content</td>
<td>Parochial</td>
<td>Global</td>
</tr>
<tr>
<td>Specific</td>
<td>Non-specific</td>
<td></td>
</tr>
<tr>
<td>Organisation of content</td>
<td>To meet demands of local need</td>
<td>To maximise student self-learning</td>
</tr>
<tr>
<td>Curriculum</td>
<td>Fact acquisition to gain body of knowledge</td>
<td>Self-reflection and self-awareness of students</td>
</tr>
<tr>
<td>Teaching focus</td>
<td>Groups (treats people as groups)</td>
<td>Individuals (views individuals as potentially parts of different groups in different contexts)</td>
</tr>
<tr>
<td>More service centred</td>
<td>More patient centred</td>
<td></td>
</tr>
<tr>
<td>Focus of content</td>
<td>Students learn about others</td>
<td>Students learn as much about others as themselves</td>
</tr>
</tbody>
</table>

4.7 Educational outcomes

This section compares the purpose of the assessment, the methods used, who leads the assessment process and outcome measures. The application to clinical practice and the definition of a successful course are also compared and summarised in Table 6 (page 78).

In assessments, the 'cultural expertise' model tends to seek demonstration of knowledge of other cultures and, typically through paper and pencil tests, multiple-choice questions, short-answer questions or essays or the production of checklists. The results of assessment may be norm-reflected (a mark is calculated as reflecting the average pass mark for the class) with teachers assessing whether or not students have achieved the learning goals. The outcome of learning is students learning about other cultures. Learning applies to specific contexts and is not necessarily transferable. Robins et al (2001) assessed students' performances on a health-beliefs communication OSCE. They compared whether or not there were differences based on students' ethnic background. Whilst there were differences
between underrepresented minorities and white students, the overall conclusion was that cultural competency deficits and differences were measurable using OSCEs. There is a perspective that once the course is over, competency has been achieved.

‘Cultural sensibility’ encourages an openness to new possibilities by focusing on a willingness to accept not always knowing and developing a capacity to engage in dialogue with others and withholding a judgement. The focus of the assessment is that students take responsibility for their own learning and reflective journals or project work are the main assessment tools. The assessment process is not norm referenced. ‘Cultural sensibility’ is more reflective about itself and its impact on the wider issues. Students are expected to be critical and self-reflective in practice. The learning has broader application because students have learned about a method of inquiry that can be applied to any situation. It equips the student to be aware that other individuals may have different perspectives from them irrespective of whether or not there are initial overt differences. The learning, as an ongoing process, is expected to continue beyond the lifespan of the teaching module.

The ‘cultural expertise’ has at its centre the belief that the clinician is an expert and that through training knowledge can predetermine the needs or wishes of patients based on their ‘ethnicity’. The doctor or clinician is objective, professional and scientific, so their personal perspectives play little part in the interactions they have.

The ‘cultural sensibility’ model purports to be one of seeing patients as individuals with expertise in their own lives and works on the basis of shared decision-making about health issues. The therapeutic alliance is difficult to view as a separate dimension as it relates very closely to sharing power and responsibility. Using Mead and Bower’s (2000) the ‘doctor-as-person’ dimension there is acknowledgement that doctors carry their own perspectives and these play a part in the decisions made as much as other so-called ‘objective issues’. Young (1990) argues that the idea of impartial neutrality echoes a broader social commitment to formal equality based on liberal individualism.

“We see a society in which differences of sex, race, religion and ethnicity no longer make a difference to people’s rights and opportunities. People should be treated as individuals not as members of groups” (Young, 1991: 157).
Whilst ‘cultural sensibility’ supports this, the philosophy is not that sex, race, religion and ethnicity do not make a difference, but that they have varying influences for different individuals.

Table 6: Outcomes (including assessment and evaluation)

<table>
<thead>
<tr>
<th>Outcomes</th>
<th>‘Cultural expertise’</th>
<th>‘Cultural sensibility’</th>
</tr>
</thead>
<tbody>
<tr>
<td>What purpose does the assessment serve?</td>
<td>Demonstrates knowledge of other cultures</td>
<td>Demonstrates some understanding of self and ability to evaluate their own learning</td>
</tr>
<tr>
<td>Which methods are used?</td>
<td>Paper and pencil tests ranging from multiple-choice questions and short answers to long essays</td>
<td>Reflective journals, project work (usually experientially based)</td>
</tr>
<tr>
<td>Results of assessment</td>
<td>Norm referenced (i.e. students ranked against peers)</td>
<td>Not norm referenced</td>
</tr>
<tr>
<td>Who leads the assessment process?</td>
<td>Teacher assessment</td>
<td>Student self-assessment</td>
</tr>
<tr>
<td>Measures to check outcomes</td>
<td>Checklists</td>
<td>Self assessment</td>
</tr>
<tr>
<td>Outcome in clinical practice</td>
<td>Practical in that have facts about other cultures</td>
<td>Practical in that have a method of inquiry to be aware that others may have different perspectives. More critical and self reflective. Capacity for dialogue</td>
</tr>
<tr>
<td>Applicability</td>
<td>Learning can only be used for cultural issues</td>
<td>Learning can apply to any context in which there are differences between the doctor and patient be they cultural, gender, education</td>
</tr>
<tr>
<td>Patient centredness</td>
<td>Doctor has position of expert</td>
<td>Doctor and patient are active partners in care</td>
</tr>
<tr>
<td>Definition of successful course</td>
<td>Students learn competence in other cultures and bonus if students learn about themselves</td>
<td>Course is only successful if students learn about themselves as this is necessary before can relate to other perspectives.</td>
</tr>
</tbody>
</table>
Machado (2001) considered cultural sensitivity and how, if not carefully considered, it can lead to stereotyping. He concludes that constructs are useful ways for organising data, but can lead to stereotypes. They are most valuable when used tentatively and cautiously, moving in increasing levels of inference and in concert with the individual attributes, values and beliefs of the person being assessed. The stance Machado takes is that ultimately we wait for the individual to define him or herself and when these idiographic descriptions are woven against the backdrop of cultural markers, there may be a multi-dimensional view.

4.8 Conclusion

The different underlying philosophies of the 'cultural expertise' and 'cultural sensibility' models result in differing educational process, contents and assessments. Using the 'cultural expertise' model, the following outcomes in each of the learning domains might be used:

**Knowledge:** history and culture of country of origin; pertinent psychosocial stresses, family life and intergenerational issues; culturally acceptable behaviours versus psychopathology; role of religion; cultural beliefs about causes and treatments of disease; and differences in disease prevalence and response to medicine and other treatments.

**Ability:** interview and assess patients in the target language (or via translator); communicate with sensitivity to cross-cultural issues; avoid under/over diagnosing disease states; understand the patient’s perspective; formulate culturally sensitive treatment plans; effectively utilise community resources; and act as a role model and advocate for bilingual/bicultural staff and patients.

**Attitudes:** as evidence of understanding, acknowledge the degree of difference between patient and physician; to demonstrate empathy, recall the patient’s history of suffering; have patience in shifting away from the Western view of time and immediacy; respect the importance of culture as a determinant of health, the existence of other world views regarding health and illness, the adaptability and survival skills of patients, the influence of religious beliefs on health, and the role of bilingual/bicultural staff; and demonstrate humour by having the ability to laugh with oneself and others (Lee, as cited by AMA 1999: Section X: 17).
Possible learning outcomes for using the 'cultural sensibility' model might be:

**Knowledge:** the focus of 'cultural sensibility' is not knowledge about groups. There is an expectation that students are aware of broad psychosocial issues that can affect the way individuals perceive health and access health services. There is a need to have knowledge of the contexts information is presented or received in.

**Ability:** the greater focus on this model is the acquisition of a method for acknowledging difference, and working with it in a constructive and positive way. Difference between the doctor and patient is potentially present in all encounters and not just those where ethnicity differs.

**Attitude:** the focus is on self-reflection and awareness - the interaction between two individuals, which generates effective, shared understanding and dialogue. The dialogue has the potential to change either, both, or neither of the participants. It is built on transformative learning approach.

The discussion has focused on the conceptual differences between the two models at their purest. 'Cultural expertise' models arose from the recognition that cultural influences impact on healthcare provision and utilisation. The approach of 'cultural sensibility' is presented as an evolution of the 'cultural expertise' approach, which potentially limits the benefits of 'cultural diversity' teaching. In an environment that demands increasing evidence-based approaches, it may be time to develop tighter teaching models that have clear conceptual frameworks and can evaluate more effectively whether or not the teaching meets its objectives.
Chapter 5: The teaching and learning of ‘cultural diversity’

This chapter begins by considering how widely ‘cultural diversity’ is taught in the UK and North America. The chapter then considers the different approaches used to teach ‘cultural diversity’ and questions if policies regarding ‘cultural diversity’ and educational theories are coherently integrated to devise appropriate approaches to teaching ‘cultural diversity’. There is then a review of specific educational programmes. The ideal type models developed in Chapter four are utilised as benchmarks with which to analyse and compare the programmes to teach ‘cultural diversity’. The issues of evaluation and assessment of ‘cultural diversity’ are also reviewed.

5.1 ‘Cultural diversity’ teaching in medical schools

This section reviews the limited published material on how widely medical schools teach ‘cultural diversity’ in UK and North America. A questionnaire postal survey of Deans of English medical schools found that all of the eighteen respondents (out of a possible 23) reported that there was no specific teaching on the cultural aspects of ‘ethnic minority medicine’ (Poulton et al, 1986). A third of the respondents had specific lectures on their main curriculum with four having additional optional lectures. Ten medical schools had no teaching in this area at all (Poulton et al, 1986). In 1995, the BMA identified that little had changed. They surveyed postgraduate and undergraduate medical education institutions. For the undergraduate sector, the response rate was 79% (23/29) (Robins, 1995). Ten of these respondents (44%) reported that the medical programmes contained courses/lectures/seminars on health and health care in different cultural groups. Of the 12 (52%) who stated that they did not, only two had considered their introduction. In seven that did not have such a course, there was felt to be no need for such teaching. Interestingly only five respondents (22%) were aware of such courses being run by other organisations. Nineteen (89%) respondents perceived that there was a need for improved education of the medical profession in the health and health care of different cultural groups (Robins, 1995). Loudon et al (1999) reviewed published medical and nursing literature to identify the content, methods, assessment and evaluation strategies of workers in relation to teaching diversity to medical and nursing students. Loudon et al (1999) particularly focused on ethnic and racial diversity, and argued that a broader view of culture and diversity might have incorporated gender, age, disability and sexual orientation. Their survey of medical
education found that little was published on programmes, which might be taking place in
the UK and much of what was published on teaching ‘cultural diversity’ was happening in
the US. Of the 17 identified programmes, 13 were North American. Courses with clinicians
in charge tended to be run by specialists in family medicine, community medicine and
psychiatry. Two of the programmes were identified in response to student need and a third
to enhance ‘cultural competence’. Fourteen of the programmes did not directly state the
context. A variety of teaching methodologies were adopted but the content focus was
essentially on attitudes and health beliefs, alternative healing systems, demographics,
complementary medicine and language barriers. Only student-initiated programmes took a
broader view of cultural diversity, and included sexual orientation and alcoholism, as well
as ethnicity. Sessions were generally practical and fact focused. Only seven of the courses
were mandatory and only one assessed students. Generally, evaluation was through student
satisfaction.

Whilst little activity was identified through Loudon et al’s 1999 and 2001 reports, medical
education conferences have shown that ‘cultural diversity’ is an area that is being addressed
increasingly by medical schools in a variety of ways (for example: Association for Medical
Education in Europe 2001 Conference). Uncertainty remains about who should lead the
development of these programmes and how they should progress. Some programmes have
been recently described (Conning et al, 2001; Dogra, 2001; Loudon et al, 2001). Kai et al
(2001b) explore the perceptions of educators who provide ‘cultural diversity’ training to
different health professionals. The data collection method (through those who participated
in facilitated workshops) had limitations, but the findings suggest that current provision for
‘cultural diversity’ training is generally limited, and educators lacked specific training to
facilitate the learning of others in this field. The dilemmas faced by educators were fairly
diverse and ranged from the philosophy of teaching through to practical difficulties. The
teaching also often lacked a clear evidence-base and conceptual frameworks confirming the
analysis presented in Chapter Three. A survey of UK and Irish medical schools in 2003
revealed that whilst more medical schools now stated that there was teaching in ‘cultural
diversity’, it remains fragmented and unsystematic (Dogra et al, unpublished).

Medical schools in the US have addressed ‘cultural diversity’ more often than UK schools.
In 1992, only 13% of accredited US medical schools offered courses integrating social and
behavioural sciences into medicine, and these were largely optional with low enrolment (Lum & Korenman, 1994). By 1998, however, the situation had changed, with 68% of North American medical schools reporting some formal training in ‘cultural competence’. Flores et al (2000) undertook a telephone survey of Deans of Students and/or course directors in the United States and Canada. They found that 87% (109 out of 126) US and 67% (11 out of 16) Canadian medical schools incorporated multicultural issues with one to three lectures as part of a larger module or as an elective. Only 8% taught ‘cultural sensitivity’ as a separate module and 8% did not address the issue in any forum. Most of the programmes used case-based didactic and group learning, and were taught in the first two years of medical school. Just over a third of the programmes did not teach about a specific ethnic group but on a general basis. The disciplines of psychology and nursing, again mostly in the US, have a longer history of tackling ‘cultural diversity’. (Allison et al, 1994; Coleman, 1995; Grossman et al, 1998; Suarezbalcazar et al, 1994; Yutrzenka, 1995).

Azad et al (2002) reported on a survey to determine the status of ‘cultural sensitivity’ training in 16 Canadian medical schools, using a structured telephone interview. Eight schools integrated cultural sensitivity within their objectives, with only one of these mentioning it specifically in the evaluation form. Seven of the 16 schools did not have any statement on cultural sensitivity in their curricular objectives; it was integrated in a variety of educational methods generally offered in just 2 years of the curriculum. Student participation was required and programmes varied from 2 – 40 hours. The authors conclude that whilst progress had been made, it is perhaps insufficient and obstacles remain to inclusion of multicultural health content in curricular.

Using several methods, Wachtler and Troein (2003) investigated the current status of cultural competency training at a medical school in Sweden. They reviewed the published list of learning objectives, interviewed staff and undertook focus groups with students in all stages of the medical programme. They found that whilst cultural competency was present, it was a hidden part of the curriculum and considered to be integrated into the curriculum by both staff and students. Students were unable to identify specific learning instances where cultural competency was the main theme and the subject was not assessed. They concluded that cultural competency is not defined clearly in the planned curriculum and the subject is not presented thematically in the taught curriculum. Inclusion of cultural
competency in specific educational environments depends on time and interest. There is no verification that all students leave the medical programme with adequate skills and the knowledge required to take care of patients regardless of their background.

In summary, programmes in this area are developing, but it is unclear if they are integrated with policy documents, which is crucial if they are to be successfully implemented and sustainable. There is perhaps a need to proactively involve more staff in this type of teaching rather than leaving it in the hands of a few interested individuals. As discussed by Loudon et al (2001) and supported by Wachtler and Troein (2003) much of the teaching of ‘cultural diversity’ has been developed and delivered by committed advocates. There is little evidence to suggest that programmes have moved beyond this and become a mainstream medical school activity.

5.2 Approaches to teaching ‘cultural diversity’

This section considers different approaches to teaching ‘cultural diversity’, some of which have arisen out of some dissatisfaction with the principle of ‘cultural competence’. The usefulness of considering these alternative approaches is that they highlight potential problems with all approaches, especially when there is a lack of coherence between the educational philosophy, course design, process and outcomes. Considerable work has been undertaken in the context of training Peace Corps volunteers to prepare them effectively for their overseas assignments (e.g. Bennett, 1986 amongst others). As this work is occasionally referenced in some of the programmes described later, it is included as Appendix Two.

Berlin and Fowkes (1983) developed a teaching model that focused on a suggested process for improved communication seen as central to effective cross-cultural patient-physician interactions. Although the model did not emphasise dissemination of cultural information, this is perceived to be helpful. Berlin and Fowkes (1983) LEARN model guidelines, which are:

- Listen with sympathy and understanding to the patient’s perception of the problem
- Explain your perceptions of the problem and strategy for treatment
- Acknowledge and discuss the differences and similarities between these perceptions
- Recommend treatment whilst remembering the patient’s cultural parameters
• Negotiate treatment

It is arguable that this model is no more than patient-centred care with an understanding that patients have a right to be involved in decisions about their own care if they so wish. The latter issue may be influenced by generational factors as well as cultural factors, in that there have been changes in the doctor/patient relationship as discussed in Chapter Two; more doctors now expect patients to be active partners in their own care but older patients may not share this expectation (Lowry, 1993:8). Berlin and Fowkes concluded that, given current demographic trends, it is probably unrealistic to assume that health care providers can gain in-depth knowledge about the health-affecting beliefs and practices of every ethnic or cultural group they are likely to encounter in practice. They developed a process-orientated model by which the cultural, social and personal information relevant to a given illness episode can be elicited, discussed and negotiated or incorporated. However, they add,

"it is of value for providers who deal with culturally diverse patients to have some understanding of common basic conceptions of health, illness and anatomy held by these persons. Much work needs to be done in codifying these conceptions and making them available to professionals in medicine" (Berlin and Fowkes, 1983:938).

This appears to have a philosophy based on 'us and them'; that is, us and those that are different. 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, and also the value they place on what their patients say.

Nunez (2000) expressed her view that the term ‘cross-cultural efficacy’ may be preferable to cultural competency as a goal of cross-cultural education. This is because it implies that the caregiver is effective in interactions that involve individuals of different cultures, and that neither the caregiver’s nor the patient’s culture offers the preferred view. Nunez stated that, in her view, ‘cultural competence’ implies a discrete knowledge set that focuses on the culture of the patient as ‘other’ and somehow aberrant from the norm. She believed that the purpose of cross-cultural education was to enable students to gain a broad appreciation of interactions among cultures, rather than just memorising characteristics of certain broad
groups. Nunez viewed ‘cultural competence’ as ethnocentric and cross-cultural efficacy as ethno-relative.

Leininger (1991) proposed a model known as ‘transcultural nursing’. In essence this model is very similar to the ‘cultural competence’ model in the way that culture is used and the way in which ethnicity defined. The nursing profession in the UK accepted this model so readily that the Foundation of Nursing Studies even has an association so named (Trans-Cultural Nursing and Healthcare Association). Even within the US, nurses and nurse educators have begun to express dissatisfaction with this model and challenge it. One such example is Duffy (2001) who proposed a new transformative, post-modern approach to cultural education. It proposed greater critical self-reflection and an acknowledgement of the self. It also recognised that this approach is riskier than some of the other approaches used and how this may impact on student vulnerability. It challenged students to practice cultural inclusion, personally and professionally. Duffy (2001) saw her approach as building on the traditional approach but did not comment on whether or not it would be sufficient to meet the educational needs of future healthcare providers.

A widely discussed but less written about model is that of ‘cultural safety’. Polaschek (1998) provided an overview and critique of the model, which arose out of Maori nursing in New Zealand because of dissatisfaction with Leininger’s model. Carberry (1998) queried whether the competency framework is the most appropriate way forward to ensure competent professional practice and advocates the ‘cultural safety’ approach. In this view, “Nursing practice that is culturally unsafe includes ‘any actions that diminish, demean or disempower the cultural identity and well being of an individual’.” “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: 453) Whilst this model acknowledges the need to recognise negative attitudes and stereotypes of individuals because of the ethnic group to which they belong, it makes assumptions that, whilst all those within the ethnic group may be diverse, their attitudes are likely to be similar. Additionally, there is a strong political drive behind the model aimed at striving for equality rather than devising an educationally sound model. The emphasis of this model has been to relate individual attitudes to various contexts and attempt to change attitudes. Polaschek (1998) highlighted the fact that the concept of ‘cultural safety’ has yet to be clearly articulated with great methodological rigour by its proponents, and, therefore,
it is difficult to present it as an alternative model to ‘cultural competence’. This model appears to assume that it is mostly the ‘white’ majority that need to learn about other cultures. There is an assumed understanding of what is perceived to be the dominant culture by those from non-dominant cultures.

Another approach that has attracted attention is that of ‘cultural humility’. The aim of this perspective is to deliver health care effectively and respectfully to the increasingly diverse populations of the US (Tervalon & Murray-Garcia, 1998). This approach observed the need to define educational and training outcomes consistent with this aim. The authors argued that the detached mastery of a theoretically finite body of knowledge as proposed by the ‘cultural competence’ model may be inappropriate for multicultural medical education. The authors suggested incorporating a lifelong commitment to self-evaluation and self-critique to address the power imbalances in the patient-physician relationship, and to developing mutually beneficial partnerships on behalf of individuals and defined populations. This model has perhaps most in common with the ‘cultural sensibility’ approach.

Kim (1992) presented a systems-theoretic view that emphasises the dynamic, interactive nature of the communication process between two or more individuals. The relationship between the individual communication system and the multi person (including two person) communication system is multidirectional and multilateral in causality. Like the relationship of the mind and the reality it experiences, the relationship between the person and the environment is viewed as mutually reinforcing. All parties involved in a given encounter, including the conditions of the social context in which the encounter takes place, codetermine the communication outcome. This means that no single element in a multi-person communication system can be separated out for being solely responsible for the outcomes. Each person has a reality of his/her own and its own tokens of significance with which the individual comes to organise new experiences (Kim, 1992: 371).

Gudykunst (1992: 388) in discussing issues relating to being a competent communicator raised tolerance for ambiguity. An individual tolerance for ambiguity affects the type of information we try to seek about others. People with a low tolerance for ambiguity try to gather information that supports their own beliefs. People with a high tolerance for ambiguity may seek more ‘objective’ information about others. This approach requires
flexibility and an ability to tolerate uncertainty, which can create discomfort in some. If
these issues are not addressed, students may accept the factual components of courses but
fail to take on other aspects. In this case, ‘cultural competence’ teaching stands to do
nothing more than reinforce stereotypes, as health professionals try to resolve ambiguity by
interpreting messages in ways which suit them rather than being open to really hearing
what is being said or meant.

Sue (1991) presented a model that is widely referenced to in the American literature. The
model was originally developed for business and industry but because of its perceived
usefulness generalised to education and mental health organisations, particularly in the field
of counselling. Sue (1991) began by stating that counsellors who are involved in
organisational change need to face, and convince others, about the inevitable challenge of
cultural diversity. He argued that the diversification trend means that counsellors and other
mental health service provide need to:

1. Increase their cultural sensitivity
2. Obtain greater knowledge and understanding of various racial-ethnic groups
3. Develop culturally relevant counselling strategies

In a paper that plans to discuss cultural sensitivity, the word ‘racial-ethnic’ is used without
any mention of the ambiguity and indeed merit of the term. Sue (1991) argued that
counsellors need to leave their offices and meet clients in their own home environments,
and learn that many problems encountered by the culturally different individual reside in
institutions. Whilst the intentions were clearly positive, the framing of this negated the
perspective of those so-called culturally different. It failed to address important issues
concerning power differentials. It appeared to advocate the view that those who are
culturally different need those from the majority to be their voice. This is the background
Sue provided for the model and stated three major barriers to incorporating diversity:

- Differences in communication styles, characteristics, or both
- Interpersonal attitudinal discrimination and prejudice
- Systemic barriers

Whilst Sue (1991) argued that stereotypes, such as ‘blacks make good athletes but poor
scholars’, may be used as a justification for not promoting blacks; there is a danger that
seeing groups as homogenous promotes thinking in stereotypic ways rather than about
individuals. The discussion also appeared to be one-sided, as if only the majority have negative views about minorities. The approach appeared not to consider that all individuals whatever their backgrounds have the potential to have negative attitudes towards others they perceive as different to them. The competencies were discussed along the three dimensions of beliefs and attitudes, knowledge and skills. When discussing attitudes, Sue only explored the attitudes held by whites. The assumption appeared to be that ‘minorities’ are homogenous. For example, Hispanics intrinsically know how blacks might feel just because both are minorities. There appears to be no acknowledgement that minority groups might hold views about other minorities. Sue (1991) presented a useful overview, which is perhaps now dated in that it perceives cultural diversity training as a requirement for the majority white. Now it is arguable that the need for cultural diversity is relevant to all staff whatever their background. As more minorities are represented increasingly in organisations, they will also need to be aware of how they view the world and the way it affects their work. It may be unwise to make assumptions that minority professionals will understand the experience of other minority individuals just because they share the same ethnicity (Gurung and Mehta, 2001).

In another paper, Sue (1997:178) quoted Helms as arguing that:

“The pluralistic version of multiculturalism that now dominates the field relies on conceptualisations of culture that are so broad as to be almost impossible to investigate or implement” (Helms, 1994: 163).

It is by no means clear that the same competencies required to deliver effective services to clients for whom racial-group membership is central are equally appropriate for clients for whom other social identities (e.g. gender, age or religion) (1994: 163). Sue (1997) described several approaches:

- Generic approach - little questioning of whether or not theories or approaches of ‘one’ culture are applicable to others
- Etic approach - identify universal aspects of human behaviour
- Emic (culture specific approach) - different ‘cultures’ hold different worldviews
The perspective appeared to be that views are based on colour/nationality of origin basis, e.g. comparisons are between white Americans, Asian Indian or South Koreans. Sue (1997) also explored single course approaches that deal with the major ethnic groups in the US. The disadvantage with this approach is that it may promote the view that ethnic and multicultural issues are not part of the mainstream. Race or ethnicity is given greater emphasis than other factors. The focus may also mean that the training is too specific to particular groups and contain little that can be generalised. The advantage of an interdisciplinary model in which students from different courses come together is that it can lead to exposure to broader perspectives; a disadvantage may be that no-one takes responsibility. The integration model is viewed as most promising with cross-cultural material being an integral part of every course.

With some approaches there is a perception that if ethnic minorities access services differently from the white majority, the reason has to be related to ethnicity (e.g. Bhui and Sashidharan 2003). This implies that ethnicity is the most important factor influencing access to services, and that all ethnic groups and all those defined as belonging to an ethnic group, hold similar views regarding healthcare services. This approach has led some to suggest that the most appropriate way forward is to develop ‘culturally-specific’ or ‘ethnic-specific’ services; that is, services run by ethnic minorities for ethnic minorities (e.g. Takeuchi et al 1995; Saha et al, 1999; Ferguson & Candib 2002).

In summary, medical education appears to have made little use of the breadth or depth of existing work in ‘cultural diversity’ education. Even when models or programmes have been developed for other contexts, they can still be useful when it comes to considering the priorities medical education must set and the need to modify them for a clinical context. Medical educators have also failed to consider how their own perspectives may influence the types of teaching they develop or sabotage. The philosophies behind many of the approaches are not clear. Unless these issues are debated openly ‘cultural diversity’ may remain in the hands of a few unsupported champions who may or may not be aware of their personal motivations.
5.3 Specific ‘cultural diversity’ programmes

This section considers specific programmes to teach undergraduates medical students ‘cultural diversity’. Only programmes published in the medical literature with some detail are included in this review. There is much more available on the Internet but few of these programmes have been subject to any kind of peer-review process and details about what the programme actually entails are often lacking (e.g. Cross Cultural Health Care Program [CCHCP], 2001 and Department of Health, 2003). Most of the peer-reviewed information about educational programmes has been published in the form of brief communications so, again, detail is often lacking. A review of all published undergraduate programmes is presented in Table 9 (Appendix 2: pages 278-285). Few of the programmes reviewed neatly align with either the ‘cultural expertise’ or ‘cultural sensibility’ model. The review that follows shows that, in practice, there is little clarity about the educational philosophy, process, contents and outcomes.

5.3.1 UK programmes

The Human Diversity Module at Leicester was a 12-session module that addressed equal opportunities, human sexuality, special needs, death and dying, substance addiction and genetic diversity (Dogra, 2001). Only the teaching related to ethnicity as such is described. This is one programme that commented clearly on the philosophy behind the programme and related it to the teaching developed. It also discussed the confusion that exists with respect to terminology. The programme was designed to be reflective and stated that it perceived ‘cultural diversity’ teaching as a necessity for all practitioners and not just for the majority white. The objectives of the teaching were for students to be able to gain factual and practical information of other cultures and also for them to examine their own attitudes. Examples of the objectives include:

- Describe at least two cultures different from your own culture
- Evaluate your own attitudes and perceptions of different groups within society including people from different cultural backgrounds and people with different coloured skin.

The teaching that formed the cultural diversity component of the module consisted of two 3-hour contact sessions and was developed by the module leader and the university’s equal
opportunities officer. The first session considered equal opportunities, the legislation and the meaning of equal opportunities. Stereotypes of different groups were considered before focusing on cultural diversity. The introduction, completion of the research questionnaire, and legal background were undertaken in a lecture theatre with all the students together. The rest of the work was undertaken with groups of 30 students. During the group work, students had discussion time, exercises to challenge assumptions, an opportunity to feedback on the self-study, and discussion of clinical scenarios to consider the application of their learning. All the group facilitators were experienced teachers and detailed tutor notes were sent to all teachers. Although 30 is a relatively large group, limited tutor and room numbers precluded other options. Students completed a questionnaire designed in a previous study, at two stages: the first before the component on cultural diversity was delivered and, the second after the sessions on cultural diversity. The time interval between stage one and two was one week. The cultural diversity component was developed using a range of sources. The questionnaire was completed at both stages by 140 of the 181 students (77.3%). There were a number of statistically significant findings that indicate that the teaching enabled the session objectives to be successfully met. These included statistically significant changes that reflected more ‘positive’ attitudes about cultures coming together and about specific cultures. This programme has a clear educational philosophy consistent with ‘cultural sensibility’ but has components, which are consistent with ‘cultural expertise’. The programme uses a combination of cognitive and transformative learning.

Birmingham (Loudon et al, 2001) developed a programme entitled: Making medical education responsive to community diversity. This included a range of topics such as health inequalities, genetics, cultural issues in health, communication skills, health, beliefs and culture, family attachment scheme, ‘race, ethnicity and health’, religious belief, patterns of stereotypes and working with interpreters. The module used lectures, tutorial, small group work, self-study, and role-play and community placements. The teaching was, in part, developed following focus groups with members of the community and students. The session on health inequalities had a module outcome ‘understand that an individual’s health may be affected by social factors, observing and describing the effect of gender, ethnicity, social class or age on health beliefs. In another part the outcome was: describe the patient factors that the practitioner must take into account when exploring the range of therapeutic options available, e.g. personality, medical experience, ethnicity, lifestyle and social class.
The former has an individual approach to patients and the latter a group approach. The module has similarities to Leicester’s session regarding a discussion of different definitions. However, the focus appears to be predominantly on ‘race and ethnicity’, which is consistent with ‘cultural expertise’. London & Greenfield (1998) commented that the aim was to develop an integrated strand of teaching throughout the undergraduate curriculum through family placements with families from ethnic minorities. This approach may leave to chance whether or not students use the opportunity to explore their own attitudes and may lead them to view the ethnic minority family as representative of all others of the same ethnic group or of minorities. The module at Birmingham has been evaluated using student feedback (Loudon et al, 2001) and received mixed reviews. There were comments by students that the course encouraged them to respect a heterogeneity of opinion and beliefs, but a failure to extrapolate from the specific to the general. The educational theory that appears to be substantially used relates to cognitive approaches.

Guys, Kings and St Thomas’ medical school had a programme (Guys, Kings and St Thomas’s School of Medicine, 2001) that highlighted the difficulty in achieving the balance between the cultural sensitivity agenda and meeting the demands or expectations of the ‘cultural competence’ model. The programme consisted of 4 full days and a 90-minute seminar session. The module had a combination of formal teaching, tutorials and clinical experience through GP placement are used. Examples of outcomes are:

- Explore their own values and attitudes in relation to different ethnic/cultural groups
- Outline the issues related to the health care needs of people with disability

There is an implication that disability has the same meaning to all. The programme attempts to balance sociological theories with pragmatic clinical needs. It is unclear how helpful it is to define objectives such as “to know the meaning of ‘ethnicity’ and critics of this social category” and directly relating it to clinical practice. The outcome: “to describe policies to reduce inequalities and increase the cultural sensitivity of services.” may be a way for students to disengage from some of the more difficult and personally challenging objectives as discussed above. The objective “to describe local service to meet the needs of a specific minority ethnic group” again implies that the needs of all group members are similar and can be identified exclusively on the basis of ethnicity. This module, although less broad, is similar to the Leicester one in that it covers sexual orientation, ethnic minority groups and disabilities. It has not yet been formally evaluated and analysis of the learning
outcomes using the ideal type models reveals a very muddled picture. Part of the confusion may be generated by a wish to cover all aspects of diversity (such as ethnicity, sexuality, etc) in a short timeframe. Again the educational approach is unclear, although use of discussion groups suggests more than a cognitive approach.

Thistlethwaite and Ewart (2003) report on recent developments at Leeds. Here the teaching is a component of the broader programme on Personal and Professional Development. A series of seminars were run on valuing diversity to encourage students to develop insight into and reflect on their attitudes to diversity. Whilst the implication is that the approach uses reflective learning, the use of ‘experts’ giving a perspective may mean that the reality is more a cognitive-driven programme. The use of ‘groups’ and identification of group needs suggest a more ‘cultural expertise’ approach although this programme clearly moves beyond ethnic diversity.

5.3.2 US programmes

Robins et al (1998) commented that although the opportunities to learn cultural competence skills have increased, there may be other barriers to acquisition. Through course evaluation, students have indicated their discomfort with material focused specifically on culture, sexual orientation, power, and the significant role that each plays in shaping academic, peer and clinical interactions. Robins et al (1998) described the programme used at University of Michigan Medical School which was developed after consultation with faculty staff and medical students from racial minority groups, gays and lesbians, and women. The approach focused on: students exploring their own perspectives, and recognising the diversity within their own cohort; engaging in non-judgmental discussions about cultural beliefs, attitudes and behaviour; and discussing how the delivery of culturally competent care might result in improved patient satisfaction and clinical care. All students were required to participate in the programme in their first year. The course was evaluated and majority men (white) consistently gave the lowest average ratings, followed by majority women (white), minority men (non-white) and minority women (non-white). Focus groups, which followed, revealed that the majority groups had felt under constant attack, so the programme was modified to address this by increasing the clinical focus. The course was re-evaluated and received better ratings. This programme uses an approach that is more consistent with ‘cultural
sensibility’. The educational theory is stated unequivocally but appears to be based on reflective learning.

Crandall et al (2003) described a pilot programme developed at Wake Forest University School of Medicine (WFUSM) which drew on communication theories that move from level 1 (unconscious incompetence) to level 5 (unconscious super competence). Whilst no reference is made to Cross et al (1989), this approach has similarities to the way ‘cultural competence’ was developed in that moved through levels of ‘competence’. The group also used the work of Culhane-Pera et al (1997) who developed a postgraduate ‘cultural diversity’ programme for family physicians. The course consisted of 20 two-three-hour sessions during the second academic year and was piloted on twelve volunteer students (of whom 58% were from minority groups compared to 20% in the year as a whole). Presenters were local, national and international experts on cultural influences on health. Students were asked to undertake some self-study and a variety of assignments including a critical and self-reflective journal, an interview with an individual culturally different from the student and an essay based on this interview. Students completed pre-and post-teaching self-evaluations and believed their knowledge, skills and attitudes improved dramatically, and that they achieved competence. The authors believed that the value of the programme related to the use of a theoretical framework. The approach is more consistent with ‘cultural expertise’ in that it focused on perceived minority groups but did include non-ethnic minorities (e.g. gender). However, at its heart, the programme has the intention of developing expertise. This paper related the developments it underwent in line with the current US context and evidence-base.

An examination of column seven of Table 9 (Appendix 2: pages 278-285) reveals that of thirteen programmes reviewed, four use an approach more akin to ‘cultural sensibility’. Two of the programmes attempting a ‘cultural sensibility’ approach have single sessions to deliver their programmes suggesting that there is, perhaps, little support for these approaches in practice. However, there is little clarity about the educational philosophy or the evidence-base applied.
5.4 Evaluation of specific programmes

When considering the need for an evidence-based approach to medical education, it is clear that evaluation of new programmes needs attention as discussed in Chapter Three. Very few programmes have been subject to evaluation beyond student feedback. The exceptions are Culhane Pera (1997), Majumdar (1999) and Dogra (2001) who all used pre- and post-teaching questionnaires. All reported some degree of ‘positive’ changes in student perspectives. Of these only Dogra’s was with undergraduates. This might suggest that whilst medical schools overtly state that these types of programmes are relevant to medical education, the programmes receive little support from those that have influence over students or the school to validate their work. The area may also be considered to be fraught with difficulties so the issue of evaluation is perhaps sidestepped.

5.5 Assessment

Assessing students in issues relating to ‘cultural diversity’ is a difficult topic because assessing attitudes is fraught with complications (e.g. Kelly et al, 2002). The issue is further complicated by a lack of clarity about learning outcomes and a coherent educational approach. Few of the programmes discussed above included assessment as part of the programme. For students, the implication of this may be that this means the subject is irrelevant and/or unimportant because everything that matters in medical education is assessed. As Table 9 (Appendix 2: pages 278-285) shows all the four UK programmes that have been published include assessment. In contrast, of eight US programmes only one expressly mentioned assessment, whilst a second mentioned assignments.

Some work has been done to assess the impact of ‘cultural diversity’ teaching on clinical practice albeit in postgraduate education. Altshuler and Kachur (2001) described the piloting of a culture OSCE on 23 second-year paediatric residents. The assessment was formative and found to be a useful learning experience. This paper raised the question of whether or not diversity in health care can be separated from health issues. Do clinicians need to be tested on whether or not they are effective at establishing with patients when cultural differences are relevant, rather than pursuing assumptions that if someone looks different, or has a different religion, they have a different understanding of the issues? This may be equally relevant to the undergraduate curriculum.
Inguisrud et al (2002) investigated the assessment of cross-cultural awareness through evidence of critical thinking in student-generated text. The Kyushu Lutheran College in Japan in 1997 offered a liberal arts curriculum with a required study-abroad component, for all students majoring in this area, to develop student worldviews and for students to become motivated to engage in serious study and become socially mature. The nature of the study-abroad programmes varied but the aim was to develop ‘cross-cultural’ awareness. The portfolio was used as it allowed for a more holistic approach and inclusion of various kinds of assessment. Students had a pre-practicum and post-practicum portfolio to enable pre- and post- measures. Through critical text analysis, the authors were able to evaluate awareness, as that was remit of the course. Student observations were analysed to determine if they demonstrated any reflection contained with the observation, i.e. whether they related their observations to other aspects. There was acceptance that critical thinking and reflection are related to North American norms of self-expression; investigation in greater depth revealed that while the language is North American, the concept may not be; that is, the words used may not be the same but the educational principle is shared.

Students were given questions to stimulate the reflective process. An operational definition of awareness, which is the sum of recognition and reflection, was provided. There may be recognition without reflection but there cannot be reflection (i.e. the thinking about an observation) without recognition. There was good inter-rater reliability. Investigations will continue to observe how the experiences have been integrated into their lives and further analysis of the reflection into categories, simple deep and critical. Whilst time-consuming, this shows promise as an effective assessment tool to measure change in cross-cultural awareness.

5.6 Conclusion

This chapter began by considering how widely ‘cultural diversity’ is taught in medical schools and highlighted that it is more widely taught in the US than in the UK, although it is now receiving attention in the UK. Various approaches have been developed. However, little of it is systematic or embedded in the curriculum as a whole. Very few of the programmes are clear about the frameworks and philosophies that have guided their development. Additionally, very few programmes have been subject to evaluation beyond student feedback. Analysis of the programmes for which sufficient information is available
reveals that few programmes neatly fit into either ideal type model. However, the majority of programmes use an approach more consistent with ‘cultural expertise’. The fact that most US programmes did not include assessment is noteworthy because in contrast, all four UK programmes have this as an integral part of the programme. This might suggest that whilst medical schools overtly state that these types of programmes are relevant to medical education, the programmes receive little support from those that have influence over students or the school. It may also suggest that this area suffers from a lack of coherent educational models that consider every stage of the educational process.
Chapter 6: Method of study and analysis

This chapter begins with a summary of the research questions that arose out of the literature review undertaken in Chapters One to Five. The research objectives are then described, followed by the methods for meeting them. Figure 1 (page 101) summarises the key research steps. The chosen methods of website content analysis and the use of semi-structured interviews are justified. Ethical issues are discussed as part of the research design. The justification for sampling is followed by a description of the sample. The administration of the project is discussed including how the semi-structured interview was modified as the interviews were conducted. The role of the researcher in the research process is also discussed. Validity and reliability are discussed before the chapter concludes with an explanation of the data analysis and the generation of themes.

6.1 Issues raised from literature review

The author proposed that there is great variation in the way ‘cultural diversity’ is understood and used within medical education; part of the thesis explored this variation and its influence on the types of teaching programmes that are developed.

At present, it is unclear how a broad range of people involved in medical education in the UK conceptualise ‘cultural diversity’, whether or not they believe it should be taught, and if so how. The main research question attempts to investigate how medical stakeholders (such as policymakers, teachers, service-users and students) conceive the term ‘cultural diversity’ and their beliefs related to its teaching and learning. Teaching ‘cultural diversity’ to medical students, so that they are able to meet the needs of a diverse population as future doctors, became a priority following the publication of Tomorrow’s Doctors (GMC, 1993).

In a survey of medical education, Loudon et al (1999) found that little was published on ‘cultural diversity’ programmes in the UK. Since this paper, there has been some published evidence of programmes being developed in the UK (e.g. Dogra, 2001, Conning et al, 2001). How isolated these programmes are, the status of such teaching in British medical schools and the level of support for the GMC perspective are all unclear.
The extent to which medical education utilises educational theories to formulate and deliver teaching is also unclear.

Chapter Four outlined two ideal type models of ‘cultural diversity’ teaching programmes, designated as the ‘cultural expertise’ model and the ‘cultural sensibility’ model. This raises questions on the philosophy and beliefs behind the approaches used to develop teaching in ‘cultural diversity’. This, in turn, raises the issue of how programmes are developed and what influences their development. The literature suggests that this area suffers from a lack of coherent educational models that consider every stage of the educational process. The research agenda described below sets out to address the above questions.

6.1.1 Research objectives

The above review has laid the foundations leading to the research objectives, identified as follows:

1. To identify the process by which Tomorrow’s Doctors came to include aspects of diversity
2. To identify which medical school curricula have ‘cultural diversity’ teaching in the UK
3. To apply the ideal types of ‘cultural expertise’ and ‘cultural sensibility’ to those ‘cultural diversity’ educational programmes in UK medical schools identified in objective two
4. To identify perceptions and evaluations of ‘cultural diversity’ and its teaching held by policy makers in the UK
5. To identify perceptions and evaluations of ‘cultural diversity’ and its teaching held by medical faculty staff in the UK
6. To identify perceptions and evaluations of ‘cultural diversity’ and its teaching held by teachers in the UK
7. To identify perceptions and evaluations of ‘cultural diversity’ and its teaching held by researchers in ethnicity who also teach ‘cultural diversity’ in the UK
8. To identify perceptions and evaluations of ‘cultural diversity’ and its teaching held by medical students in the UK
9. To identify perceptions and evaluations of ‘cultural diversity’ and its teaching held by service users and advocates in the UK.

10. To identify how the perceptions of ‘cultural diversity’ identified in objectives 4-9 align with the models of ‘cultural expertise’ and ‘cultural sensibility’.

**Figure 1: Flowchart of study steps**

- **Summary of method for objectives 2-9**
  - Obtain website address of all 26 medical schools running 2002
  - Search websites of all 26 medical schools
  - Content analysis to answer 4 key questions
  - Identify 4 schools
  - Main Study: interview sample identified

- **Responded**
  - Yes
    - 9 C Heads
    - 9 Others
    - 14 CDT
    - Interviewed
      - 7 C Heads
      - 8 Others
      - 14 CDT
    - 27 Policy
    - 7 Users
    - 7 Students
  - No
    - 0 C Heads
    - 4 Others
    - 1 CDT
    - 10 Policy
    - 1 User
    - 1 Student

C: Heads curriculum heads
CDT: cultural diversity teachers
Policy: Policymakers
6.2 Methodology for objective one

Establishing how ‘cultural diversity’ was included in *Tomorrow’s Doctors* (GMC, 1993)

*Method*

I made written, telephone and email contact with the 1993 GMC Education Committee responsible for producing the first version of *Tomorrow’s Doctors* (GMC, 1993). The interview schedule developed for meeting objectives 4-9 also helped meet this objective as there were specific questions related to the development of *Tomorrow’s Doctors* (GMC, 1993). Individuals belonging to organisations including the GMC and BMA provided perspectives on their understanding of the reasons they felt that the GMC had included diversity in this document.

The written and email contact asked how the issue of ‘cultural diversity’ had been initially raised and included in *Tomorrow’s Doctors* (GMC, 1993). The telephone contact expanded on the written response.

*Justification for method*

Written and email contact was chosen as the first form of contact. A telephone conversation was felt to be sufficient to meet the objective but the option for a face-to-face interview was available if needed.

*Conducting the study*

Two committee members of the GMC in 1993 from the group that formulated *Tomorrow’s Doctors* (GMC, 1993) were approached. There was email contact with one member of the 1993 GMC Education Committee, letter and telephone contact with another. It was not possible to talk to other members on that committee, as they could not be identified through publicly available records. The information given was dependent on the member’s own memory of the process. The BMA were also approached on three different occasions to establish whether or not they had influenced the document in any way or whether they had views in it given they had produced a document in 1995. Each time the BMA agreed to undertake an inquiry but did not respond despite follow up.
Methodology for objectives two and three:

To identify which medical school curricula include ‘cultural diversity’ teaching in the UK.

To apply the ideal types of ‘cultural expertise’ and ‘cultural sensibility’ to the analysis of ‘cultural diversity’ educational programmes in UK medical schools.

Method

The second research objective was to be met through undertaking Internet searches of every UK medical school website and searching out information on their curricula. The website list of all UK medical schools is available on the Council of Heads of Medical Schools (CHMS) website. Through the Internet search, the data available were analysed to identify whether:

1. The course addressed the issue of ‘cultural diversity’
2. The issue of ‘cultural diversity’ was specifically discussed as part of the curriculum
3. There was consistency between ‘the behavioural sciences’ and the biomedical sciences in how courses were described
4. Any information on whether or not the approach adopted in the course was more aligned with ‘cultural expertise’ or ‘cultural sensibility’

Justification of method used

A content analysis was undertaken on the information available on the Internet to review existing curricula. The purpose of content analysis is either to describe the characteristics of communications from manifest content and/or to make inferences about the causes and effects from latent aspects of them (Correa, 1998). Robson (2002: 358) highlighted some of the advantages and disadvantages of content analysis. The advantages are that, when based on existing documents, it is unobtrusive. Quantitative assessments and comparisons can be made about the data. The data are in a permanent form and can be reanalysed. This was not the case, in this study, as websites were reviewed and these are subject to regular change.

The disadvantages of content analysis include; that the document may be partial or limited, written for some other purposes, and might be difficult to assess the contents for
the purpose of the research. The ease with which information was obtained was dependent on how readily the website could be navigated. The websites of some schools were much more explicit and easily accessible than others. For example, Cardiff and Belfast provide detailed information that is publicly accessible. Glasgow, Manchester and Birmingham provide very little. Additionally, in an attempt to categorise the data in some meaningful way, issues may be oversimplified. The categorisation codes need to be exhaustive, theoretically driven, complete and independent of each other. Again the extent to which this is done will depend on the objectives of the content analysis. For this study, the purpose was to identify specific information relating to ‘cultural diversity’ teaching.

Jackson (1998) argued that ‘classical content analysis’ views language as something than can be objectively studied (a positivist view of language) and that there is another form which views language as a metaphor, i.e. a representation or system of codes of cultural formations. The second interpretation views the process of analysis as subjective and potentially creative with an opportunity to explore interpretations, inferences and latent content, as well as analyse that which is explicit. There are denotative and connotative meanings that can be taken from data. Denotative meaning is the literal, surface meaning. Connotative meanings take into account the context of the culture surrounding the issue and account of the myths and assumptions held.

In the context of this study, it could be argued that what medical school websites did not say was as important as what they did say. The fact that ‘cultural diversity’ is not on the website could lead to legitimate inferences that the school did not consider this issue important or it was not considered discretely enough to warrant a specific mention. Jackson (1998) argued that ‘classical content analysis’ is not as objective as often stated and that the very task of the way contents are analysed inherently has a degree of subjectivity. This might relate to what the researcher really wants to achieve with the content analysis. If it is to make a specific point, different aspects may be given greater or lesser prominence in the way the content is read. Careful analysis is necessary so that the interpretation process is not reduced to finding some explanation to fit the data.

Whilst use of website searches is a limitation, surveying twenty-six medical schools through interview or questionnaire would have generated too much work and was not the
key objective of this research. Additionally it was not appropriate to undertake a questionnaire survey at the time of the study, as there was a potential for bias in meeting research objectives four to nine described below. There was an interest in what was actually happening rather than an in-depth reflection by the institution, which a questionnaire may have prompted. Circulating a questionnaire simultaneously may have generated different responses about 'cultural diversity' and also influenced the way the project was perceived by potential participants and impacted negatively on the main study.

Conducting the study
Medical schools were identified through the Council of Heads of Medical Schools website (CHMS, 2003a). In November 2002, there were 26 medical schools, which were operational with medical students (Table 10, Appendix Five: page 297). All 26 websites were searched. The introduction to the medical school and all publicly accessible available information on the curriculum was reviewed. The websites searches were used to find out what information was available about the curriculum on the web.

6.2.1 Analysis of the curriculum of UK medical schools
The findings of the content analysis are described and discussed in Chapter Seven, which addresses the organisation of 'cultural diversity' teaching.

6.3 Methodology for objectives four to nine
To explore perceptions about cultural diversity and its teaching with a range of stakeholders
Research method
To meet objectives four to nine a semi-structured interview with a range of stakeholders was conducted with a study specific interview schedule. The central hypothesis of the research was that most stakeholders in the teaching or learning of ‘cultural diversity’ adopt a ‘cultural expertise’ model, and have little awareness of the alternatives. The study sought to explore how the various stakeholders in medical education understood the subject on which they formulate policy, teach or learn.

Justification of method of qualitative interviewing
Unstructured or semi-structured interviewing is a research method that generally aims to move away from fixed answer questions (Strah, 2000:197). The ontological position held by most qualitative researchers suggests that people’s knowledge, views, understandings, interpretations, experiences and interactions are meaningful properties of the social reality of the subject under study, which in this case was ‘cultural diversity’. The epistemological position in qualitative research is that to interact with people is a viable way of accessing their accounts and articulations (Mason, 1996). Semi-structured interviews were selected as the main tool in data collection as they helped answer the key research questions more than other tools. Interviews with individuals from different groups help clarify whether or not there are similarities and differences within and between the groups interviewed.

This study used semi-structured interviews for data collection despite the potential benefits of standard questionnaires. Although, questionnaires allow the participation of a greater number of people and enable a more ‘standardised’ approach (Strah, 2000: 187), they do not allow effective detailed exploration of individual perspectives. The research question of this study centred on the kinds of views that exist on ‘cultural diversity’ in individuals with a stake in medical education. For this reason questionnaires were considered to be inappropriate.

The interview needs to be flexible and sensitive to the specific dynamics of each interaction; although the interview is semi-structured, it does allow additional questions depending on the context. This research drew on people’s thoughts, ideas, experiences, feelings and perceptions as the data source. Face-to-face interviews allow the possibility of pursuing interesting lines of inquiry and investigating the reasoning behind responses in a way that other forms of data collection do not. Interviews can also help clarify the way in which questions are phrased so that improvements can continue to be made. This results in a flexible research design and considered further in the section on validity and reliability. A major practical disadvantage of interviews is that they are time consuming, which may deter potential participants. People sometimes having difficulty understanding the worth of their contribution when asked to participate in research, but especially when asked to be interviewed (Strah, 2000: 201).

Interviews also allow a greater depth of response and for respondents to clarify their responses as well as provide examples. Written responses would not give a sense of the
potential difficulties around 'cultural diversity' and this research required unrehearsed and unprepared responses. 'Gut' responses were required because these reflect the way we think much more often than most people acknowledge. Our own perspectives and views usually influence our behaviour much more than might evidence that exists or what we learn, especially with respect to 'cultural diversity' (Fulford, 2003).

There is always difficulty in being certain if interviewees will give a version of what they believe the required 'right' answer is, rather than what they really believe or think. The 'right' answer may be what is believed to be 'politically correct' or that which fits with widely accepted policies. For example, respondents might say they agree with the contents of Tomorrow's Doctors (GMC, 1993) but, in reality, feel very differently. This potential problem can be countered by establishing rapport, using questions that facilitate discussion and ensuring that the respondents are encouraged to be open and honest. This may need the interviewer to demonstrate a non-judgemental approach. Robson (2002: 270) described the semi-structured interview as having pre-determined topics but that the order can be modified based upon the interviewer's perception of what seems most important. Question wording can be changed and explanations given. Particular questions, which seem inappropriate with a particular interview, can be omitted or additional ones included. The semi-structured interview allows dialogue. It does not aim to collect a fixed and uniform series of responses to particular questions but to engage the interviewee in a 'conversation with a purpose' (Strah, 2002:203).

Semi-structured interviews were preferred to unstructured interviews. The latter were not considered appropriate in this study; to answer the research questions, it was important to ask about specific issues relating to the understanding of 'cultural diversity' and its teaching.

The research design anticipated that an informal part of the interview was the 'small talk' at the beginning and the closure of the interview. Depending on the interviewee's interests and time pressure the conceptualisation of educational models were to be discussed with respondents and his/her views sought. The interview style at this point was designed to be different as it was less exploratory of respondent perspectives and instead more challenging and inviting them to think differently from how they had thought about the issue previously. Subject to agreement, the whole conversation was audiotaped. There
is always the question of whether or not the interviewer and respondent share the same understanding of how information from the non-formal parts of the interview process might be utilised. If respondents specifically state that their remark is off the record, there is less of an ethical dilemma although it is useful to consider why some comments are only made in that context. It is important that respondents are clear about the parts of the interview, which constitute the formal and informal interview.

In orthodox approaches to research, O’Connell Davidson and Layder (1994: 119) suggested that questions must be asked as well as phrased in a neutral way; if interviewers make it plain through facial expressions, intonation or verbal comment that certain views are either desired by, or unacceptable to them, an interviewee is likely to modify his or her responses. Orthodox interviews are also concerned with the need to control the subjectivity of the respondents. There is a need to avoid striking up a conversation about the research and related issues to ensure standardisation. O’Connell Davidson and Layder (1994: 119) distinguished neutral from leading questions. However, qualitative research interviewing is not generally concerned with obtaining accurate responses to close-ended questions, as with obtaining full and sincere responses to relatively open-ended enquiries; questions may be less neutral, but perhaps still not leading. Each interviewee is seen as an individual, subjective being and it is, therefore, accepted that each interview will be different and individual regardless of whether or not a structured interview schedule is being followed.

**Interviewer skills**

Individuals carrying out research interviews need several key skills. The first of these is to engage respondents effectively in the research process. This may vary from containment of respondent anxiety to coaxing them into expanding their responses. Other skills include an ability to listen more and speak less, posing questions in a straightforward, clear and non-threatening way, eliminating cues, which lead interviewees to answer in a particular way, and looking like the interview is enjoyable (Robson, 2002: 274). Additional interview skills include recognising the verbal and non-verbal cues and following up these as appropriate (this can be difficult if the researcher and interviewee have never met except for the research interview). The interviewer needs to be able to take cues from what is said by the interviewee and allow the possibility of pursuing interesting leads with subsequent or ancillary questions. This makes the assumption that, to obtain data that is
comparable in key ways, the interviewer needs to ask different questions of different interviewees. The interviewer needs to remain flexible and be aware that they are to some extent in a privileged position with the interviewee having given up their time without any guarantee that the outcomes generated may necessarily be of any personal benefit. As with all research, but especially one-to-one qualitative type interviews, there are the issues of the relationship between the researcher and the participants, which is dependent on the various factors (such as gender, professional status and age) that all influence relationships.

**Alternative methods**

It is arguable that focus groups could have been used for this study instead of interviews. A focus group is

> "a group of individuals selected and assembled by researchers to discuss and comment on from personal experience, the topic that is the subject of the research" (Powell et al, 1996:1).

Typically focus groups typically involve six to ten individuals who have some knowledge of, or experience with, the topic and last up to two hours (Glitz, 1997). A moderator guides participants through a series of open-ended questions and leads the group discussion. The focus group responses are a result of the discussions and interactions that take place in the group rather than simply direct responses to the questions. The role of the moderator is important because he/she needs to facilitate discussion and interaction, whilst keeping the group focused on the topic. The facilitator needs to ensure involvement of all members and, on occasions, may play devil’s advocate to ensure that all potential aspects of the questions and meanings of the responses have been explored. At the same time he/she needs to maintain a professional distance and not show approval or disapproval for any particular perspective. Gibbs (1997) outlined the advantages of focus groups as a method for gaining insights into people’s shared understandings of everyday life. Focus groups also benefit from the interaction between individuals and generating data in a more time effective manner. However, as Sim (1998) indicated, there can be difficulties with using focus groups. One of these is that it is probably not appropriate to infer an attitudinal consensus from focus group data, as there may be an apparent
conformity of view, which reflects the emergent property of group interaction, rather than individual participants’ views.

Interviews were the method of choice in this study because focus groups were considered difficult to organise due to the geographical distance between participants and organising mutually convenient times. It was felt that individual interviews would allow for a greater exploration of individual perspectives, an issue that was considered to be central to this research.

6.4 Devising the interview schedule

A semi-structured interview with mostly open-ended questions was used in an otherwise structured interview schedule. The interview began with broad general questions and then focused on different aspects of teaching such as:

- Learning outcomes
- Delivery methods
- Assessment
- Impact on clinical practice
- Student perspectives

As the schedule was being devised, there was awareness that the different groups of respondents may have different levels of understanding or experience of terms such as ‘cultural diversity’, race, culture, ethnicity or multiculturalism and the educational terms used. For example, patients/users might have a different perspective on the learning outcomes. Patients and users are unlikely to frame learning outcomes in educational terms but rather in how they might want their doctor to behave, or what they might personally expect from their doctor. As the interview schedule was being devised, it was important to be mindful of the role of the researcher in that his/her own biases may influence what is asked in the schedule. This issue is discussed in greater detail later.

The interview schedule drew on:

The literature base:

- Sociological theories about culture and related terms
- Medical education literature about ‘cultural diversity’ teaching
• Literature from other disciplines such as work with the Peace Corps, psychology and nursing as highlighted in Chapter Five
• Educational theory and course design

Previous research, clinical, educational and personal experience

• I also drew on my own previous research in 'cultural diversity' issues and teaching experiences. The latter influenced the idea of a systematic approach to devising teaching programmes
• My clinical experience of dealing with patients and families from diverse backgrounds was also relevant as it helped relate the teaching to practice issues
• My own experience of the ways in which I have been defined that did not reflect my own sense of identity was used to enable respondents to identify themselves before they were asked whether they felt they could adequately respond to ‘ethnic’ groups as used by the 2001 census (National Statistics, 2003)
• Earlier interviews with members of the GMC Education committee responsible for the first Tomorrow's Doctors (GMC, 1993)
• The Internet search used to meet objective two

In designing this research, I had anticipated that the approach to developing teaching programmes would be systematic. Having undertaken some training in teaching practice through formal programmes and informally through self-study, I have developed a systematic approach, supported by the literature (e.g. Toohey, 1999: 21-43). This is demonstrated in Dogra (1999 and 2001). Whatever the context I had anticipated that there would be discrete although interlinked stages such as a needs analysis; course design with explicitness about its purpose; clarity about the teaching approach, assessment and evaluation built in as part of the course design, and using the literature available.

6.4.1 Interview development

The schedule (Appendix Four) consisted of three parts as now discussed. The interview schedule began with an introduction to the researcher and the context of the research. The introduction stated the way in which the study was using the term 'cultural diversity'. Participants were given reassurance regarding confidentiality and permission to tape the interview was sought. Part I collected basic demographic data (age and gender), as well as job titles, roles and professional experience. Part II began with four broad open-ended questions and respondents were allowed to talk for as long as they wished, the interviewer
clarified points if necessary. The questions remained open-ended and participants were asked about specific issues relating to the teaching of ‘cultural diversity’.

Part II continued with a sequence of questions followed systematic course design (Toohey, 1999), beginning with philosophy behind the subject area, contents, process, outcomes, examples of practice, policy, and theoretical underpinnings. The rationale and justification for responses were to be actively pursued. Specific programmes and GMC policy were also inquired about. This then led on to the Part III, which asked about the ways in which respondents used or understood key terms. The interview schedule concluded by asking respondents if they had experience and/or training in ‘cultural diversity’, and whether or not they could suggest colleagues for subsequent interviews.

6.5 Sampling strategy

Due to limitations of time and financial resources, every single individual with a stake in medical education could not be interviewed, so a sample was selected. Strah, (2000:201) discussed the researcher knowing who to include in the study and suggested listing the factors that were deemed pertinent to the project to ensure appropriate selection. 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. With respect to this study 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 also ensured that interviews continued until saturation was achieved (that is until no further new data was being generated).

Those interviewed are not representative or presumed to be representative of their ‘group’ but in most cases they are 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, gender, socio-economic status or 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; whilst they might not have a representative view of the group
as a whole, they could potentially have a group perspective or a view of the group consensus. The research question was to identify the perspectives of stakeholders about 'cultural diversity' and its teaching. The data collected might potentially feed into a position statement about 'cultural diversity' teaching in the medical curriculum in the UK and ways to develop this further. Therefore, it was important to consider which parties potentially have an interest or are involved in or affected by this research and the implications for these parties of framing these particular research questions. This is relevant in terms of engaging all interested parties, giving them a real stake in the research, the application of any outcomes and setting the future agenda. The research successfully engaged all groups of stakeholders. However, there was also a strategic reason for this sampling frame as discussed above. Theoretical sampling incorporates certain characteristics or criteria that help develop the research question. Using a broad range of stakeholders with different priorities means that a various perspectives were explored. The sample taken encapsulated an inclusive range of views in relation to the subject of 'cultural diversity' and medical education. The sample selected enabled between-group comparisons and identification of whether or not the perspectives fit with 'cultural expertise' or 'cultural sensibility'.

6.5.1 Sampling frame

The research objective was to explore the perspective of key stakeholders in medical education; the first decision involved identifying the stakeholders in medical education and/or cultural diversity. This included those organisations that are responsible for setting the standards and for training doctors, such as the General Medical Council and medical schools. Stakeholders also included those who have responsibility for implementing the policies and delivering the teaching, which are mainly medical school teachers. The recipients of that teaching and those who receive the healthcare ultimately given by these recipients also have a stake. The following groups were thus considered essential in the selection of the sample. Justification of their inclusion is also provided.

Policymakers: members of organisations that decide or influence policy on medical education including:

- The General Medical Council
- The British Medical Association
The major Royal Colleges (i.e. Psychiatrists, General Practitioners, Surgeons and Physicians)

The Department of Health

The General Medical Council sets the standards of undergraduate medical education in the UK; a statutory responsibility under the Medical Act (1983).

The BMA represents doctors' interests from students through to consultants and GPs.

The Royal Colleges have a major role in postgraduate education. They also have representation on the GMC Education committee through the ARMC. As the Colleges build on the broad medical education provided by medical schools and enable doctors to specialise, their perspectives might be relevant.

The Department of Health, as a future employer has an interest in medical education.

Those who implement policy: Heads of medical education and curriculum committee members. Heads of medical education/curriculum designers have a responsibility of implementing policy within medical schools in relation to medical education, but must ensure that the curriculum delivers and produces doctors as set out by the GMC.

Teachers: Teachers are responsible for developing and delivering cultural diversity within the outlines prescribed by their organisation (medical school). Teachers in the related area of communication skills were included specifically because communication skills teaching is often developed by GPs and psychiatrists. The literature review also suggests that some learning outcomes for ‘cultural diversity’ teaching are framed in developing effective communication skills.

Researchers in ‘cultural diversity’ and associated areas: Researchers in ethnicity actively teaching in this area were also included. Many researchers in this area are not necessarily involved in medical education, although their views on health care provision and ethnicity influence policymakers such as the GMC, the Royal Colleges and teachers in diversity to varying degrees.

Medical students: Students are recipients of medical education, and thereby have an interest in the process and outcomes. The students who head student representational bodies were included, as they inform some of the above organisations. Students were identified through student representative bodies, British Medical Association and Medical
Students International Network (MedSIN), which is a student-led body to develop links between students from different countries. The year of training may influence student perspectives. It was decided that as their experience of education formed a very small part of the schedule, the year of training would not be a factor in selection. Students from the four medical schools discussed below were an alternative but this option was not chosen as it was practically more difficult to identify students and make contact. It was felt appropriate to ask staff to identify students because of potential bias.

**Users/patient representatives:** Users of healthcare provided by doctors and the carers of users are also stakeholders. Some of these may also be policymakers.

**Medical schools:** A list of these was generated using the Internet site of the Council of Heads of Medical Schools (CHMS, 2003) (Table 10, Appendix Five: page 297).

### 6.5.2 Sampling of medical schools

Objectives four and five were to identify perceptions and evaluations of ‘cultural diversity’ and its teaching held by medical faculty staff and to identify perceptions and evaluations of ‘cultural diversity’ and its teaching held by teachers in the UK.

To meet these objectives specific medical schools were required. The decision was made to contact the heads of medical education, curriculum designers and teachers with a remit for teaching ‘diversity’ of four medical schools. Four institutions were selected, based on the search generated in meeting research objective one and through additional extensive personal knowledge of programmes in the UK. Some of the information was triangulated by speaking to students at these organisations and clarifying whether or not my analysis of the website was appropriate and/or seeking information through other contacts at the institutions selected. A list of all the schools was drawn up and information tabulated with respect to the presence of a ‘cultural diversity’ programme (Table 10, Appendix Five: page 297). If there was a ‘cultural diversity’ programme and the curriculum available, it was analysed to establish whether or not it was more consistent with the ‘cultural expertise’ or ‘cultural sensibility’ model. The ranking of the schools according to the Times was also considered. As only 24 of the 26 schools were ranked, schools were ranked as belonging to the top eight, middle eight and bottom eight. The city in which the medical school was located was rated for ethnic population and rated as having a low,
moderate or high ethnic population. However, using a combination of the level of
ethnicity, the Times ranking and the approach used to teach diversity would have given
too many schools to follow-up. It was decided to sample schools based on their
approaches to ‘cultural diversity’ over any other criteria. At the time of the study, three of
these had ‘cultural diversity’ programmes and the fourth did not. One of these three
programmes was more consistent with the ‘cultural sensibility’ model but with elements
of ‘cultural expertise’. The second had elements of both models. Based on information
about the undergraduate curriculum, the third programme was more consistent with the
‘cultural expertise’ model. The fourth school did not have a formal ‘cultural diversity
programme. Comparable data were available on all four schools. The schools are
described under the section on the sample.

6.5.3 Sample size

Time and resources meant that a minimum target of a fifty interviews was set as the
sample needed to be sufficiently large to enable valid comparisons. This sample size also
meant that at least six individuals in each of the stakeholder groups needed to be
interviewed. In some ways, this equates to a degree of quota sampling, as the
‘professional role’ was a controlled variable. Beyond that no other quotas were set. 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. The range selected was intended
to enable generation of data to explore processes, similarities and differences. Based on
this number, developing and testing a theory of explanation to account for those
similarities and differences was possible, rather than seek statistical comparisons between
the groups and infer causality on that basis.

6.6 Ethical issues

For this study, there were more ethical issues in terms of undertaking the interviews than
in the study design. The questions posed in the interview schedule were unlikely to cause
distress, although they had potential to worry or embarrass the interviewees. The
challenging questions might also make respondents uncomfortable and there is a balance
to be struck between meeting research objectives and causing discomfort. It is possible to
warn respondents that there are questions that may be difficult, and that they could choose
not to answer them. The choices will to some extent depend on the relationship between
the respondent and interviewer. Participants were assured of confidentiality and
preservation of anonymity particularly if they could be identified indirectly (e.g. as the
principal member of an organisation). As confidentiality was given, it was important to
preserve this even if it meant limiting disclosure in the findings. The dissemination
process considered the presentation of the research data without disclosing the names of
individuals or schools. There is also the issue of how the researcher uses what is said, and
whether or not it is fairly represented. This has been addressed by ensuring that the
context of the comments is not lost and that they were transcribed as spoken. There is also
a clarity regarding the analysis of that which was literally said and that which is inferred
by the researcher.

The issue of informed consent was not a problem in this study as interviews took place
with adults who could choose to decline. Participants may agree to participate in research
without having been made fully aware of the research purpose and implications. The
invitation gave some basic information and also included a clause inviting contact if there
were any queries. Participants were made aware of the context, purpose and intentions of
the research. I did not answer respondents’ questions about my perspectives when they
arose, during the interview, but did so at the end of the interview and giving the
respondents justification for this approach. The models that were to be used for analysis
were openly discussed with respondents and their views welcomed. All respondents were
offered (and accepted) a final project summary. It was felt that this would demonstrate
researcher commitment to making use of the time and input, and provide something they
could potentially use in their own work.

To enable the interviewer to focus on the interviews, the decision was made that all
interviews would be audiotaped, but notes would also be taken to increase familiarisation
with the contents. Again this information was shared with respondents. Interviewees were
aware that the tape remained on throughout the interview (including the conversation that
did not directly relate to the interview schedule) and that they could ask for recording to
be stopped at any time.

Power in relationships and ensuring that it is not abused is an important ethical issue. I
interviewed those that could be perceived to be more powerful, less powerful, or equal to
me. Irrespective of this, all participants were treated similarly and the process of
recruitment and arranging meetings was similar. It is possible that my professional position increased the likelihood of participation more so than other factors, such as age and gender, which would have been less clear from the invitation letter. My role and position are discussed in detail after detailing the administration of the interviews.

6.7 Administering the interviews

Interviews to meet objectives four to nine took place face-to-face whenever possible and by telephone, if the former was not possible. Initial contact was through a formal introductory letter that invited the respondent to contact the researcher if there were any queries. The letter (Appendix Three) also stated that the interviews would be confidential and that the local research NHS ethics committee had approved the project, although ethical committee approval was not officially required as the project did not involve patients. It was estimated that the interview would take between 45-60 minutes. If there was no response, the initial letter was followed-up by email or by a second letter. This was only done until enough participants had been recruited. No-one was contacted more than twice if they failed to respond. Most respondents replied by letter or email to agree to take part and copies of these were kept, making written consent forms unnecessary.

Within key policymaking organisations initial contact was made with the Chairs of the Education Committee and Ethnic Issues Committee if such committees existed. The Chairs were asked to pass on the invitation to the rest of the committee. Where this was not the case, contact was made with the organisation’s policy department or a senior member of the organisation such as the secretary or head. If individuals did not feel they were the appropriate person within their organisation, they were invited to communicate with me and advise of a more a suitable contact.

The heads of medical education at the four sample medical schools were contacted to request the participation of their medical school in the study. They were also asked to state whether or not they wished their colleagues to be contacted directly by the researcher or through them. In two cases, communication skills teachers, diversity teachers and curriculum advisors were approached directly by the researcher. In one case, the head of medical education contacted the appropriate individuals and obtained their consent and passed this information to the researcher. The fourth case, which was the
school that did not formally teach ‘cultural diversity’, struggled to identify individuals who were aware of course developments and several individuals were contacted before a person able to comment on some aspects of diversity teaching was identified. This medical school did not have a clearly identified department of medical education, unlike the other three.

Researchers in ethnicity who are also involved in ‘cultural diversity’ teaching were identified through snowballing.

Students were identified through the BMA Medical Student Committee and snowballing. The BMA has a dedicated medical student committee with officials elected by their peers. This committee works closely in partnership with the BMA, and represents student interest at several forums including the GMC and Department of Health. Every UK medical school has representatives linking to a central committee.

Patient groups, except for the Patients’ Association, were difficult to identify through formal channels. Many patient groups are concerned with specific medical disorders, e.g. diabetes or asthma. Mental health patient groups generally tend to be broader and consider general mental health issues. Patient/user groups were identified through Internet searches. This process also identified an advocacy group, through which one individual was identified and further individuals suggested by this recruit. The Patients’ Association has a remit of voicing patient interest and, for this reason, it was contacted directly.

This process identified approximately 30 individuals, who subsequently identified further potential participants. If assessed to be appropriate (that is, having a relevant role or background that made them suitable potential participants) by the researcher, each suggested participant was invited to participate in writing. The name of the person proposing the potential participant was included in the letter of invitation without disclosing whether or not the person suggesting the name had himself or herself participated in the study. Some of these identified were not contacted as enough participants had been recruited.

At the outset, the researcher explained how the term ‘cultural diversity’ was being used in the study but gave permission for the interviewee to use it as they thought appropriate.
During the interview, the term was used in the same way in which the interviewee used it. As issues covered in the schedule often overlapped, I needed to ensure if the interviewee had already mentioned a topic, this was acknowledged otherwise the interviewee may have disengaged if he/she felt unheard. It was acknowledged that the part of the interview, which asked for definitions of terms might be difficult or threatening for participants, so was broached carefully. Respondents were reassured that there were as such no singular right or wrong answers, but that the researcher was interested in the different ways these terms were used and their impact on medical education. The research did not set out to provide definitions of keywords but to explore possible uses and interpretations and the potential impact of these different uses. The extent to which information about models developed in this research were shared with respondents depended on where their answers took the discussion. The researcher perspectives were to be presented as an alternative, and used as an opportunity to further explore issues relating to ‘cultural diversity’. The challenging questions planned in this part of the interview were not neutral as respondents were to be encouraged to be reflective and critical of the models presented. In the part of the interview that posed some challenges, the questions were not leading, in that no answers were presented. The questions did perhaps force respondents to consider issues in ways they may not have done so before the interviewer posed the question. After the interview, immediate observations, thoughts and interpretations of what had taken place and the researcher role in the interaction were noted.

6.7.1 How the schedule changed as the interviews progressed?

In qualitative research, the modification of interviews is accepted as part of the research process, that is that the theory informs the research and vice versa. However, it does raise the issue of consistency. The rationale for a flexible design is that as the interview progresses, interview two informs interview three, and so on. While, there is a need to ensure that the research topic and themes remain the same, it is accepted that the exact wording may be modified and more themes explored if necessary. As the interviews progressed, there were modifications to the schedule.

The second part of Question 16 that asked how learning outcomes might be phrased was not asked after the first three interviews, as participants struggled to respond with
appropriate objectives immediately - they knew what they wanted to cover but could not be specific in voicing them. As the exact wording is less important than the overall aim and purpose of the teaching, this question was omitted: Persisting with it would be time consuming and would not yield useful data and may have been frustrating for participants.

The question that followed on from who constitutes an expert was to have been: “On what basis have you formed your opinion?” (Opinion/advice from experts; evidence-base; literature; own experience). However, this was generally answered according to how individuals defined experts thereby becoming redundant.

Question 25: “In your opinion, how do you think programmes that endeavour to teach cultural diversity might be evaluated?” often needed clarification, as many participants thought that this was similar to the question about student feedback. There was confusion between student feedback and more formal evaluation in terms of whether or not learning outcomes were successfully met.

There was some overlap between questions 26 and 28, so the question was reframed depending on responses given. The question regarding the GMC perspective was often reworded to clarify that even speculation on what had prompted the GMC to include the phrase regarding respect for diversity was included.

Where previous participants had expressed discomfort, I acknowledged this and stated that “some participants have found the next question quite difficult”. In this way, it was envisaged that the interviewee’s anxiety might be quelled.

Question 39 regarding participants classification of ethnicity was fairly broad and participants were not pressurised to complete a tick box if they did not feel this was relevant to them.

In summary, the changes made to the interview schedule were minor adjustments and there was no shift in the overall interview strategy.
6.7.2 Transcriptions

The same person transcribed all the tapes; an independent paid audio typist. Transcriptions were completed throughout the data collection period. There can also be disadvantages of relying on textual transcribing as a main source of evidence. Poor equipment may render the material unusable. Relying too heavily on transcriptions may result in meanings and contexts being lost, as transcription cannot convey body and non-verbal communication. However, videotaping is prohibitively expensive, and potentially inhibiting and more intrusive than audio taping. It was, therefore, important to note how the interviews had progressed and to explore cues given by non-verbal cues such as smiles and frowns. The transcriptions were verbatim; everything said was transcribed, including hesitations.

6.8 The sample

Medical schools

Medical school 1 – This school has a well-established ‘cultural diversity’ programme that had undergone review, development and evaluation. The programme is more consistent with ‘cultural sensibility’ than ‘cultural expertise’.

Medical school 2 – This school’s programme for ‘cultural diversity’ had been established for some time but had not undergone formal evaluation. The programme had elements of ‘cultural sensibility’ but less so than medical school 1 and elements of ‘cultural expertise’ model.

Medical school 3 – This course had elements that had been established for some time, but had recently, undergone major revisions. The programme was more consistent with ‘cultural expertise’ but with some aspects of ‘cultural sensibility’.

Medical school 4 – This school offered no specified programme regarding cultural diversity, although health inequalities and ethnicity were addressed in theoretical sociological frameworks rather than clinically relevant teaching.

The information given is limited to prevent identification of the schools. School two is considerably larger than any of the other three; no medical school had an intake of less than 100. Three of the medical schools have trained doctors for over a 100 years and one was established in the 1970s. One of the schools addressed the changes in Tomorrow’s Doctors (1993) very early, another a little later, a third did not so until two years ago and
the fourth has yet to make significant changes consistent with *Tomorrow’s Doctors* (GMC, 1993). Three of the medical schools have formal divisions of medical education and one does not.

**Individual participants**

Using sampling and ‘snowballing’, a total of 61 individuals were interviewed. Their professional roles, ethnicity, gender, age and institutional affiliations are summarised in Table 7 (page 125) and detailed in Table 11 (Appendix Six: pages 299-302). 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. The names of the schools and the organisations to which the participants belong are not presented to preserve confidentiality.

Through this process, staff or students from 14 of the 26 established medical schools in the UK were involved (2 schools have campuses at 2 sites, therefore, 12 curricula were effectively covered). A member of staff from a new school, yet to take in students, was also involved, thereby increasing the number of schools to 15. A clinical teacher came from yet another medical school but as he was in training and had no formal teaching role, he was unable to comment on the curriculum and so that school is not included in the above. For another school, one of the participants had been an external examiner, but this school is also not included in the 15 described above number as the appointment was not current. Only one Scottish school perspective was obtained, although participants had experience of Scottish medical schools.

Members of the following policymaking organisations were interviewed:

- The Department of Health
- The General Medical Council
- The Royal College of Physicians
- The Royal College of General Practitioners
- The Royal College of Psychiatrists
- The British Medical Association
- The Sainsbury Centre for Mental health
Participants from clinical medical backgrounds covered the following disciplines:

- Surgery
- Psychiatry (adult and child)
- General medicine
- Paediatrics
- Immunology
- General practice

Other ‘clinical’ perspectives included:

- Pharmacy
- Social work
- Community youth work
- Nursing

Non-clinical participants came from sociology, anthropology, accountancy, research and advocacy work.

Detailed notes were taken for all 61 interviews, of which one was a telephone interview. Fifty-eight interviews were audiotaped. The same transcriber transcribed all 58 audiotaped interviews. Technical difficulties were encountered in recording two interviews and a further tape was faulty when it came to transcription; in these cases transcription relied heavily on the notes taken at the interview. The handwritten notes for which there was not a tape or the tape was defective were also typed out so that ultimately 61 transcripts were produced.

Of the 61 interviews, 5 had to be rearranged. Four took place at a neutral venue; all others took place at the organisation of the participation. There were 39 male and 22 female participants. There were 28 medically qualified doctors, 3 participants with non-medical
clinical backgrounds. Twenty-three of the sample were non-clinicians and the 7 students were in training. Fifty of the respondents were white, 9 with origins or from the Indian sub-continent, 1 was black and 1 had mixed heritage. Seven (of whom 6 were students) of the sample were under thirty years of age; 10 aged between 31-40 years; 22 aged between 41-50 years; 20 aged between 51-60 and 2 over 60 years.

Table 7: Summary demographics of participants

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<th>Role</th>
<th>Men n = 39</th>
<th>Women n = 22</th>
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<tr>
<td>Communication teachers</td>
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<td>3</td>
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<tr>
<td>Curriculum heads/leads</td>
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<td>3</td>
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<td>3</td>
</tr>
<tr>
<td>Users</td>
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<th>Women</th>
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<tr>
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<tr>
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<td>18</td>
</tr>
<tr>
<td>No</td>
<td>12</td>
<td>4</td>
</tr>
</tbody>
</table>

*Excludes medical students and three of the females with clinical backgrounds who were no longer practising

A further 12 individuals responded but did not take part in the study. Their details including the reasons given for not participation are shown in Table 12 (Appendix Six:
A further 17 individuals did not respond to my letter of invitation and their details form Table 13 (Appendix Six: page 304).

In summary, there was generally a positive response to the project; non-response rates were highest among policymakers. This may be because they receive more requests to participate in research or because of the perceived irrelevance of the study to their direct work. It may, of course, also be that they as a group are least committed to the way the policies they generate are implemented, and that production of the policies rather than their implementation may in itself be viewed as an effective outcome. Committee members who did not respond may not have done so as they felt that it was sufficient for the chair to respond. Additionally, the area under study may not have been one in which they felt they could usefully contribute.

6.9 The researcher's role in the research and interview process

There are three major issues to consider in relation to the researcher's role. First is the way that the researcher's own perspectives may colour the research as summarised by Robson (2002: 173). Then there are the issues of how the researcher is perceived, and how that perception influences the research process.

This research was undertaken by a female, of Indian origin, aged forty, 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', I had some professional familiarity and experience with the topic. This experience suggested that much of the teaching was perceived to be marginal and, as yet, had not been embraced by medical education as a whole.

Robson (2002: 173) suggested that reflexivity is a useful way for the researcher to identify potential bias. He suggested potential biases and how to address them. His first suggestion is that the researcher writes down their personal issues in undertaking the research, the assumptions associated with gender, race, socioeconomic status and the political milieu of the research, as well as where the power is held in relation to the research, and where the researcher is within the power hierarchy. The researcher should also identify gatekeepers’ interests and consider the extent to which they are favourably
disposed to the project. The issues of reactivity and respondent bias also need to be addressed. Reactivity refers to the way in which the researcher’s presence may interfere in some way with the setting, which forms the focus of the study, and in particular with the behaviour of the people involved (Robson, 2002:172). This issue was slightly less relevant in this study as the research interviews were discrete. Respondent bias is always a potential problem and the relationship between the researcher and respondent needs to take into account aspects of human relationships that are now discussed.

The political climate in which this research took place is important and followed the MacPherson Report (Home Office, 1999); institutional racism had become a buzzword. The Race Relations Amendment Act (2000) demanded that organisations demonstrate commitment to addressing equality. Equality and diversity as a whole preoccupied many organisations including medical schools. The nature of the topic also raised anxieties in terms of potential problems if organisations were shown to be lacking. Placing the research in an educational, rather than political context, helped focus the project. The project was placed in the context of training prospective doctors to meet the diverse needs of patients. That doctors are not discriminatory, is much more clearly and directly clinically relevant, than a stance that doctors should not have any prejudices. The lack of a political agenda may have deterred those who felt a political stance was necessary.

For this research I was in a relatively privileged position. As a female of Indian origin, it is possible that based on these characteristics I was given credibility about having some ‘expertise’ or interest in diversity. Although my name may have had no implications for some people, to others it might suggest a non-English background. Similarly gender might be inferred for some participants. Their responses might have been modified by their impression, expectations or suspicions about the researcher. They might be reluctant to disagree and fearful of making comments that might be incorrect or interpreted negatively. There was a positive response from those with whom direct contact was made. The response was less favourable when letters were circulated to a committee from their chairperson (three committees received invitations from their chair). Generally, a good rapport was developed with most of the participants. The approach was fairly consistent in that initially participants did most of the talking. I was often asked for ‘right’ answers and usually deferred this until the end when we engaged in a discussion about broader issues. I did not provide ‘right’ answers; there were few questions to which such a
response was readily available or appropriate, and this was discussed with respondents after the interview. The discussion often included the researcher discussing the concept of 'cultural sensibility'. Participants were encouraged to contribute their views.

Holliday (2002: 148) described what can happen when two groups of people such as researchers and participant from different backgrounds come together. He used the analogy of tourists and local people, where the researcher is the tourist and the research setting is the tourist business set up by the villagers. It could also illustrate the everyday clinical encounter. Holliday (2002: 148) considered three issues:

1. A specialised culture of dealing between the tourist and the villager is set up
2. The dealing is influenced by and to some extent a product of the complex cultural baggage that each of the involved parties brings
3. What is perceived by each party of the behaviour of the other party or parties and is influenced by a and b but is easily prone to essentialising cultural over-generalisation

The second point implies that the researcher culture has significant influence on the research setting making qualitative research impossible if the aim is to see, naturistically, what was there before the researchers arrived. Holliday (2002: 149) believes that within the third point lie the seeds of 'otherising' or reducing whole swathes of people to deterministic description. For these reasons, it is important to be aware that for some organisations, it may have been difficult to decline to participate in the research because of the impression that might have given to external observers. Three individuals who declined to participate held positions, which the current research might have challenged, and it may be because of this that they declined to participate although other reasons were given.

In terms of hierarchy as a senior clinical academic I was able to engage some very senior respondents. This may relate to the perceived research outcomes, which participants may feel are more likely to be disseminated than if a more junior member of staff undertook the research. It was possibly easier to access psychiatrists, especially child psychiatrists, given my clinical background. Those external institutions with which there had been previous personal contact were also more accessible. If suggested by a colleague, people may have responded positively as they did not want to let down the colleague who had
recommended them. Also those who were interested in the subject area may have been more likely to respond because they wanted to share their own experience and views. My position as a consultant in the health service is a senior post in medical terms, and the job title would have been familiar to most participants. This may have encouraged some to participate, but made it difficult for others, especially students, to decline (although one did decline).

For the purpose of engaging as a researcher, whenever possible, background research on the participants was undertaken and familiarisation with their recent work and or interests. Being a clinician was useful because issues of quality patient care were central to the idea of developing ‘cultural diversity’ teaching. Valuing the sociology perspective was helpful in engaging some of the non-medical academics who often felt that medicine, as a discipline, does not always value the contributions of the ‘psychosocial or behavioural sciences’. Having considerable experience of direct teaching, course development and educational research prior to the PhD project was also potentially useful. An approach of inclusiveness and valuing all contributions probably helped participants feel valued.

Extensive clinical experience, considerable clinical training in interviewing skills, and working with potentially difficult issues were all probably more helpful than unhelpful in this study. For some participants, the thought of being interviewed by a psychiatrist may have been a little daunting. There may have been concerns about what judgements were being made, particularly for the users, some of whom had used mental health services. Other participants may also have been anxious about being analysed, perhaps seeing me more as a psychiatrist than a researcher. There might also have been some suspicion about why a senior doctor was data collecting, although this may have been allayed by the declaration that it was a PhD project. For some participant’s disclosure of sensitive information or acknowledging that they did not know, might have made them feel vulnerable or increased their discomfort. However, this was negated to some extent because the interview was set up as an exploration of views to try and establish a broad picture of the status quo. This approach may also have dispelled doubts about whether or not perspectives were really valued. There was no attempt to railroad participants into certain ways of thinking as different models may have different strengths in different contexts. Whilst I had developed the ‘cultural sensibility’ model and it is my preferred choice, this was not disclosed until we discussed different models. When analysing the
data, there was a need not to focus on those who shared my perspective but present a balanced interpretation of the data collected.

Some participants expressed dissatisfaction with people I knew, or was interviewing, for the research. It was important not to disclose this to others, although there was an acknowledgement that I had already made contact with some people who were suggested by participants; I did not disclose whether or not they had participated but confirmed that they had been approached.

In general, interviews were held at a mutually convenient but flexible to accommodate the interviewees. I travelled to all interviews, most of which took place at the interviewees' workplace. No interview took place in my office but some took place in neutral venues because they were mutually convenient. Students and users were least likely to have offices so were interviewed in empty teaching rooms and/or other neutral venues, such as cafes.

I openly acknowledged the time and commitment given by participants, and demonstrated respect for their time by being punctual. With most participants, there was a common connection either as a doctor, teacher, policymaker, or researcher which has great potential to bias what information respondents share because there may be concerns that they may encounter me in other contexts. There may be concern about how I interpret their comments and how this might influence my view about them and whether or not this would potentially undermine them in future meetings. The nature of the connection meant that the interviews as such could not be anonymous. Interviewing with someone you may encounter again in a different professional context is a different experience from being interviewed by someone you are unlikely to meet again. On the whole, I was conscious of not focusing on ethnicity, gender or age as a predominant factor, although all these factors do play a part in the establishment of a relationship. It is unclear how these factors may have affected those being interviewed.

All participants were generous with their time and supportive of the project. There is no doubt that personal persuasion and 'charm offensive' were used to engage participants, with the appropriate use of humour or engagement on a topic that was relevant or important to the interviewees. Those interviewees who began slowly, warmed up as the
interview progressed. From my perspective, none of the interviews were hurried, insincere or obligatory. Most were relaxed and comfortable. This may be related to the researcher’s experience as well as to participants’ own experience and positions (that is, regularly presenting their perspectives). This also applied to the student and users interviewees, all of whom had experience in official positions.

The introduction given to users and those not directly involved in medical education was longer than for those directly involved. This provided reassurance that answers did not have to be word perfect.

Robson’s (2002: 173) second suggestion is to clarify personal value systems and acknowledge areas of greater subjectivity. Three interviews were somewhat difficult to conduct. One of these was because the participant spoke with a very soft accent, which was at the worst range for my hearing loss. The other was difficult because the participant initially gave the impression that they thought there was a hidden agenda and another because very short non-elaborative answers were given. As I have a tendency to interrupt a conscious decision was made to leave any explanations or answer questions until the end. There was perhaps a tendency by me to reassure or accept too readily some of the definitions given to avoid discomfort for the interviewees, as I did not want the interviewees to feel ignorant; I did try and pose tentative explanations to seek their responses.

Whilst enough information was provided to potential participants to help make an informed decision, the researcher’s personal views or beliefs about the teaching of ‘cultural diversity’ were not communicated to respondents. As I had published and presented at conferences in this area, some professional colleagues may have been aware of my perspectives, although the ideal types models had not been previously articulated in the present form. Some participants’ key motivation to participate in the research was that it supported their own research experiences, as much as for the subject matter. Five interviewees were initially a little hesitant, but following a telephone conversation were reassured that I was interested in their perspective.

For some questions, the response was perhaps predictable, that is, there was in effect a ‘correct response’. For example, should student feedback be gathered? The led up to this
question being altered by acknowledging that no-one had said no. Participants then started to qualify their responses by saying, only if feedback were to be used and the taken for granted response explored. Some participants asked about the schedule, and the researcher explained that some of the questions were introduced as there were similarities between teaching and learning in diversity and other areas and perhaps not enough has been made of this because of anxieties around diversity.

The last question of the formal schedule was whether or not participants wanted a summary of the final project report. No-one declined which raises the question of whether they were really given the option to do so. A few had already asked for it, and a few stated that they did not want to generate extra work. This was a difficult issue as my research training has strongly advocated that I have a responsibility to give something back to respondents considering the time they had given me. There is also the issue that the summary is unlikely to be definitive but maybe in itself a useful tool in focusing debate in this area and helping develop the learning and teaching in diversity.

Robson’s (2002: 173) third suggestion is to describe possible areas of potential role conflict and be aware of what kinds of situations and people might increase frustration, anxiety or preferred situations, as unless these are clear, there is potential for bias. There is also a need to recognise when there is a lack of neutrality and how that is approached.

I have been told on numerous occasions that my body language and facial expressions are open and easy to read so whilst that can be positive in conveying enthusiasm and warmth, it can also convey surprise, disappointment or disapproval. I was, therefore, more reserved especially when respondents made remarks, which I found uncomfortable such as: “All whites are racist”. It was important to ensure that while the interviews should not be mechanistic, nor should they be completely unrelated to the research topic. There was also a need to ensure that I actively listened to the perspectives of those respondents whose views were very different to mine.

A fourth suggestion made by Robson (2002:173) is that the researcher critically consider whether the evidence in the literature is really supports the analysis or does it just reflect the researcher’s personal biases. The researcher needs to remain constantly open to the idea that subjective perspectives can be hard to abandon. After each interview, I reflected
on my thoughts and feelings about the interview experience and this was also discussed at research supervision. The supervision sessions were also an opportunity to consider whether all aspects of the issue had been considered, even those that I found uncomfortable.

Few of the interviews finished at the end point of the schedule; there were often discussions relating to questions raised by the participants, which were left until the end. There were times when it felt that a participant made an initial reserved judgment about me but then, during the interview process, opened up because they engaged well with me. It was unclear if respondents worried that the research would be ‘politically correct’ and that I would suggest that ‘cultural diversity’ should take up the whole curriculum. It is unclear whether or not the perceived warmth was related to the researcher being more ‘reasonable’ and ‘balanced’ about the diversity debate than they might have anticipated.

In summary, whilst there were many potential difficulties most of the interviews went well and respondents gave full accounts of their perspectives. Before discussing the data analysis, issues of validity and reliability relating to methodology and analysis are discussed.

6.10 Issues of validity and reliability of the research

Mason (1996: 24) raised the issue of validity and stated: ‘If your research is valid, this means that you are observing, identifying, or “measuring” what you say you are’. Validity is often associated with the ‘operationisilation’ of concepts and is more often associated with quantitative and experimental research. Validity of qualitative research concerns the conceptual and ontological clarity of the research question and the success in translating these into a relevant and meaningful epistemology (Mason, 1996: 148). Assumptions are often made about quantitative research having greater validity than qualitative research, as it supposedly has fewer opportunities for subjectivity (Silverman, 2000: 176).

Qualitative researchers must be able to convince themselves and their audience that their findings are genuinely based on critical investigation of their data, and do not depend on a few well-chosen examples or anecdotally. Validity needs to be demonstrated in the way the data are generated. The issues that need to be clarified are on what basis was the research design chosen, did the research design effectively address the research question,
and why were alternatives not considered. There is also a need to consider the researcher’s own biases, as discussed above.

A valid description of what was seen or heard is threatened if the data are inaccurate or incomplete. The data validity may be improved by having notes and audiotapes as in this study or videotapes (not used).

Interpretation is another issue when considering validity. Mason (1996: 150) argued that this is best demonstrated by stating exactly how an interpretation was reached. There should be clarity and transparency of the step-by-step route that led to a particular interpretation. The main threat to providing a valid interpretation is that of imposing a framework, or meaning, on what is happening rather than this occurring or emerging from what is learned during the process (Robson, 2002, 171). Robson (2002: 173) suggested that researchers should reflect on how the account is written up and to be aware of bias by assessing whether or not particular respondents are more quoted than others (such as those who support the researcher’s perspective). In reading through the transcripts it was necessary to ensure that all responses were considered. Some respondents are also more articulate than others and again it is necessary to ensure that these respondents’ statements are not given undue weight. The researcher should be able to justify the selection of quotes, and present the range of perspectives rather than just those that fulfil a particular agenda.

Reliability is attained when repeated measures with the same instrument on a given sample of data yield similar results (Correa, 1998). This is more likely if the research method is fixed rather than fluid, for example content analysis compared with interviewing. However, even when using content analysis, reliability is likely to be higher in those circumstances in which coding is essentially a mechanical task, for example recording whether ‘cultural diversity’ was specifically mentioned. Reliability is likely to be reduced when there are judgements to be made, for example about whether or not the diversity programmes described were more closely aligned with ‘cultural expertise’ or ‘cultural sensibility’. However, reliability can be improved by being clear about the basis on which judgements and interpretations are made. In this study, comparisons were made with the components of the ideal type models described in Chapter 4.
For the interviews, reliability was improved by transcribing the tapes verbatim including hesitations, pauses, asides and so on. The use of an independent transcriber also helped in that as she was not familiar with the data, no short cuts or interpretations were made at the point of transcribing.

6.11 Process of analysis for the interview data

Robson (2002:458) described four different approaches to qualitative analysis:

1. Quasi statistical approaches
   This approach uses word or phrase frequencies and inter-correlations as key methods of determining the relative importance of terms and concepts and is typified by content analysis.

2. Template approaches
   Key codes are determined either on an *a priori* basis (e.g. derived from theory or research questions) or from an initial read of the data. These codes serve as a template for data analysis and this may change as analysis continues. Text segments, which are empirical, evidence for template categories are identified.

3. Editing approaches
   This approach is more interpretive and flexible with few if any *a priori* codes. Codes are based on the researcher’s interpretation of the meaning or patterns in the texts which is typified by grounded theory approaches.

4. Immersion approaches
   This is the least structured and most interpretive, emphasising researcher insight, intuition and creativity. Methods are fluid and not systematised. It is close to literary/artistic interpretation and calls for expert knowledge. This is a difficult approach to reconcile with the scientific approach.

The most commonly used approaches in this analysis were a combination of the first two methods and followed a series of systematic steps. The justification of this was the need to relate the findings to existing theory. However, to enable the findings to be related to the educational models of ‘cultural expertise’ and ‘cultural sensibility’ developed in Chapter Four, there was a greater degree of interpretation, and the immersion approach applied. Miles and Huberman (1994:9) stated that, whilst the possible approaches to
analysis are very diverse, there are recurring features and these can be viewed as a sequential list of 'a fairly classic set of analytic moves':

1. Affixing codes to a set of field notes drawn from observations or interviews
2. Noting reflections or other remarks in the margins
3. Sorting and sifting through these materials to identify similar phrases, relationships between variables, patterns, themes, distinct differences between subgroups, and common sequences
4. Taking these patterns, themes, etc, out to the field to help focus the next wave of data collection
5. Gradually elaborating a small set of generalisations that cover the consistencies discerned in the data
6. Linking these generalisations to a formalised body of knowledge in the form of constructs or theories

The process of analysis for this research study took into account the steps outlined by Miles and Huberman (1994:9):

1. Read the complete scripts and identified key terms, words, themes and issues
2. Reviewed field notes and identified further themes
3. Collated responses to each question and from these identified types of response to issues that the question was based on
4. Looked at the information leading to the development of the schedule and again identify themes
5. The themes were linked with the theory discussed in Chapters 2-5
6. Ran systematic searches using key words and identified themes overarching different issues

After each interview had been completed, observations of the experience and issues that were especially relevant, or had provided a new perspective or question, were noted and transcribed. Issues that arose from reflection of the interviews are listed in Appendix 8 (page). All of the above issues continued to develop through the interview process.

The tapes were transcribed and read as complete documents to increase familiarity with the data. As I read through each interview, I noted any particular issues that were highlighted. I also noted words that might be relevant to operate searches to identify
whether or not different individuals had used particular terms or words in other parts of the interview. This also helped identify similar themes in different parts of the interview: for example, a concern of many appeared to be a checklist-type approach, so the word ‘checklist’ was noted as a potential key word. After this first reading, the issues or questions raised were reviewed and grouped into appropriate themes. These were as follows:

- Philosophies and beliefs about the concept of ‘cultural diversity’ and associated terms, policies which help identify the origins of ‘cultural diversity’ teaching
- Organisation of the curriculum including curriculum design and implementation issues including teacher issues
- Content and delivery of ‘cultural diversity’ programmes (including community involvement)
- Outcomes such as assessment and evaluation, student issues and application in clinical practice

The themes were not generated until after all the transcripts had been read to ensure that a complete picture was obtained rather than just selected insights. At each stage of the analysis, there was an attempt to relate the issues identified through the above process to the published theories discussed earlier in the thesis, and to use the interview data as supporting evidence.

Using the transcripts, responses to questions 8-38 were collated. Responses were grouped into broad categories to determine a sense of some quantitative responses. Following this grouping, the collated data were read and themes were identified. Themes, or questions, identified from the first reading were added to themes that arose out of this.

Throughout this process, consistencies within the data, highlighted by the questions, below were sought. In reading the interviews the following questions were considered:

- How many respondents gave a broad inclusive definition for the term ‘cultural diversity’ but focused on a group perspective when talking about this in other contexts. Conversely, how many defined ‘cultural diversity’ in quite a narrow sense but, then when talking about teaching it, were fairly broad in its application?
To what extent did respondents have a sense of the general philosophy about cultural diversity and the way in which it should be taught?

Was there internal consistency with the use of different terms by respondents?

Did respondents focus student learning on knowledge or attitudes?

How respondents perceived the relationship between teachers, students and the community with regards to teaching cultural diversity?

How consistent were the responses with the models of 'cultural expertise' and 'cultural sensibility'?

The findings were also related to the ideal type conceptual models developed earlier in the thesis. As the broad categories of philosophies, policies, curriculum design, content, teacher issues, student issues, community involvement and relevance to clinical practice were considered; the responses were again related to the categories developed for the ideal type models. The questions generated from the transcripts, the collated documents and key word searches are presented in Appendix 9 (page).

6.11.1 The use of computer programmes to assist analysis

Several computerised programmes exist to assist with qualitative data analysis. Robson (2002: 462) highlighted the advantages and disadvantages of specialist qualitative data analysis (QDA) computer programmes as follows. Advantages of computer QDA include:

- They provide an organised single location storage system for all material
- They give quick and easy access to material (e.g. codes) without using 'cut and paste' techniques
- They can handle large amounts of data very quickly
- They force detailed consideration of all text in the database, as opposed to the text that particularly appeals or interests the analyst
- They help the development of consistent coding schemes

Disadvantages

- Proficiency in their use takes time and effort
- There may be difficulties in changing, or reluctance to change, categories of information once they have been established

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Particular programmes tend to impose specific approaches to analysis

However, given that computer programmes can only help with analysis (they do not perform the analysis), can take some time to learn, and the researcher’s inexperience with qualitative studies of this size, it was decided that manual analysis would be undertaken, recognising the limitations of the human as analyst highlighted by Robson (2002: 460). The number of interviews was manageable for manual analysis and, additionally, there was a need to be able to consider how the interviews read as a whole (a need to bear the context of the statement with regard to the interview as a whole). Manual analysis also enables the researcher to become more familiar with the data and potentially enable more reasoned interpretations.

6.12 Recognising and reading data

There are three levels of analysis described by Mason (1996:109):

- Literal reading (cf denotative meaning): the content of the data and that, which is literally said by the respondents in the case of interviews. In the case of the interview transcripts, this means considering the words and language used, the sequence of the interaction and the form and structure of the dialogue.

- Interpretive reading (cf connotative meaning): this involves the analyst in constructing or documenting a version of what the analyst thinks the data means or represents; that is, what can be inferred from the data?

- Reflexive reading: this refers to theoretical reflection and reflexivity and concerns not only the researcher’s role in the process of generation and interpretation of the data but also the way the data is read with respect to theoretical readings.

For the analysis undertaken, all three methods of reading were relevant for this research. That is much of what respondents said was taken and the contents analysed to identify how they perceived ‘cultural diversity’. The responses they made to different parts of the schedule were compared to explore whether or not they were consistent with their use of language. The researcher made some interpretations as the contents were considered in the context in which they were shared. This was particularly relevant in areas such as teacher issues when the researcher was able to interpret and infer what was perhaps unsaid. Reflexive analysis enables researchers to link the findings with the theory and
form this study generate new ideas for the teaching of ‘cultural diversity’ in medical schools.

6.13 Conclusion

In summary this chapter began by reviewing questions generated from the literature review and identifying the key research objectives. This was followed by a discussion of the method, methodology and analysis. The researcher’s role in the research is a key component of qualitative research so was discussed in some detail. Issues of validity and reliability were discussed before data analysis. Having discussed the process of analysis, the findings are now discussed. The findings chapters have been structured according to the major themes identified through the analysis and focus on the origins, organisation, contents, delivery and outcomes of cultural diversity.
Chapter 7: Findings and discussion on the origins of ‘cultural diversity’
learning and teaching

Chapter Seven begins by reporting on the interviewees’ perspectives on the role of Tomorrow’s Doctors (GMC, 1993) on the origins of ‘cultural diversity’ teaching. The origins of specific programmes are also reported. It reviews respondents’ awareness of their own curricula and those outside of their organisation addressing ‘cultural diversity’. This helps establish whether or not the principle of evidence-based practice has been applied to ‘cultural diversity’ teaching, and the process medical schools have followed to develop such programmes. The chapter then reports on how the interviewees understood key terms and the ways they considered that different understandings might influence programme development. A loose-leaf copy of the table of participants is attached for ease of reference for the reader. Chapter Seven then presents the argument that the origins of ‘cultural diversity’ teaching lie in political, rather than educational agendas. Given the political agenda, the issue causes considerable anxiety and medical schools appear very afraid of making mistakes. The perceived pressures for a need to be ‘politically correct’ rather than educationally sound are discussed.

7.1 The influence of Tomorrow’s Doctors on the origins of ‘cultural diversity’ in medical education

As discussed in Chapter Two, the first Tomorrow’s Doctors (GMC, 1993) is the policy document that has had the most impact on medical education in the UK over recent years. Therefore, specific inquiries about this were made in the interviews. Policies shape the way that organisations respond to the issues perceived as relevant to them. It is, therefore relevant to identify and analyse the philosophy behind Tomorrow’s Doctors in exploring the origins of ‘cultural diversity’ teaching. Participants were asked if they were aware of the document and their perceptions of the GMC agenda. The brief remarks in Tomorrow’s Doctors (1993) could be said to be consistent with both the models of ‘cultural expertise’ and ‘cultural sensibility’. However, if the spirit of Tomorrow’s Doctors (1993) is delivered, the philosophy would be more consistent with ‘cultural sensibility’ and the outcomes have a more patient-centred approach.
Prior to the interviews, GMC personnel involved in the development of the first *Tomorrow’s Doctors* were contacted. A conversation in February 2002 with a member of the GMC Education Committee at the time of the first *Tomorrow’s Doctors* showed that the Committee advocated an integrated curriculum. The GMC Education Committee had commissioned a working party to recommend curriculum revisions, as the Committee believed that there was information overload for medical students. The Committee recommended a core curriculum with optional modules. The Committee had wanted to commit one-third of the curriculum to special study skill modules (called SSSMs at the time) intended to enable students to broaden their learning experiences; for example, research skills, interest in the humanities, language training and medical education. The personal experiences of the Committee led to views that the GMC needed to be more explicit when stating the attitudes and skills required of medical students at the point of graduation. The respondent could not recall how the statement pertaining to respect for colleagues and patients irrespective of background came to be included. He thought it might have reflected wider changes that were taking place within the context of the medical profession.

The BMA did not to make a response to explain how the BMA position was formulated (Robins, 1995). However, the document forward included information on members of the Board of Science and Education of the BMA and the working party that advised them (1995: 2-3). Amongst it are leading epidemiologists (study populations) but no medical educationalists. It is surprising that a document entitled: *Multicultural Health Care: Current Practice and Future Policy in Medical Education* chose not to involve medical educationalists. Several of those on the working party came from minority backgrounds (including Indian, Palestinian, and Jamaican) and several have strong political agendas in ethnicity and healthcare as evidenced by undertaking website searches of the individuals on the working party.

Of 61 respondents, 45 knew of the GMC perspective in *Tomorrow’s Doctors* and 16 did not. The 16 who did not know comprised 5 of the 7 users and 6 of the 18 policymakers. None of these 6 policymakers were involved specifically in undergraduate education. All curriculum heads and diversity teachers, and all but one of the communication teachers were aware of the GMC perspective.
When the 16 who did not know were read out the GMC statement relating to ‘cultural diversity’, their responses were positive (10); no specific view (4) and mixed views (2).

Of the 45 who were aware of *Tomorrow’s Doctors* (GMC, 1993), 25 had positive views, 11 had mixed views and 9 had negative views. Non-medical staff tended to be more positive about the document and perceived the GMC, through *Tomorrow’s Doctors* (1993) to be a key driver in placing ‘cultural diversity’ on the medical education agenda.

“I do think the GMC seems to be a very forward thinking organisation that actually has taken the lead in kind of pushing forward this agenda to a large extent. I mean whether medical schools have actually followed it, but certainly Tomorrow’s Doctors is a really radical document really” (R22: Diversity teacher)

In this sample, there was no-one who thought the document was too radical. However, some of those who viewed the document critically felt it had not gone far enough and it was a cynical and/or defensive move rather than being motivated by any genuine desire to address the issues. There was a perception, mostly by doctors that the GMC wanted to be seen to be doing what was politically appropriate rather than because of any desire to drive forward the educational agenda.

“It might have come from the government, you know everybody thinking we’ve got to get ethnic diversity, ethnicity into the curriculum, there was a push by the GMC 4 or 5 years ago, they were going around the medical schools, what ethnic teaching are you doing? I think it came from that... To be seen to be doing the right thing” (R17: Diversity teacher)

This response implies that the GMC were merely following a political agenda rather than leading an educational one. Those who expressed mixed views thought the document was a positive good move but expressed concern as to how it would be implemented.

“...For every decade for about a 100 years the GMC has said something along these lines to medical schools that you have got to start teaching students about social and behavioural things and the broader picture. ...I think it’s a kind of circular thing, hence Tomorrow’s Doctors. The whole thing was about, we’ve got to kind of move, we’ve got to start producing doctors who can respond to all the changes in society. So I think it was
just recognising the fact that we live in diverse communities; that we’ve got patients, that we’ve got a society now that won’t take paternalistic attitudes as they might used to have done. We must be accountable so we are going to have to start addressing some of the things that have not been addressed before” (R23: Diversity teacher)

Regarding respondent views, there was some concern by some respondents (2 diversity teachers and 1 student) that the GMC had focused on outcomes and expressed little interest in the educational process.

“The thing with the GMC, it’s not interested in process, only outcome, because its main job is to protect patients by guiding doctors. They specifically said to me, the GMC is not interested in process, it’s up to the medical schools how they implement that. We are just interested in outcome, and that’s why this is a guidance document for medical schools, to start the process of education so that it finishes how we want, it with safe doctors” (R51: Student)

Three participants (2 diversity teachers and 1 policymaker) also mentioned the Race Relations Amendment Act (RRAA, Home Office 2000). They suggested that legislation might be an important factor in developing ‘cultural diversity’ in the context of institutional responses to comply with the legislation but this was not clearly related to medical education. There was a strong sense, that irrespective of the legal requirements, ‘cultural diversity’ is currently fashionable and that those committed to developing teaching and practice in this area, need to act on it now and maximise any available opportunities. One user also mentioned the need to ensure that philosophies are couched in the current fashion, as it often appears that projects using the jargon of the day are more likely to receive financial support.

7.1.1 Other factors influencing the development of ‘cultural diversity’ programmes

When considering the agendas for teaching ‘cultural diversity’, 2 respondents felt that workforce issues, such as low recruitment in some specialities, in some areas had driven the agenda rather than any commitment to the issue.
"I think it's the workforce issues that are forcing that [introduction of the Royal Colleges considering diversity]" (R45: Policymaker)

"I'm sure that we get them all mixed up and muddled round, often overusing them [the terms] waters it down. Also sometimes unhelpfully used for political purposes, then you think well are you just doing this because it's politically correct. It's actually quite important because it needs to be done not for political reasons" (R60: User)

Both these responses suggest that the origins lie in agendas or motivations that are not primarily educational and in part this may relate to an unclear educational agenda.

In summary, most of the respondents were aware of Tomorrow's Doctors (1993), which they viewed favourably; they perceived it as central to placing 'cultural diversity' on the medical education agenda. Few perceived that the agenda had been driven by factors other than Tomorrow's Doctors (GMC, 1993). Most were positive about the role of the GMC and its’ intention regarding ‘cultural diversity’; doctors conveyed the most cynical views. This may reflect doctors’ broader dissatisfaction with GMC (Fitzpatrick, 2001).

7.2 The origins of specific programmes

This section reports on the awareness that respondents had about specific programmes and whether this awareness had influenced course development in any way. Those who were attached to a medical school were also specifically asked about the origins and development of the programme that their medical school offered. Training of respondents in diversity was inquired about as often those who teach others have themselves been taught or trained in ways that may influence the teaching they develop or support.

7.2.1 Awareness of existing ‘cultural diversity’ programmes in general

This subsection reports on the awareness that respondent had about any programmes to teach ‘cultural diversity’. One respondent raised the issue of a national curriculum, although another assumed that one already existed. No respondent thought that ‘cultural diversity’ teaching should be optional.
"I think it will become a part of the core curriculum to be honest, but I think it is something that you need to be seeing something that is also everywhere" (Respondent 19)

Of the 61 respondents, 15 (2 communication teachers; 1 curricula head; 1 diversity teacher; 8 policymakers and 3 users) did not know of any specific training programmes to teach diversity (undergraduate, postgraduate or even informal training programmes although 2 of these were aware of planned developments within their own Royal College) and 1 policymaker was unsure. The diversity teacher felt she taught more about communication than diversity. It is interesting that over a third of policymakers were unaware of specific programmes, as it raises the question about how policies are informed, although most policymakers are likely to work with other individuals who may be more informed. Twenty-four respondents knew of programmes only within their own organisation, and of these 5 were outside of medical schools. Two represented a voluntary organisation, 1 a government department, 1 a postgraduate organisation and the other an NHS initiative. Twenty-one respondents knew of programmes outside their own organisation; 3 of these did not have any diversity training programmes in their own organisation. Of these 21, 16 were aware what was happening in medical schools other than their own. Seventeen of the 45 who were aware of specific programmes agreed that their models presented good as opposed to best practice. No-one gave a resoundingly positive response. There was concern that this was difficult to do, as they were not necessarily aware of what was happening elsewhere. Many felt repetition might be taking place and that experiences were not sufficiently shared. Some also provided information that was contradictory to other sources; for example, students (not involved in study) reporting to peers (involved in study) that their medical school did not address diversity but the medical school believed it did so. No-one mentioned programmes outside of the UK, although 1 respondent believed that the US was less proactive than the UK, and another believed the US to be further ahead.

Those who were aware of programmes gave only tentative approval:

"I think we've got a long way to go before we could lay any claim to operating best practice, but I do not think we do anything that is terribly wrong. It's a start maybe, but not that good" (R2: Communication teacher)
"Without being biased, I think some of the ideas at A are excellent, though I have to say I have had complete overkill in some areas of diversity and ethnicity and the like. I have to say it has been at the expense of some basic science teaching which worried me in terms of is this going to make me a nicer doctor, but less safe, but I think some of the ideas are good" (R5: Student)

"Here, at this medical school, and other bits. There is a big programme in B that I am aware of. I am aware that most medical schools have something with this label, and have had for some time. Often it’s made up of quite a lot of little bits buried in a professional personal development strand, somewhere or another, which is not quite as co-ordinated as elsewhere. I am very aware of the fact that around the world there are quite a lot of places which are pushing cultural diversity, for good reasons, less so I think in the USA, strangely enough. That may reflect the particular nature of medical education there. ...I’m not sure that you could pick one to be quite honest. Obviously everyone believes that what they do in their place is the right one, but trying to stand back from that, I’m not sure that any of them are very solid" (R10: Curriculum head)

On the basis of published literature, the comment regarding the US is clearly incorrect. Others were more reserved, for example:

"I don’t think ours is extensive enough actually. It’s restricted to general practice teaching and I don’t think that is best practice, I think best practice is to ensure that this is much more widely disseminated and woven into teaching by many other teachers”
(R37: Policymaker)

Others questioned whether knowing what others were doing was that helpful, for example:

"Yes. I think they [other medical schools] have, I think to an extent, but I think it’s quite a difficult thing to pass over from one to another because I think it’s quite an individual thing, the way people teach and the way schools approach it and the context they’re in. It’s useful, but I wouldn’t like people to take stuff off the shelf because I think that doesn’t work" (R13: Curriculum head)
This last response perhaps confuses how information about other programmes might be used – an evidence-based approach suggests reviewing what is available and not necessarily copying other programmes wholesale. Overall, there was awareness by respondents of ‘cultural diversity’ teaching especially by those in medical schools but the nature and extent of the teaching was rather unclear.

7.2.2 Awareness of specific programmes in medical schools

This subsection reports on awareness that respondents had of ‘cultural diversity’ programmes in UK medical schools. Of the 44 respondents who had links with medical schools, 32 (3 communication teachers; 7 curriculum heads; 14 diversity teachers; 3 policymakers and 5 students) responded that their school had ‘cultural diversity’ teaching and 1 of the diversity teachers stated that the programme was optional. Two diversity teachers from the same medical school said the programme was being developed. Three respondents (1 communication teacher; 1 policymaker and 1 student) were not aware of any specific programmes within their medical school. However, course documents from this student’s school suggest there is some teaching in this area. Seven respondents did not know whether there was any such teaching at their school (5 of these were policymakers of whom 3 were postgraduate tutors). None of the students were aware of how the programme had developed although 2 thought individual teachers had pioneered the cause and another 2 thought it was a direct response to Tomorrow’s Doctors (GMC, 1993). Three curriculum heads and 1 policymaker thought that the curricular committees had developed their programme. Three teachers from the same medical school all reported that individuals working with departmental colleagues had led the development. Fourteen respondents (3 curriculum heads; 10 diversity teachers and 1 researcher) thought that interested individuals had led development. It is striking that 10 of the 14 diversity teachers did not feel that the development had been through a strategic approach. Individuals felt they had received varying support from their faculties.

“I think the people in the practice of medicine, which was largely coming from primary care, from our academic primary care” (R11: Curriculum head)
"Well we got a grant from the Department of Health work on developing diversity within
the curriculum and there was a GP, who was the lead on that...It has become more
integrated as time has gone on" (R17: Diversity teacher)

In summary, there was uncertainty about how programmes had originated but it was
largely felt to be through individual efforts, which in some cases were a response to
Tomorrow's Doctors (1993). Although there was sometimes involvement from curricular
bodies, this did not appear to be strategic.

7.2.3 Training of respondents in ‘cultural diversity’

Training of respondents was inquired about as the experience of training may influence
the types of programmes that individuals feel should be developed. Few respondents (11;
2 communication teachers; 2 diversity teachers; 1 policymaker; 4 students and 2 users)
had received formal training in diversity. Nineteen (2 communication teachers; 2
curriculum heads; 9 diversity teachers; 3 policymakers; 1 researcher; 1 student and 1 user)
had considerable experience in working with diverse groups. Nine (1 curricular head; 4
diversity teachers; 2 researchers; 1 student and 1 user) had research experience and 11
had informal experience (2 of these had covered it in sociology as part of undergraduate
degrees). Seven (1 communication teacher; 2 curricular heads; 1 diversity teacher and 4
policymakers) people had attended equal opportunities training and 6 (2 curricula heads;
3 diversity teachers and 1 policymaker) had attended specific race awareness training.
The categories were not mutually exclusive. Those professionals who had been on
diversity training identified it as being different from equal opportunities training (which
was more about ensuring practice within legal boundaries) and race awareness (diversity
training is much broader than race). As so few respondents had received any training, it
is, perhaps, unsurprising that few respondents knew what was taking place in this area in
terms of training in ‘cultural diversity’.

The following example summarises some of the factors that help and hinder programmes
which is probably relevant to most teaching activities. Teachers who are charismatic and
enthuse students by building on what students bring are more likely to be effective
(Brookfield, 1986: 10).
"Yes. I’ve been on two or three. One of them was very good, one was fairly good, and one, which I’m afraid was an in-house one, was fairly appalling, but all our training is appalling... He was a very appealing person with very appealing messages... the other one that I went on that I felt was very positive was much more personal. It was very much about exploring together as a group what the experiences of being whoever you were in that group were. And in that group what people were doing were learning from each other and understanding why so and so, and one particular white person or black person will act in this way in this particular situation, and I think we all came out of it feeling, that was about empathy, being able to explore how to use your empathy with other people and to start to see white people, black people, or Asian people, as people rather than a label. So they were two very different approaches but worked very well. The one that didn’t work was poorly taught. It was delivered by someone who essentially wasn’t a trainer who was reading out of a book, who didn’t have a full understanding of the topic, and didn’t really care about it. I mean there are people who train really well, people who care about the subject” (R56: User)

The positive points in this approach are consistent with ‘cultural sensibility’, that is that everyone is an individual. In summary, only just under a fifth of the sample had received any formal training in ‘cultural diversity’ and most of these were students.

7.3 Understanding of key terms

This section reports on the findings relating to the understanding of key terms and the potential effects of this on the programmes developed. There was considerable confusion about the meaning of ‘cultural diversity’ and why it remains novel in medical curricula. This was not an easy part of the interview for most of the participants and many acknowledged their uncertainty about the terms and usage of them. In trying to generate the definitions, respondents became aware of the way in which some of these terms are used interchangeably in medical education and beyond. This was highlighted further when the participants’ understanding of the terms culture, ethnicity, multiculturalism and race were discussed. Only 1 respondent appeared to be confident about all his responses. Those with sociological backgrounds appeared no more confident in the definitions they provided than non-sociologists. Through considering their own position, some realised how complex individuals can be. This part of the interview also raised the issue that, even
if there was consensus on the need for ‘cultural diversity’ to be knowledge-based, reaching consensus on the knowledge to be taught would be difficult. Few respondents commented on the link between understanding of key terms and the influence this might have on the types of programmes developed.

‘Cultural Diversity’
Views about the meanings and interpretations of the concept of ‘cultural diversity’ were obtained from how respondents defined this and other key terms, what they thought should be taught, and how. Their beliefs about the place of ‘cultural diversity’ in the curriculum were also evident in other aspects of the interview; for example, how much time needs to be dedicated to this subject, whether or not it should be assessed, and justifications for their responses.

There were 12 respondents (1 communication teacher; 1 curriculum head; 5 diversity teachers; 3 policymakers and 1 user) whose responses were clearly aligned with the ‘cultural sensibility’ model view of ‘cultural diversity’. Although these were expressed differently, underlying these responses was the view that individuals are multidimensional, and their identity is based on more than the colour of their skin, or a single other characteristic. Three females (2 diversity teachers and 1 user) held a ‘cultural sensibility’ perspective but came from a ‘cultural expertise’ historical context of relating the issues today as directly linked to white domination. That is while they saw individuals as defining themselves; they also continued to see them as oppressed given historical disadvantage. Two policymakers and 1 user defined ‘cultural diversity’ in a way that was consistent with ‘cultural expertise’, but then went on to use the term during the interview that was consistent with the ‘cultural sensibility’ models. The curriculum head whose response aligned with ‘cultural sensibility’ often used it later in the interview in a more ‘cultural expertise’ way but then slipped back into talking about individuals. An example of responses consistent with ‘cultural sensibility’ is:

“My definition would probably be broader than ethnicity. You said earlier that for the purpose of this research, ethnicity was the kind of paradigm, but I suppose I would see it as actually being to do with a range of ethnicity, along with religion, social class, gender, perhaps disability and sexual orientation, the ways in which people are different... I
really think that the idea, that you can learn about what your average Muslim families
are, is as stupid as suggesting that I must eat roast beef and two veg because I’m a white
and middle class” (R8: Curriculum head)

“Cultural diversity, in a nutshell, well it’s being aware of people’s views and
understanding and what they think of themselves, you know, this self-identity concept.
Whether you’re a male, disabled, female, or you’re black or white, at this particular time
and in this particular context you react... For a single-parent female black person, which
is the important thing, the black or the single parent and so on?” (R17: Diversity teacher)

Those who defined ‘cultural diversity’ in line with the ‘cultural sensibility’ model were
also more likely to suggest that teaching needed to be principle-based rather than content-
based, thus demonstrating some internal consistency in their application of the terms.

The majority of the sample (42; 4 communication teachers; 6 curricula heads; 8 diversity
teachers; 13 policymakers; 2 researchers; 4 students and 5 users) defined diversity as
being broader than ethnicity, but still saw it as a group-based identity, which was socially
rather than individually defined. An example of such an approach is the following
observation:

“I tend to take it as a broader concept, even within the different ethnic mixes. You talk
about different religious groups, you can talk about different communities within that. I
think the term we came up with was more cultural competence. Teaching cultural
competence, so how to feel confident and be competent dealing with people from different
backgrounds, different sociological groups and different cultures. I think it’s important
for doctors to remember that they have a culture which they come from which impacts on
consultation as well as the culture of the person who’s consulting.” (R19: Diversity
teacher)

This approach does not necessarily mean that diversity within individuals was recognised.
There was also a perspective that, if a curriculum included a larger number of groups in
its programme, the programme would be better. Stretched to its logical conclusion, this
approach means that ultimately, the perfect programme would teach about individuals, as
we are all potentially different.
"I think, some people think it’s just about ethnicity...we are showing that it’s broader than just ethnicity, ... So it’s about disability, it’s about social class, it’s about sexuality...We are trying to make it as broad as possible” (R16: Diversity teacher)

For 4 respondents (1 communication teacher; 1 diversity teacher and 2 students) the model with which their responses aligned with was unclear. A user and policymaker gave a rather mixed response. Three respondents (1 communication teacher, 1 policymaker and 1 student) fitted a ‘cultural expertise’ model approach more neatly with ethnicity being the main determinant of culture.

“There are lots of different cultures, so I am just looking at cultural diversity as simply being integration of all those cultures in a society. England as such is no longer simple Caucasian people with long heritage in England, it’s no longer that” (R1: Communications teacher)

Only 1 male policymaker talked consistently about a ‘them and us’ approach, which is a ‘cultural expertise’ approach, i.e. us those who are the majority (white implied) and them, those who are different and the minority.

“...The fact is that most of them are Asians or brown skinned or something doesn’t worry me in the least. But what irritates me is they say; ‘look we are different, but you are not different’. You may have suffered, but surely your suffering is something which you should be working to correct. ...We are striving to accept you into our midst on the terms that we are very tolerant and always have been. And we have a great tradition of tolerance otherwise we would not be allowing you in in the first place, but you carry on like you are currently and I’m afraid this is the problem. This is where the press is winding it all up at the moment sadly. I think there is going to be trouble. They haven’t had trouble in places like Oldham and Blackburn and places like that for nothing” (R32: Policymaker)

A clinical policymaker identified that ethnicity was not always the only difference between doctors and patients and gave the example of class and a researcher gave an example of poverty.
“As a child and adolescent psychiatrist, we have a lot of cultures in child & adolescent psychiatry. Sometimes we had really quite high class people from different cultures as part of the team who I thought were farther away in terms of perspective from some of the kids and families we saw from the same culture than some other parts of our service who, totally different culture but were on the same kind of level from lots of other different perspectives” (R44: Policymaker)

A communications teacher was unsure about how to define ‘cultural diversity’ and thought that medical education might be using too inclusive a definition.

“I get slightly irritated when the term cultural diversity is translated into ethnicity and that gets reduced even further to black and Asian, predominantly. I feel that that’s a very much-reduced notion of cultural diversity, but I think we also have problems about what we might include in cultural diversity. We could go so far as to include any sort of difference between one person and another as cultural diversity, you know, a working class, white, female aged 50 and an upper class, white, female, aged 50, would we describe that as cultural diversity... I’m struggling with it myself, but I do know intuitively that it’s not about race, per se, or nationality per se, but I also do get slightly uncomfortable when we start to introduce these differences as diversity when maybe we are encouraging diversity as opposed to minimising the differences ” (R2: Communication teacher)

This highlighted the dilemma that respondents were not always happy with the way terms were used but also struggled to identify more meaningful terms.

Culture
Regarding culture, 50 (5 communication teachers; 5 curricula heads; 11 diversity teachers; 16 policymakers; 1 researcher; 5 students and 5 users) respondents viewed it as a socially defined concept with most defining it in terms of background, diet, dress, lifestyle, values, religion and the like. Other responses were as follows (the total is greater than 61 as 3 respondents gave 2 responses):

• An interaction of the self with the environment (4; 1 communication teacher; 1 curriculum head; 1 diversity teachers and 1 policymaker)
• The way an individual made sense of their experiences and perceived himself or herself (3; 1 curriculum head; 1 diversity teacher and 1 student)

• Commented on the dynamic nature of culture (3; 2 diversity teachers and 1 user) and 2 of these also defined it in other ways (1 as a group-based identity and another as self-defined)

• Identified culture as being linked to race (2; 1 policymaker and 1 student)

• Unsure (1) and social construct that had limited basis (1)

Fairly typical responses defining culture were:

“To do with sort of religion, traditions, practices, diet, lifestyle, expectations” (R13: Curriculum advisor)

“Culture is about the way different communities hold together if you like. It’s about their own cultural practice, it could be religious aspects, could be about different views of how they approach basic things in life like marriage or family” (R15: Diversity teacher)

Less typical responses were:

“I think culture is something that generally we can assign to an individual person as belonging to a group of other people for whatever specific reasons relating to their views. I don’t think necessarily you take someone from a specific race and say you belong to that culture because you are from the same race. I think it is more of a belief, a belief system that people belong to which often relates to where they have come from and relates to ancestry or whatever. People often don’t belong to a culture because they believe their culture is something they view themselves as belonging to with a group of other people who all view themselves as belonging to, but often the views are very fine threads which bind society together, they are subjective” (R51: Student)

“It’s a dynamic complex concept, which is always shifting. It’s these ideas and views we have of the world around us now and the supernatural world” (R17: Diversity teacher)
Ethnicity

The term ethnicity generated the following responses:

- Genetic (19; 2 communication teachers; 3 curricula heads; 4 diversity teachers; 6 policymakers; 2 students and 2 users)
- Geographically defined or country of origin or ancestry (15; 3 communication teachers; 4 curricula heads; 5 policymakers and 3 students)
- One’s sense of belonging and identification (9; 1 communication teacher; 4 curricular heads; 1 diversity teacher; 1 policymaker and 1 user)
- Sharing the same background (7; 2 diversity teachers; 2 policymakers; 2 students and 1 user)
- Unsure (6, 2 of whom thought it might mean anything that was not mainstream – 2 diversity teachers; 2 policymakers; 1 researcher and 1 user)
- Sharing the same religion (2; 1 policymaker and 1 user)
- Somewhere between race and culture (2; 1 curriculum head and 1 policymaker).

The following responses were typical:

"I would say your country of origin" (R1: Communication teacher)

How second generation immigrants born in the UK are placed within this definition is unclear.

"I suppose that’s the genetic variation expressed by a given population" (R: 9 Curriculum lead)

Race

The following responses were given regarding race:

- An outdated and irrelevant term (22 of whom 11 gave an additional definition to indicate the way they thought the term was used. The 22 comprised of 1 communication teacher; 2 curricula heads; 7 diversity teachers; 7 policymakers; 1 researcher; 1 students and 1 user)
Genetically defined (that is, race is associated with ‘biological’ features and genealogy – 18; 1 communication teacher; 5 curricular heads; 2 diversity teachers; 7 policymakers and 3 students of whom 1 thought it was an artificial term)

Same as ethnicity (10; 1 communication teacher; 2 curricular heads; 2 diversity teachers; 4 policymakers and 1 user)

Country of origin (9; 3 communication teachers; 3 policymakers; 1 student and 2 users, of whom 1 was unsure)

Unsure (3; 1 curriculum head; 1 diversity teacher and 1 user)

Political term (3 diversity teachers);

Socially prescribed (3; 1 non-medical diversity teacher and 2 users)

Colour of skin (2; 1 communication teacher and 1 policymaker)

Bigger than ethnic group (1 student)

How individuals see themselves (1 student)

Examples of the range of responses included:

“I suppose that’s the ethnic group you get allocated to, not a positive term, it feels more like something people get lumped with rather than something they feel themselves” (R7: Curriculum lead)

“I do know that’s a term that should no longer be used. It’s got this biological determinate, although in common language you still see race equated with ethnicity and culture” (R17: Diversity teacher)

“A term that, as a sociologist and a biologist, I would not see is tenable. There is no such thing as a pure race” (R24: Diversity teacher)

Multiculturalism

Multiculturalism led to fewer categories, with the following responses:

Different cultures coexisting (22; 2 communication teachers; 2 curricula heads; 4 diversity teachers; 5 policymakers; 1 researcher; 3 students and 5 users)

The understanding of other cultures and respect for them (19; 1 communication teacher; 3 curricula heads; 5 diversity teachers; 9 policymakers and 1 student. One respondent gave 2 definitions)
• Blending or mixing of different cultures (10; 3 communication teachers; 2 curricula heads; 2 diversity teachers and 3 students)

• Political and unhelpful term (7 of whom 2 provided definitions included elsewhere, 1 curriculum head; 3 diversity teachers; 1 policymaker; 1 researcher and 1 user).

• Unsure (4 (1 communication teacher; 1 diversity teacher and 2 policymakers), of whom 1 said perhaps it was cultures coexisting and that individuals are multicultural (2; 1 policymaker and 1 user).

Only 12 respondents conceptualised individuals as having the potential of being multicultural. The broader definitions with the notion of blending included:

“A celebration of difference, or acceptance and respect for difference, not making everybody be the same” (R8: Curriculum head)

“Multiculturalism is an ism that is celebrating the fact that we do live in a society with diverse cultures. It’s recognising or perhaps implying that we ought to acknowledge that and celebrate it and exploit it and make the most of it rather than just recognise it and try and cope. Multiculturalism has a kind of vaguely optimistic theme to it to me” (R23: Diversity teacher)

“Well we are all multicultural, as individuals” (R57: User)

“The co-existence of people of different cultures” (R21: Diversity teacher) was a fairly typical response for those who thought multiculturalism signified co-existence.

There were also more complex responses such as:

“I don’t know, I don’t find the term a useful term. I think it’s a bit like people use multidisciplinary, a kind of catch all phrase that people then use to say that they have got it right. People say things like we are very multicultural and what they mean is they have got two black people in the room and two Indian people in the room and two white people in the room, so it’s superficial” (R26: Diversity teacher)
"All sorts of complex politics around that I think. I think possibly it has a sort of post-modern element in it that lots of the old groupings have broken down, the big structures of society. It can come from quite a liberal perspective that anything and everything is all OK and we will all get along alright. So it's almost like that consensus view, that multiculturalism is great. In its worst way, it's a naïve concept that takes away the sort of political edge that maybe people need if they are in a group that they feel is oppressed and they need their own group identity in order to fight for what they want. A blanket multiculturalism may hinder that, may" (R24: Diversity teacher)

The key findings were that views about 'cultural diversity' were conceptualised consistent with 'cultural expertise' and a more group-based identity view of individuals. The majority perceived diversity as relating to group differences, but this was not applied consistently and they slipped into talking about individuals. In summary, diversity teachers were more likely than other groups of respondents to have educational philosophies consistent with 'cultural sensibility'. However, each of the sample groups revealed a range of views indicating that educational philosophy is not dependent solely on the status or position of specific stakeholders. The different views about 'cultural diversity' were spread across the different groups. A few identified 'cultural diversity' more as an individual sense of identity but when talking about education slipped into talking about groups and their characteristics. There was commitment to the inclusion of 'cultural diversity' in the curriculum, but it was unclear how this should be framed. Other commonly used terms such as ethnicity, race and multiculturalism were no more clearly understood. There was recognition that this is a complex issue, and that debate is needed to improve clarity because the current confusion is unhelpful.

7.3.1 Views about 'cultural sensibility'

'Cultural diversity' teachers were probably most comfortable with the concept of 'cultural sensibility'. No single group could be identified as being uncomfortable with the concept although some did voice reservations (a communication teacher and a user). When asked directly about the philosophy behind the concept of 'cultural sensibility', respondents were generally positive about it, for example:
"But, it’s funny because cultural competence is a term that we used a lot in the college. It’s not a term that tripped particularly off my lips, but I take your point. I suppose it’s something I haven’t thought through, I mean that’s obvious now that you say it, you know that it is very much about groups and about stereotypes and in a sense it achieves precisely the opposite of what you intended..." (R38: Policymaker)

“That’s quite revolutionary really. Yes, another major assumption which might not be relevant to the person in front of you” (R58: User)

The following respondent welcomed the idea but had reservations about its use:

“No, I think we as a society are not that mature actually [to take on board the idea of non-group based identities]. It’s coming that way, but I think it’s an important topic. I don’t want it to be ticked off, you know, them saying; yes we’ve done it. Actually I want them to take it on board and for it to be with them throughout their lives. So I have very strong views” (R43: Policymaker)

One respondent expressed concern that it was just about reinventing the wheel.

“Not trying to be critical, but there is so much literature already, you know, relevant, out there, I suppose it’s how you make, how you as a researcher would make sense, you know for your own purposes. So for me, I think are we reinventing the wheel?” (R55: User)

However, a couple of respondents expressed concern that ‘cultural sensibility’ was not specific enough and the idea of not imparting factual knowledge caused some discomfort.

“No, but you see what I am talking about. If somebody is gay you may need to educate somebody about what that gay person, the behaviour of that gay person... Now that principle [of asking patients rather than making assumptions] I totally agree with, totally. But it’s to actually start them to recognise and that’s why I’m saying in some group work, going out and mixing with the communities, asking about these issues, talking about it, is learning from them [as groups]” (R1: Communication teacher)
This respondent felt uncomfortable about not having facts to fall back on. Another respondent felt liberated at the idea of not having to impart a contents-based programme.

"... It ought not to matter really what the content is in some sense, because that person ought to be able to accept and listen and acknowledge and empathise and try and work out why is it a problem here and what is the problem. Whether it's a problem about religion or gender, or sexuality, in a sense that ought not to matter that much because the knowledge that is encumbered with the problem can be sought, it's the attitude that you deal with it that cannot be sought but has to be brought to the table to begin with" (R2: Communication teacher)

There was also the issue of exposing students to 'others' and students not always being aware of why they were seeing the patients as an example of 'cultural diversity'.

"A student came to see me a while ago. She was on general practice in diversity thing and she felt very uncomfortable about what she had to do. She had been asked to go and see a gay-lesbian couple. She came to see me and she said 'I really feel uncomfortable about this. So they are gay, they are a lesbian couple, why am I going to see them? To see if they have any problem accessing services because you wouldn't know, if this woman comes to see the doctor, why does her being a lesbian stop her'...I so empathised with her. She felt that she was going to see these women and it was tokenism, because, just because they happen to be a lesbian couple, not because they had any real difficulty accessing services of any sort, but more, we know this lesbian couple, let's see if they won't mind some student visits " (R2: Communication teacher)

In this example, the assumption has been made that the issue of being gay is relevant whatever the context and, therefore, exposure to this client helps students address issues of sexuality. In summary, those respondents who were positive about the 'cultural sensibility' approach were more comfortable with the idea of teaching principles, for others this caused some discomfort. Few respondents had considered the idea of 'cultural sensibility' but on direct questioning gave the concept some merit albeit with some reservations.
7.3.2 The effects of understanding of key concepts on medical education

The beliefs, values and ideologies that individuals hold influence course developments (Fulford, 2003; Toohey, 1999: 44-49). Therefore, after inquiry about the way in which respondents understood the key terms, they were asked to consider, how the use and understanding of these terms, might influence medical education. The number of responses is larger than the number of participants because more than one response per person was possible. Responses were as follows:

- Greater clarity about the terms, without necessarily having rigid definitions is needed (18; 1 communication teacher; 3 curricular heads; 4 diversity teachers; 6 policymakers; 2 students and 2 users)
- Widespread confusion generally (16; 2 communication teachers; 5 diversity teachers; 5 policymakers; 1 researcher; 1 student and 2 users. They felt that raising the awareness of the confusion might reduce the impact of differences)
- Confusion encourages discussion and debate (16; 1 curriculum head; 5 diversity teachers; 6 policymakers; 2 students and 1 user)
- The different ways in which terms are used leads to different kinds of programmes being developed (11 curricular head; 5 diversity teachers; 2 policymakers; 1 researcher; 1 student and 1 user felt that, with a further 4; 1 curriculum head; 2 diversity teachers and 1 policymaker considering that the impact might be significant)
- Definitions were not helpful (6; 2 communication teachers; 2 curricular heads; 1 diversity teacher and 1 policymaker)
- Specific words were unhelpful, as they had political loading (6; 2 diversity teachers; 2 policymakers; 1 student and 1 user)
- Convey our views on how we see people (3; 1 policymaker and 2 users)

An example of the issue needing clarification was:

"I think if they are properly understood that would be a start. I think my own hesitance in answering this means I'm not sure whether I ever knew or whether I have become confused about some of those terms. I think they are often used very loosely in the media and in the educational world. So I think first of all a common understanding of what they
"all mean would be a start and then the implications that derive from them I think is really better for education" (R44: Policymaker)

Some gave a similar response but for different reasons.

"If you use a concept it might have different meanings, and that's the point. A concept is a tool that people work with and unless you actually understand somebody's interpretation of that, you aren’t really having a dialogue" (R14: Diversity teacher)

Some respondents wanted definitive answers regarding the terms as illustrated by the following quote:

"I think probably quite a lot. I think it would probably be better for people to have proper definitions. I think it would help me actually, so that we are all talking about the same thing" (R12: Curriculum head)

The implication here is that there might be a single ‘right’ answer or possibly the respondent is looking for a common language or discourse. There is a need to discuss both the way in which language is used and the words used.

"...I don't want to encourage the stereotypical responses of you know, every Jewish person isn't going to want to see you on a Saturday, because within all of those differences are a wide range of behaviours. Now I think this is a real problem for us. How do we in a sense encourage students to explore people’s different ideas and beliefs and concerns without hanging it on a label of race or religion?" (R2: Communication teacher)

In summary, most respondents felt there was confusion about the terms but only 11 explicitly stated that they felt this confusion might influence the programmes developed. This suggests that most respondents were unaware that a muddled understanding of these terms might have specific implications for ‘cultural diversity’ teaching. Few respondents were aware that the variety of meanings might lead to different types of programmes to address the same learning outcome. So whilst *Tomorrow's Doctors* (GMC, 1993) has
driven the agenda in general, the influence on individual programmes may have been variable.

7.4 What constitutes expertise in ‘cultural diversity’?

On the whole, this was quite a difficult question for many to answer and consequently there was a broad range of responses. Five types of experience that led to having expertise were identified; expertise by virtue of being a minority; clinical experience; life/personal experience; academic credentials and someone who had a combination of the previous four types. Six respondents (5 policymakers and 1 user) were unsure as to what constituted expertise. Fourteen (1 communication teacher; 6 diversity teachers; 2 policymakers; 3 students and 2 users) felt that experience through exposure to diversity led to expertise. Eight (of whom 3 were diversity teachers) felt that an expert had to have a balanced perspective and been through the process of examining their own attitudes and reflected on this. Twenty-five (4 communication teachers; 4 curricula heads; 6 diversity teachers; 6 policymakers; 1 researcher; 2 students and 2 users) respondents said expertise could be any one of the types of expertise identified. Ten of these 25 (4 communication teachers; 1 diversity teacher; 1 policymaker, 1 researcher, 2 students and 1 user) felt that to claim expertise, an individual needed academic credibility coupled with life and clinical experience. No-one felt that one needed to be a member of a minority group to have expertise. A diversity teacher and researcher saw expertise as someone very knowledgeable. Two communication teachers (both general practitioners) and a student felt that clinical experience led to expertise. Whilst some respondents recognised the possibility that different types of expertise might be relevant depending on the context. There appeared to be a general view that patients by just the virtue of being patients were experts of patient experience and perspectives, although reasons for this expertise varied, although only 3 respondents (2 policymakers and a student) felt that being part of a minority group constituted expertise. A communication teacher initially said being black was enough but then retracted that as she thought through her response. There was also an impression that academic expertise, unless linked to the ‘real’ world, had little merit. Again it was unclear why this was the case. It may be that many of those interviewed did not want to be told by ‘experts’ how to address ‘cultural diversity’. There were varying views as to the role experts could play in development of teaching in ‘cultural diversity’.
The role of experts in the origins of ‘cultural diversity’ teaching or how the views of individuals might influence developments was not mentioned by any of the respondents.

“Of course there is expertise in cultural diversity. I think there are two levels, sort of practical competence in sort of functioning in a diverse environment, which is after all what we want students to have. I think you could call that expertise in a sense. I think beyond that there needs to be a group of people who actually have a more powerful evidence-based theoretical understanding of the issues involved that goes beyond the pragmatic, the practical competence of dealing with those issues on a daily basis. I’m sure there’s undoubtedly a need for those people to be able to influence the medical curriculum. What I am less certain of is that those are the only people who should teach it, because I think that is when you start to get into difficulties. You almost have to have sort of intermediaries as it were, in order to translate so that the students can gain” (R10: Curriculum head)

“That’s a difficult one. How does one become an expert in cultural diversity? I suppose one’s own lived experience is good enough for being an expert but in terms of being an expert for teaching. I think you need to have certain core competencies. That’s jargon... If I went to Australia for example and I spoke to an Aborigine person, he or she would be an expert in their own cultural understanding but that person wouldn’t be able to go and then go and do a session to teach first year undergraduates at university of whatever. Even though one is an expert as an individual they will still need to have a certain level of knowledge” (R55: User)

Different types of expertise were identified but only a minority felt that expertise constituted a combination of academic, practical and personal experience. There was a lack of consistency about what constitutes expertise in ‘cultural diversity’. This implies that there has been a lack of consistency in how individuals have been selected to develop ‘cultural diversity’ teaching. Thereby, the origins of programmes have been dependent on individuals (with or without expertise) with particular perspectives albeit that Tomorrow’s Doctors (GMC, 1993) has been in the background.
7.5 Analysis of the origins of ‘cultural diversity’ learning and teaching

This section argues that the origins of ‘cultural diversity’ teaching lie in political, rather than educational agendas. The argument is that if teaching is undertaken in the context of political priorities, it is not necessarily informed by the educational evidence-base or theory. If education is developed because it is perceived as educationally important, it should be informed by educational practices. The philosophy, process, delivery and outcomes of educational programmes will differ depending on whether the purpose for developing them is political or educational. This political agenda has meant that the teaching is focused on outcomes rather than process; the finished product is of greater interest than how the product was delivered. Given the political agenda, the issue causes considerable anxiety and there is a great fear of making mistakes. There are perceived pressures for a need to be ‘politically correct’ rather than educationally sound.

7.5.1 The political agenda

In the UK, much of the ‘cultural diversity’ teaching was developed in response to Tomorrow’s Doctors (GMC, 1993) which forms the basis for the argument that the agendas have been, politically rather than educationally, set. There is no evidence to suggest that prior to this document, medical schools actively taught students about meeting the needs of diverse communities. No programme discussed by the respondents appears to have been a natural evolution of previous teaching. Tomorrow’s Doctors (GMC, 1993) appeared to have included ‘cultural diversity’ for political rather than educational or clinical reasons. The political pressure and influence on healthcare provision has meant that the GMC, and medical schools in turn, could not ignore the political drive demanding that health services are responsive to the needs of all members of the community. However, whilst parts of Tomorrow’s Doctors (1993 and 2002) shows clear commitment to robust educational practice and makes reference to educational theory, this does not appear to apply to diversity. This may, in part, be related to the rather vague objectives included in the document regarding ‘cultural diversity’. With respect to ‘cultural diversity’ teaching it was believed that the GMC had been politically motivated in including diversity in Tomorrow’s Doctors (GMC, 1993). The GMC was perceived to have been instrumental in placing ‘cultural diversity’ on the medical education agenda albeit without any clear direction.
From the literature review and the findings, *Tomorrow's Doctors* (GMC, 1993) has been the driving force for placing ‘cultural diversity’ on the agenda in medical schools. There is no doubt that medical schools took *Tomorrow's Doctors* seriously, as evidenced by the many curricular changes that followed (e.g. Leicester, Leeds and Sheffield) but as the GMC document was vague, interpretations of what was intended may have been too liberal. This may have forced medical schools to mention the word diversity in their documentation irrespective of whether or not it was taught. Some curriculum heads may simply have supported development of ‘cultural diversity’ because it appeared in *Tomorrow’s Doctors* (GMC, 1993). Individual teachers appear to have used the document to justify their commitment to the subject, so it has indirectly and directly driven the agenda. There was less ambivalence about the GMC than there was about genuine medical school commitment. Whilst institutional policies exist in abundance, there was concern that there is less emphasis on delivery and implementation.

The political agenda has focused on the need to teach ‘cultural diversity’, without considering the ways in which it should be taught and the issues that arise from this. As a consequence and unsurprisingly, the educational agenda is rather muddled. If, as reflected by many of the respondents, culture is seen as a group-based identity, it is possible that the philosophy that influences the teaching may be more group-based, and thus reinforce the students’ likelihood of thinking about groups, and the needs of groups rather than individuals and their needs. Dogra and Karnik (2003) found that students preferred to see individuals as having more than one facet to their identity but they conceptualised culture in a group-focused manner demonstrating some internal inconsistency.

The policies that have shaped ‘cultural diversity’ teaching have themselves been political rather than educational; in turn the teaching that results is itself a consequence of the political agenda and not because of a belief or philosophy that it is relevant (e.g. Department of Health, 2003a). Much of the research that has driven policies in this area has gone unchallenged with researchers failing to state clearly the assumptions and philosophies that underlie their work. That some ethnic minorities have disparate access to healthcare is well acknowledged, yet the reasons behind this disparity, other than ethnicity, have gone largely unquestioned. There is criticism that much of the policy continues to be developed by ‘men’ in suits and implied in the quote below was that it was mostly ‘white’ men.
“The people who own the suits are the ones that dictate, the government dictates, they are
the ones, they have the best, they have the cream service and they still give us crap
service and they have still got suits in the high places that keep it there” (R57: User)

However, in fairness, these men are advised by others, some of whom are from minority
groups. Whilst the ‘white men’ may be guilty of hearing only what they want, their
advisors may be equally guilty of preselecting the perspectives that they choose to share.
Until policymakers and advisors and the individuals within them are willing to challenge
the basis of their assumptions, it is unlikely that policies will reflect anything that can be
translated into quality teaching.

To date, it has been assumed that there is a need to identify people through their
belonging to particular groups, and that the needs of the whole group can be identified
readily by talking to a few individuals considered as representative samples; for example,

“Obviously one would need a process of consultation, because there would be different
opinions on it, but I think you could do it, as long as you took into account expert advice
from within the communities, in the kind of things we did when I developed the cultural
competence toolkit model for healthcare services delivery in Xshire and I’ve done this in
terms of religion in terms of saying well what do you think that people should need to
know about your religion in order to deliver services to people of your background, and
that’s a project which is ongoing” (R47: Researcher)

This respondent had talked about getting students to understand that there might be
differences within groups, and yet the approach suggests asking group and religious
leaders to tell providers about the needs of their groups. This respondent was not alone in
being inconsistent; the individual was often lost in the discussion about groups. Whilst
Tomorrow’s Doctors (GMC, 1993) was a driver in placing ‘cultural diversity’ teaching on
the medical education agenda, it appears to have had little influence in the specific
programmes developed. This has resulted in programmes developing in an ad hoc
fashion. The GMC placed ‘cultural diversity’ on the agenda because of wider political
pressures and changes rather than any clear educational plan.
7.5.2 The lack of an educational agenda

The argument that the agenda has been politically set is supported by the absence of a clear educational foundation for the activities undertaken. In the interviews, no respondent alluded to any evidence-base that justified the inclusion of 'cultural diversity' in the curriculum. Indeed, most medical school programmes appear to have been developed by interested individuals rather than through a planned strategic approach. While, individuals may have reviewed the literature but they may not always be aware of their own biases when devising educational programmes.

Tervalon (2003) proposed that medical educators and leaders in medical schools have the obligation to meet the urgent challenge of preparing medical students to practice for the health of all Americans. It is unacceptable for certain people to hold stereotypical views of others that they would not want held about themselves. This again suggests that, to date, the agenda has not been educational or set by clinical imperatives. Respondents hoped that teaching students about 'cultural diversity' will reduce health disparities; few thought it should be taught for more individual reasons, i.e. wanting to improve the care that individuals receive. The clinical care that most doctors deliver is not politically driven to reduce inequalities, but to improve the lives of their patients.

As long as the agenda is politically set, then the development of programmes is itself likely to be muddled because of the lack of an educational framework on which to build. Irrespective of the policies in place, implementation will be most successful if those holding the power in medical education (such as deans and heads) are committed to a clear educational agenda. Although, respondents recognised that students needed to be aware of their own prejudices and biases, they did not relate this to policymakers, faculty staff and teachers, who might implement a curriculum that directly supports their own biased perspectives. This is more consistent with 'cultural expertise', which is not explicit about individual biases, whereas 'cultural sensibility' would suggest that our perspectives influence our interactions, and that these then become an integral part of curriculum design, delivery and evaluation. In 'cultural expertise' there is a reification of culture and its meaning so that expertise can be generated from a knowledge base.

There was a view that non-whites were perhaps more likely to be heard if they claimed that 'cultural diversity' teaching needed to include whites as teachers rather than just as
recipients. This is perhaps one of the strongest indicators that the agenda remains political because there is no good educational reason why skin colour in itself should affect the teaching of ‘cultural diversity’.

This study has found that key terms describing issues related to ‘cultural diversity’ such as race, ethnicity, and multiculturalism, are understood in a variety of ways. However, only just under a sixth of respondents felt that the difference in understanding of the terms might influence the types of educational programmes developed. If there is no clear educational agenda as the evidence suggests, then individuals are more likely to develop programmes that are consistent with their own perspectives (Fulford, 2003; Toohey, 1999).

Development of ‘cultural diversity’ teaching has generally been ad hoc with individuals taking on the subject. There has not been any systematic approach to address the subject or consider how it is integrated into the curriculum. Those individuals who started developing ‘cultural diversity’ later have taken the opportunity to learn from other schools. Often, the early leaders were given a broad agenda or were driven by personal agendas. Tomorrow’s Doctors (GMC, 1993 and 2002) was clearly the initial driving force behind ‘cultural diversity’ development in two medical schools but the subsequent developments were a result of individual staff interests and initiatives; for example,

“I was asked to set up a behavioural science course by the dean because I was the only behavioural scientist in the medical school and it was when I was drafting my behavioural science programme I made it to naturally come within that” (R18: Diversity teacher)

Some respondents also felt that, for some reason, the development of ‘cultural diversity’ teaching tended to be left with individuals, who soon found themselves isolated and/or out of their depth. Whilst it is important to ensure a wide range of staff are involved, those who have championed the cause should continue to be included so that their experiences can be incorporated into further developments. Otherwise schools may find themselves repeating the mistakes.
Lip service to policy is an important factor. In these circumstances, teaching is undertaken to demonstrate a superficial response to policy as opposed to a genuine belief that it is either necessary or important. There has been little initiative for someone to take the political agenda and transform it into an educational one. There is the question of whether or not “implementation of policy into practice” holds meaning or if it is just another educational fashion complying with the political agenda. In reality, teachers are unlikely to be teaching anything radically different from previous teachings but it may be rephrased to reflect changing practice. In others, staff find themselves with the task of implementing policies without any support or resources. In some schools, teachers are hampered by visions of senior academics on the look of the curriculum, or restrained by other unworkable constraints. ‘Cultural diversity’ may be so broad and inclusive a concept that it limits what can be taught or learned, unless the use of the term is clearly defined. There is little faith in policies regarding ‘cultural diversity’ or genuine medical school commitment to the subject.

“I think medical schools should be asking all departments, to be able to show effectively their working out, because at the moment what we do is they say, ‘we’ve got this person, you can ask her’ or ‘well I think we do enough black cases’. So I think it needs to be driven from the top if you like, to say, this is important, we want to see your workings out in the same way that we have an audit trail for QAA, and that is another area in which I think this needs to be developed, because that’s what people care about, things like QAA. Now nowhere did I see in a QAA audit trail anything about ‘where do you look at cultural diversity issues’. If people had to actually prove and show their material, that’s how I think it will then be driven” (R26: Diversity teacher)

The difficulties in identifying an educational agenda may be related to the difficulties in deciding who should steer the educational agenda. A medical sociology group considered the contribution of sociology as a discipline in terms of providing information to medical schools (Russell et al, 2002); this reflected a similar meeting held at the British Sociological Association 2002 Medical Sociology Conference. Whilst in its early discussions, it was striking that the meeting focused on what sociologists felt should be taught to medical students without relating it to the whole curriculum. Again, the agenda related more to the needs of sociology rather than any coherent educational strategy or evidence-base. There appeared to be a view that sociologists needed to develop a
curriculum (which could include ‘cultural diversity’) and present it to medical schools for implementation. This approach is somewhat different from that taken by the Diversity Interest Group (DIG), an informal group comprising five diversity teachers from different backgrounds (three medical and two non-medical). This group conducted a survey to establish current practice in the UK and Eire and organised a one-day meeting (Roberts, 2004). This meeting identified that, from the outset, a multidisciplinary forum that recognised the policies by which medical education is governed was needed. It also recognised that the bodies governing medical practice need be engaged in the educational dialogue. The plan is that the educational outcomes are established taking the political imperatives into consideration. The forum also concluded that a clearer educational agenda needed to be established.

7.5.3 Concerns and fears

This subsection addresses some of the concerns and fears that were identified through the study. There was uncertainty about whether or not programmes to teach diversity should have an underlying philosophy aimed at producing students who do not hold racist, sexist etc views. This again suggests that there is a stronger political concern that undesirable views such as racist views are forced out of the student body than considering that which is educationally realistic or achievable. It may be more realistic to expect students to behave in non-discriminatory ways rather than expect to change their views radically, otherwise less desirable attitudes may be left unaddressed. It also raises the question of how much of our own beliefs we are expected to change or suspend to accept alternative viewpoints. In accepting others, do we have to become less of what we are or do we have to comply with politically correct perspectives. The way in which ‘cultural diversity’ has arisen adds to the confusion about the educational agenda in ways that do not apply to other aspects of medical education. The purpose of medical education is clearly to produce clinically competent doctors. Teaching in ‘cultural diversity’ is, however, perceived to have a different purpose, which perhaps reflects the association between ‘cultural diversity’ teaching and politics.

Many respondents seemed uncomfortable with defining their own ethnicity, as though this was in itself a commitment to a certain kind of thinking. Many ‘whites’ felt they had little of value to say, or little that would be valued even if it were said. The view that
whites have little to contribute is reinforced by statements such as Robinson (in Coker, 2001: 192) who stated that articles and books on communication written for health professionals are basically Eurocentric and, as a result, required considerable adaptation before they were responsive to some of the needs of black groups. The assumption was that there was a Eurocentric and a non-Eurocentric way of looking at the world. The non-Eurocentric way was essentially the ‘black’ way. Robinson (in Coker, 2001: 192) did not appear to consider the possibility that there were many different ways of looking at the world. In her conclusion she stated that:

"White health practitioners must become aware that black people have different interpretations of what is said as opposed to what is intended. Practitioners must learn how their own cultural experiences affect their perceptions of black people and the circumstances that activate racial stereotypes" (Robinson in Coker, 2001: 206).

Robinson (2001) stated that the term ‘black’ was being used to be inclusive, but in the above statement demonstrated no awareness of its’ divisive potential. Some ‘white’ respondents had negative experiences on account of being white, which they felt was often dismissed as irrelevant. Some respondents (3, all white) believed that whites had little to contribute to the debate whilst others strongly (3, of whom 2 were white) resisted this. This detracts from the potential contribution from all perspectives to the educational agenda.

There is fear in medical schools of offending minority groups. One policymaker felt that political agendas ignored the realities of the social world and that some actions taken to appease the vocal minorities, were themselves divisive. The issue is that appeasement potentially causes more harm than good and 2 white male policymakers questioned the use of the term ‘institutional racism’ and its place in ‘cultural diversity’ teaching. The views of the respondents compare unfavourably with Esmail’s (2003) perspective that organisations have a greater responsibility than the individual when addressing issues of racism.

"They had one room in the previous hospital with the symbols of the 5 leading religions in one room so that everyone can pray. Just to take students there, be in that room for a
moment and to see maybe people from two different religions going in there, praying in their own way and still being patients in the same hospital is great. The problem is there can be an interest in political power that basically almost cynically ignores the real issues” (R41: Policymaker)

The respondent continued to talk about the detrimental effect of labelling institutions as racist and making it difficult to talk about the issues.

“To call institutions becoming institutional racists is a good example, I mean it drives me up the wall...I think they are wrong calling services institutionally racist and I have to stand up for my team, who do a great job. There are experts from Europe coming over here and feel they have seen the real thing in terms of seeing a multicultural society and, national experts who have never set a foot in a service, who haven’t got the faintest idea of what is going on the ground, that they are institutional racists, so I just stood up. What is even worse is that that is detrimental; it actually makes it more difficult to deal with the issues” (R41: Policymaker)

“It depends, if they get the GMC stamp, if it was something that had something to do with the GMC ...” (R37: Policymaker)

The last statement is significant as many respondents implied that they did not always feel that those in powerful positions in medical schools supported diversity teachers.

The difficulties and divisions in sociology also make it difficult for it to set a clear agenda and few diversity teachers were convinced that the subject was taken seriously. However, in some contexts, ‘cultural diversity’ teaching is an opportunity to ‘show off’ medical school achievements rather than because there was genuine support for it. One user who defined himself as Indian had a clearly expected minority academics to take a major role, thus placing the teaching of ‘cultural diversity’ in the hands of minorities. The responses also tended to confirm the uncertainty regarding the current practice of ‘cultural diversity’ teaching and anxieties about the top down approach through the development of a national curriculum. This may reflect concerns that the agenda will remain political rather than educational; that is, political pressures will influence policymakers more than educational imperatives.
Whilst there appeared to be overwhelming enthusiasm, there was also anxiety and a lack of awareness of what was happening in the field. However, few people were aware of existing programmes and developments in this field; it was clear that medical educationalists in diversity have yet to build effective networks to promote such work.

Medical schools may be driven by single-minded approaches to their curriculum, either structurally in that all modules are of a specific length and slot into a specific part of the timetable (e.g. Leicester), or through a certain teaching approach (e.g. Manchester with a problem-based approach). The adherence to structures may suggest that there is a lack of clarity about the purpose of the education and may also mask the anxieties that medical schools have with respect to making errors; that is the teaching of ‘cultural diversity’ is tackled using the same methods as other teaching without openly acknowledging that the political context makes the subject more prone to external scrutiny. Given the political nature of diversity, schools may be thwarted in their desires to develop innovative and potentially unpopular programmes.

*Tomorrow’s Doctors* (GMC, 1993) did not dictate adhesion to any particular perspective, except that any medical programme must ultimately deliver effective practitioners. This may leave medical schools, especially white teachers, uncertain as how to address teaching in this area. What schools say about what they intend to deliver may be very different from what is actually taught or learned. With respect to ‘cultural diversity’ teaching, there is perhaps too much variation in the differences between the planned, taught, and learned curriculum (Lowry 1993, quoting Coles). The fact that *Tomorrow’s Doctors* (1993) lacked the detail of American policies may also have been unhelpful. In trying to engage with medical schools, the GMC left its document open to interpretation resulting in the perception of the GMC as ambivalent at best and unwilling at worst in addressing this central issue. The general belief is that the GMC needs to take a greater lead as opposed to leaving medical schools to determine the policy by themselves. In an area that is already confused, the fears and concerns may prevent appropriate support and development of programmes and staff.
7.6 Conclusion

With the interviews, there was a wide range of views about Tomorrow’s Doctors (GMC, 1993 and 2002). However, Tomorrow’s Doctors (GMC, 1993) was perceived to be responsible for placing ‘cultural diversity’ on the medical education agenda but appears to have had little influence over the types of programmes developed. There were those who felt it was a far-reaching innovative document and those who felt the GMC was interested only in presenting a positive public image. Doctors were more inclined to be cynical about the GMC and its role. This is likely to reflect the broader dissatisfaction within the profession about the way the GMC conducts its business. Overall, there was some confidence in Tomorrow’s Doctors (GMC, 1993) but this was rather measured. There was awareness of existing programmes but little to suggest that these programmes were evidence-based or part of a wider strategic plan. Few respondents perceived expertise as an amalgamation of experience in several areas. Programmes appear to have originated mostly through individual interests. A majority of respondents’ understanding of diversity aligned with ‘cultural expertise’.

Tomorrow’s Doctors (GMC, 1993) resulted in most medical schools reorganising their curricula. In the context of ‘cultural diversity’, the document set a political agenda rather than led an educational one. There is considerable evidence from the literature and from this research to indicate that there is little clarity about education in ‘cultural diversity’ and that the origins lie in political agendas. This has led to inconsistencies between educational programmes, which may now need addressing. Inconsistency in the way in which terms are used and understood has also influenced the origins of ‘cultural diversity’ teaching. When the origins are political and little attention paid to the educational philosophy or theory, all stages of education are affected. The confusion that surrounds this subject is related to the fact that to date there has been no clear educational agenda alongside the political agenda. There is a lack of clarity about the purpose of ‘cultural diversity’ teaching and this causes considerable anxiety, which, in turn, inhibits open dialogue. All these factors have affected the organisation of ‘cultural diversity’ teaching within the curriculum, which is discussed in the next chapter.
Chapter 8: Findings and discussion of the organisation of ‘cultural diversity’ learning and teaching

Chapter Eight begins by considering the place of ‘cultural diversity’ in the medical curriculum. The content analysis of medical school websites is also presented. The status of ‘cultural diversity’ teachers in medical schools is considered. The chapter continues by considering respondents’ views about the stage of the medical student’s education that the teaching should take place and whether or not the teaching should stand alone or be integrated into other aspects of the curriculum. All these issues help identify the way in which ‘cultural diversity’ teaching is organised. This chapter also reviews findings about who should teach ‘cultural diversity’ to medical students. Respondents’ views about the place of potential future guidelines are also reported and discussed in order to clarify how the organisation might be developed. Chapter Eight proposes that the political agenda discussed in Chapter Seven has influenced the organisation of the teaching of ‘cultural diversity’. Chapter Eight proposes that there is a lack of clarity about the place of ‘cultural diversity’ in the curriculum. This is reflected in the lack of any kind of systematic approach in developing specific ‘cultural diversity’ programmes. This may be related to the lack of any clear educational models and an emphasis on the political agenda. The organisation of ‘cultural diversity’ teaching in medical schools appears to be related closely to the issues that surround the teaching of ‘behavioural sciences’. It is argued that whilst there are clear ideas about the principles that should underlie ‘cultural diversity’ teaching, the rationale about why this should be the case is less clear as is how these ideas could be effectively implemented. There a discussion regarding the mismatch between the actual organisation of ‘cultural diversity’ teaching and how respondents thought it should be organised. It is proposed that little use has been made of educational theory or any evidence-base. It is argued that perspectives about the ‘behavioural sciences’ and those teaching ‘cultural diversity’ do not encourage the involvement of such teachers in strategic planning and that ‘cultural diversity’ teaching still lacks credibility.
8.1 The place of ‘cultural diversity’ in the medical undergraduate curriculum

8.1.1 Introducing ‘cultural diversity’ into the curriculum

There were many individual differences to approaching ‘cultural diversity’ and its introduction to the curriculum. Few of those interviewed based their ideas on clear theoretical underpinnings. There was an acknowledgment that this area is complex and the field of medical education has no clarity on the meaning of widely used terms as highlighted in Chapter Seven.

The organisation of the curriculum is about implementing the policies that relate to the subject and 1 policymaker raised the issue of a national curriculum to help consistency of programmes.

“This is one of the questions of course, why don’t we have a core curriculum, nationally for undergraduate medicine?” (R37: 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. Medical schools with an established track record in ‘cultural diversity’ teaching may not want to take advice from the GMC about how to implement policy. However, the GMC may be missing a key opportunity to lead and support medical schools in an area that has proven difficult to address, especially as there was an impression that a core curriculum for medicine is not far off.

The assumption that teaching in ‘cultural diversity’ would have kind of systematic approach has perhaps been challenged significantly by the review of the literature and the interviews. There appear to be many different ways in which curricula have been developed. None of those interviewed related teaching or specific programmes to educational theory or considered stages of course development. It cannot be taken for granted that curricula are developed systematically.
8.1.2 Where in the curriculum should ‘cultural diversity’ be taught?

There was a genuine enthusiasm for ‘cultural diversity’ being part of the curriculum for undergraduate medical education and no-one felt that it should be an optional component of the curriculum.

The use of the term ‘behavioural sciences’ in medical education was considered to be a way of referring to anything other than ‘physical sciences’ as discussed in Chapter Two. This may mean that psychology and sociology are taught as one block, without enough regard to the distinct approaches of these disciplines.

"I know it's quite interesting how, it started of with social class in medical education and then the psychologists felt left out...[But they are very different, sociology and psychology are incredibly different?]...Yes, as disciplines, and yet it is interesting how they often 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" (R22: Diversity teacher)

The content analysis revealed that the websites of the majority of UK medical schools (16 out of 26, 61.5%) gave equal attention to behavioural sciences and to biomedical sciences (Table 14, Appendix 7: pages 305-6). Drawing firm conclusions on this is difficult given the varying quality of the websites. However, it does show behavioural sciences are central in the curricula of medical schools, but for some reason these have failed to make the impact one might expect. The content analysis also showed a prevailing emphasis on considering ‘minorities’ with health disparities as the main focus. Issues tend to be externalised: ‘other people’ and ‘other groups’ indicative of the ‘cultural expertise’ approach. These findings suggest that the links between what is included in a curriculum and what is delivered are unclear.

In response to the question whether or not ‘cultural diversity’ (meaning diversity associated with ethnicity or race) should be taught separately from other aspects of diversity or with them, the majority (45; 4 communication teachers; 5 curriculum heads; 12 diversity teachers; 13 policymakers; 2 researchers; 5 students and 4 users) felt it should be taught together. Five (1 communication teacher; 3 policymakers and 1 student) felt it should be taught separately. For the student amongst these respondents it was
mostly for practical reasons, and for a policymaker his justification was that it was a
current (political) agenda. There were 10 other different justifications and 2 users felt it
should be taught both separately and together. The idea that it should taught be together
and the idea of a ‘cultural expertise’ approach are only consistent if the idea of teaching it
together means as part of the same course. As the ‘cultural expertise’ approach has a
greater emphasis on facts and knowledge, this information about different groups
presumably would need separating out. There was also a view that ‘cultural diversity’
needs to be raised consistently in clinical aspects of the course, as highlighted above, but
in a way that is consistent with preclinical teaching.

There were several justifications for teaching all aspects of diversity together including:

“My fear is that if you just do it discreetly, 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 and what where we are trying to move it, 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” (R15: Diversity teacher)

Sometimes the responses were similar superficially i.e. that it should be taught together
but the underlying explanation different, in that some respondents (3) said this for
practical reasons:

“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” (R7: Curriculum lead)

Others thought it should be taught together for educational reasons:

“I think, 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, so attitudes almost certainly are pretty common. You might be fantastically open
minded and reflective about working with people from an ethnic minority background and
whatever, age, etc, 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 a sort of you know,
prejudice and being reflective about it" (R23: Diversity teacher)

A communication teacher felt that although ‘cultural diversity’ issues should be an
integral part of the curriculum, there was a high risk of these not being taught at all and
that was the justification used for separating teaching.

“Within each culture there is 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, they should be some basic lecture format to support it” (R1:
Communication teacher)

This response also indicates a ‘cultural expertise’ approach of different ‘cultures’ as
being rather homogenous with similar needs. One student felt that the subject should not
be taught separately 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 science, you
know, they have social science. What you’ve got to do is fit them in where appropriate. So
you could be teaching genitor-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” (R53: Student)

This is consistent with ‘cultural expertise’ in that it presupposes that sexuality issues are
only relevant in a single context, when they could easily feature in diabetes given the
side-effects of some of the treatment regimes.
The response reflects a lack of understanding that might underlie the philosophy behind such approaches and about educational practices. The latter suggest that before teaching 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 raised the issue that if ‘cultural diversity’ was not taught separately, students may not realise it had been taught. This is, perhaps, particularly important in light of recent findings by Wachtler and Troein (2003) who found that students often missed the so-called hidden curriculum. One respondent considered that addressing ‘cultural diversity’ as a discrete issue would be wrong because it was superficial. Again, there was no comment on how to ensure that students were aware that ‘cultural diversity’ was being taught if it was being taught in an integrated fashion.

In summary, the consensus was ‘cultural diversity’ is not the province of any specific discipline and should be taught in an integrated fashion although it was less clear how this might happen in practice.

8.2 When should ‘cultural diversity’ be taught?

There was consistency in the responses although the reasons justifying the responses were variable to the question “At which stage of the medical student’s career should the teaching take place?” Fifty of the 61 respondents (6 communication teachers; 6 curricula heads; 14 diversity teachers; 11 policymakers; 2 researchers; 5 students and 6 users) stated that the teaching on diversity should begin in year one and continue throughout training. Thirty-three respondents (6 communication teachers; 7 curricula heads; 10 diversity teachers; 8 policymakers; 1 researcher and 1 user) stated that diversity training should be integrated into other parts of the curriculum. Of these, 4 (1 curriculum head and 3 policymakers) did not say when they thought the teaching should begin but were explicit that it should be integrated. Three respondents (1 policymaker and 2 students) felt that the teaching should take place before there was patient contact and this determined when it might begin. A user, unsure of her response, thought that it would have to begin after training was completed. Policymakers, students and users stated that the teaching should be integrated less often than others. One respondent thought that early teaching in
this area was appropriate but that caution was needed; another felt, that although early experiential learning was useful, students also needed first to learn how to learn.

Communication teachers, curriculum heads and diversity teachers talked about diversity teaching (with or without professional and personal development component) as being a vertical strand (i.e. running throughout the years of medical education), which also ran horizontally (i.e. cutting across modules) throughout the curriculum.

Justifications for early inclusion included:

"Week one, right at the beginning. Because they are, from the minute they walk through the medical school, they are on the road to becoming doctors and the notion that, most of us went through, our generation, was you spent your whole time dealing with the nuts and bolts and when you’d emerged, then you could start thinking about those issues. Fat chance of that really because decisions have already been made. You have formulated your own ideas and you have absorbed the values of your teachers, who themselves weren’t educated in a climate which encouraged them to be flexible when dealing with patients" (R21: Diversity teacher)

"Certainly within the first term. Just that it’s an underpinning principle really. That medicine is about people, not about bodies" (R56: User)

The idea that medicine is about people is perhaps is relevant. Most medical students spend a significant part of their first term of medical school in anatomy laboratories. This emphasis may present a perspective that medicine is about inanimate objects, rather than individual human beings. One policymaker guarded against introducing it too early without preparing students adequately:

"I’ll tell you a story somebody told me. Their daughter was at X and she was on the final day of the first week, had to interview a role play patient, who I think was HIV positive male, she wasn’t prepared for that… I think one’s got to be careful about recent entrants to medical schools ability to absorb this stuff. Now clearly some people will have had personal education or cultural careers that make it very easy for them, but some people
coming to medical school may have quite different expectations and perceptions. 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, I mean 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” (R37: Policymaker)

This response implies that there are several different ways in which ‘cultural diversity’ can be addressed and that teaching material in all areas should reflect ‘cultural diversity’, and not just specific areas. In some problem-based programmes, there may be assumptions that all areas are covered but deeper examination shows this is often not the case (Turbes et al, 2002).

There were those (3 diversity teachers; 3 policymakers and 2 users) who wanted to introduce the subject early to influence students more strongly:

“I think that’s [from the beginning] the way we are going to change things, people’s ways of viewing things. It can’t be a separate issue, there isn’t a kind of magic time where people can say this is the right time or this is the wrong time and I think there is too much of people saying well, they’re not going to be going into practice yet so we will wait until they go into practice… I believe that all white people are racist, it’s a long, long journey in order to examine that racism and the impact it’s going to have on practice, you need to start as soon as possible” (R26: Diversity teacher)

“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, sort of a two-way process, proper training I think should be to include the students because they are part of it as well and it is very important to understand that, but it’s just to reinforce in the early stages how people are different” (R60: User)

Both of these 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 beliefs.
"In a curriculum which is so designed that, there is no sort of completely pre-clinical phase, where students have no patient contact they can experience, then they are going to have the opportunity to explore issues of cultural diversity at a very early stage and as I said they need to have the awareness of these issues raised within themselves at a fairly early stage, so when they do come into contact with patients they can explore these issues for themselves" (R4: Communication teacher)

This response still presents 'cultural diversity' in terms of learning about patients rather than students thinking about how their own ways of thinking and behaving might influence their interaction or communication with others.

Whilst there was consensus that 'cultural diversity' should be taught early, and be integrated in the curriculum, the reasons for this were variable and there was little detail on how this might be achieved. The consensus that 'cultural diversity' teaching should be integrated in all aspects is more compatible with the 'cultural sensibility' model. Whilst the majority of respondents had a philosophy more consistent with 'cultural expertise', the way they viewed the organisation of 'cultural diversity' teaching was more consistent with 'cultural sensibility'.

8.3 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 course to suggest potential time slots. For some respondents, the timing did not matter as long as the learning outcomes were met. The difficulty with this is that, as yet, little work has been undertaken to determine which outcomes in ‘cultural diversity’ are being met. If outcomes were being achieved, it would perhaps be helpful to know this. The number of teaching hours being spent is unclear, and it can be difficult for staff to know where to begin in arguing for some curriculum time.

“Well, of course the clever answer would be as much as it needs. I don’t know, there is that answer, but 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 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” (R12: Curriculum head)

Those who had struggled in getting their own clinical disciplines on the agenda were more forward in suggesting specific time slots.

“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 20-30 hours [formal contact teaching time] (R5: Communication teacher)

A respondent was prompted given his difficulty in responding and made the following response.

“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” (R45: Policymaker)

The time spent raises an important question. If medical schools place ‘cultural diversity’ in the curriculum in response to external pressures as opposed to a genuine belief and commitment that such teaching is important, ‘cultural diversity’ teaching is likely to disappear from the curriculum when the external pressures ease. There were also those who thought that not much time was needed, although the justification for this was unclear.

“Probably not that much time ...” (R48: Student)
This respondent generally had a very ‘cultural expertise’ approach in that she saw it largely as learning information about groups so may not have considered much time was needed to impart factual information.

Some of the other student responses were also interesting in that they felt ‘cultural diversity’ would be more demanding than many of their other learning experiences if it was addressed appropriately. They felt learning time needed to include opportunities for reflection. This demonstrates a higher-level approach to learning about diversity.

“I think a week. ...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 six hours teaching at the most I think. 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, so I think 6 hours at the most... ...Just because 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”

(R51: Student)

This response suggests that, in practice, course design fits with curriculum structure, which contradicts educational theory covered by Toohey (1999). Course design and curriculum structure are not abstract concepts and the relationship between the two is relevant in the final outcome. Whilst integration may be desired, as suggested earlier, the evidence is that unless courses are specific about what they teach, students may miss other aspects. The notion of teaching ‘cultural diversity’ as a single module to arm students with knowledge is consistent with ‘cultural expertise’. The idea of teaching ‘cultural diversity’ as a single module in which a method is acquired for use in everyday practice is consistent with ‘cultural sensibility’. For ‘cultural sensibility’ to be applied, students need to learn about learning. This is less true for ‘cultural expertise’.

Those adhering to a ‘cultural expertise’ model tend to think in terms of facts that need to be learned and found it somewhat easier to say how many hours of teaching might be needed. Neither early introduction nor integration of the subject is inconsistent with either model. However, the ideal of early recognition of students’ own biases is consistent with ‘cultural sensibility’.
There was also a view that the time for ‘cultural diversity’ teaching should be part of the core curriculum and that it should not be only student selected or part of the SSSM options.

“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” (R47: Policymaker)

The difficulty in using terms such as ‘modules’ 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, too much the other way, certainly there is enormous importance to that stuff… …Obviously, I think it’s important. I think it should have a module” (R14: Diversity teacher)

There were concerns that the subject should not be ‘overdone’ as students would then fail to recognise its importance.

“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. But the other, it’s the informal teaching, the other opportunities, the informal teaching, we are expecting the staff who are teaching in clinical situations, to be aware of the cultural issues as well as the formal teaching” (R9: Curriculum head)

Time allocated to ‘cultural diversity’ teaching was considered irrelevant to some extent because students decide for themselves what warrants their attention. It was 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 had to work with whatever the conditions and it was easier to start and then improve a course rather than waiting for a perfect course to be developed before implementation. Perhaps, unsurprisingly, there was less consensus about the number of hours taught. There was, however, clarity in that ‘cultural diversity’ should be part of the core curriculum and warranted more than a one-off teaching slot or being an add-on to other modules.

8.4 Who should teach ‘cultural diversity’?
This section focuses on who should teach ‘cultural diversity’ in the context of medical educators. The role of the community is discussed in the next chapter. Nineteen respondents gave more than one response to this question. Responses were:

- Mixed group of staff (27; 3 communication teachers; 3 curricula heads; 11 diversity teachers; 5 policymakers; 2 researchers and 3 students)
- Staff with clinical or frontline experience (23; 3 communication teachers; 4 curricula heads; 8 diversity teachers; 3 policymakers and 3 students) Of the 6 diversity teachers who did not mention this 4 were non-medical with social work backgrounds.
- Those with appropriate skills (21; 1 communication teacher; 1 curriculum head; 5 diversity teachers; 9 policymakers; 1 student and 4 users)
- Community staff (15; 1 communication teacher; 3 curricular heads; 6 diversity teachers; 1 student and 2 users)
- Sociologists (3 of whom only 1 was a sociologist)
- Faculty staff (1)
- Peers (1).

There was concern expressed that, if designated to only those with appropriate skills, this excused other staff from developing the necessary skills. Being a good facilitator with some experience of ‘cultural diversity’ were on the whole considered appropriate skills. There were also those who felt it was the responsibility of every teaching member of staff and that having key people to take on all the responsibility marginalised this subject. All 6 teachers who talked about feeling alienated or marginalised were female and white. Of the 15 who explicitly said the community as opposed to multidisciplinary teams, needed
to be involved, there were 6 (1 diversity teacher; 2 policymakers; 1 student and 2 users) who said only the community. None of these were clear as to how the community should be involved apart from relaying experiences of specific groups and facts about their perspectives. The diversity teacher who said only the community had a long experience of community-based work. Ten respondents (2 communication teachers; 2 curricula heads; 3 policymakers; 1 student and 2 users) identified teaching skills to be of greater importance than expertise in specific areas when teaching students about diversity.

"I have been trying very hard to get this mainstreamed here for a long time and not with a huge degree of success. I have trained a lot of people working on the ground but no political clout. What I think happens is that, I'm actually seen as a bit of a quack being interested in this...So there is a sort of, you almost begin to experience the same discrimination, you are marginalised for it. Because you are trying to push this issue as important, you start to experience discrimination" (R27: Diversity teacher)

The issue of credibility with students was also raised and this was most often the reason cited for involvement of clinical staff.

"...I think that's where sometimes the theory of what people are wanting to do by teaching about cultural diversity is very good, but the reality of the teaching isn't. My experience is the curricula people who are often teaching are within medical education but are coming from outside medicine....I think it needs people to do it who are respected by the students, i.e. people like Dr Y in Z who is respected, who has got, people like him who do it, and also he's part of the club, because he is one of the doctors, because unfortunately I think it needs to be taught by doctors at the moment because the culture of medical schools is that they respect doctors more. Now I don't think they should, but it doesn't matter what I think. The reality is that people don't take it as seriously. And here at (name of place) at the moment practically has no doctors who are actually involved in the curriculum" (R54: Student)

"I would like to see, in an ideal world, you would want every single teacher, certainly every single clinical teacher to draw attention to relevant issues as they arise. So if you've got and I use stereotypes here just to point out the issues, if you've got some kind of trendy, greying hippies like me standing up teaching these issues that's going to be
easier for students to marginalise and not to value it perhaps than if an orthopaedic surgeon in a bow tie also mentions the fact in his out-patient clinic that, he saw a couple from a different background to discuss hip replacement or something. The surgeon says now obviously some interesting issues there that we have to value, so that's the ideal scenario" (R23: Diversity teacher)

Others also saw it as a multidisciplinary activity but one that needed to ensure doctors from all disciplines were included as shown by the following responses:

"I think there should be some medical involvement in cultural diversity because I think it's very important that medical students see it as something that is important to doctors, but I do think there should also be inter-professional, and multi-professional aspect to it and that's people such as, I think lots of people can do it. I think you can include chaplains, sociologists, nurses, other professionals, I think there is no limit to who you can include. I think it is very important that doctors are seen as being involved in the teaching otherwise it tends to sort of not get that same importance" (R5: Communication teacher)

"I think it would be a shame if diversity were to be seen as having to be rooted in particular subject areas, you know like in law women have to do conveyancing and in accounting women have to do taxation and I think it would be a shame if diversity issues were the preserve of psychiatry or behavioural science, they ought to be in surgery and everywhere" (R18: Diversity teacher)

Students wanted doctors, especially seniors to be more involved in teaching ‘cultural diversity’, as this would convey a clear message on the importance of ‘cultural diversity’ in medical practice. They also expressed the view that senior clinicians also needed training in managing diversity, as students often witnessed poor examples in practice.

"Because I think you do get prejudices, and I think that a lot of doctors, now that are consultants, don't have an appreciation of where a lot of patients are coming from....and it is more about the people than it is the science side of it” (R50: Student)
This is consistent with a recent finding by Tang et al (2003), which found that senior physicians might have had less exposure and education regarding sociocultural issues. There was also an emphasis that teaching staff reflected the diversity of the community and that ‘cultural diversity’ should not be taught by ‘ethnic’ experts or the like.

“I think it is important to involve people who have a direct experience and interest, because one of the problems is that although I’m saying that everyone ought to be involved in teaching this, we have, the diversity of our teachers doesn’t fit with the diversity of our population so I think it is important that people are involved in this. I think that anybody who has thought about it and has an interest in it is in a way an expert. But I think one has to be very careful about the experts one uses in this, because I think it needs to be, they need to be people who are balanced and not coming wholly from one cultural area because I think there are dangers about using people who are sort of experts from one area of culture or racial diversity who may not themselves have tolerance for other areas, so I think one has to be rather careful” (R11: Curriculum head)

“I think it’s got to be someone who feels comfortable doing it, I’m sure a lot of people wouldn’t. Someone who has got some background knowledge of the issues, if it’s going to be a specific curriculum event. Those are probably the main things. Preferably also someone with clinical experience because I think it will have much more credibility with students if the person has got clinical experience” (R13: Curriculum head)

This is interesting as students are expected to engage with ‘cultural diversity’ but staff may be able to opt out if they are uncomfortable with the subject. This would be inconsistent with ‘cultural sensibility’ as in that model teachers would be expected to challenge themselves as well as challenging their students. Two respondents felt that ‘white staff’ were less able to train, and 1 felt that whites should not train; all these respondents were themselves white.

“...I also think that preferably, again, you would, because it is woven into different parts of the curriculum, that you will have different teachers picking up the same thing throughout and reinforcing the message that, the area of core work and then cultural diversity should not come from a white person, certainly should not come from a white British person” (R56: User)
This fails to look beyond the ethnicity of a facilitator, and is consistent with ‘cultural expertise’ in which ethnicity is a more dominant definer of individuals than other factors. Two white respondents (1 male curriculum head and 1 female ‘cultural diversity’ teacher) highlighted why ‘black’ trainers might be potentially unsuitable in some contexts, for example:

“I think actually there are reasons why they shouldn’t be black in some cases... I think when you have white trainers and they are saying I’m not an expert, it means that people are much more confident to speak up, to say what they think. Their colleagues may then say well actually we don’t agree with you because and then you have got discussion and movement, but that confidence will only come when they feel safe and often you have white professionals being trained by a black professional who is there as the ‘race expert’” (R27: Diversity teacher)

The notion of expertise is, thereby, not challenged. The idea that whites are less able to teach may be linked to political perspectives in which all whites are perceived to be potential oppressors (for example, Robinson, 2001). In thinking about teaching skills some respondents commented on specific teachers characteristics.

“I think a teacher is somebody who aids somebody else’s education, rather than dispenses knowledge or skills. Although they may do that. I think teachers need to be culturally aware and able. It goes beyond being culturally competent, they need to be culturally capable and I see the difference in the two being, the competent person has knowledge, has skill; a capable person can actually roll with the changes and actually adapt that skill, that knowledge and actually is prepared to change their position according to evolution of knowledge and skill and is therefore able to help other people with doing that same process. So I think we need to be training teachers who are able to handle that kind of thing and each of us will have a different take on it in a different capacity...... I think we need to think much more clearly in medicine than we ever have done before, about who are teachers” (R45: Policymaker)

There was also the view that, whoever taught, needed to do so in a way, which engaged rather than alienated students.
"Well I think they have to have really good human qualities, so that they don't just come in and attack and criticise medical students and put them off. There was a stage when race awareness was done in a very attacking way... Get groups to talk and be open about their own background" (R58: User)

"I know a few people actually walked out of group work sessions because their views weren't being listened to by the facilitators, rather than within the group itself... I also don't think it necessarily needs to be taught by, I mean all of the small group sessions at X were taught by sociologists because it's kind of what sociologists do, but actually it just needs to be taught by people who can teach, or who can facilitate, rather than have a specific knowledge base on it" (R51: Student)

In summary, the general perspective was that although 'cultural diversity' would best be taught by a multidisciplinary team, senior medical doctors must be a visible part of this team, so that students have confidence in the medical school’s commitment and the relevance of ‘cultural diversity’ to clinical practice. There was also a strong view that teaching skills were perhaps more relevant than ‘expertise’ in diversity, especially if students were to be asked to explore their own perspectives. There was an underlying theme that ‘cultural experts’ as consistent with ‘cultural expertise’ might be useful. Staff support was felt to be lacking and teachers involved in this area were generally perceived as holding low status. The views relating to the organisation of ‘cultural diversity’ teaching are less clearly aligned with either ‘cultural expertise’ or ‘cultural sensibility’.

8.5 The role of guidelines

Other than Tomorrow's Doctors (GMC, 1993 and 2002), there are no national policies in place regarding the place of ‘cultural diversity’ teaching within medical education. There are some NHS initiatives, although these are lacking in substantive educational theory or philosophy (e.g. DoH, 2003a). When asked whether or not it would be useful to have guidelines, 51 (5 communication teachers; 6 curricula heads; 13 diversity teachers; 13 policymakers; 2 researchers; 5 students and 7 users) respondents felt that guidelines would be useful; 17 (3 communication teachers; 5 curricula heads; 3 diversity teachers; 3 policymakers; 1 researcher; 1 student and 1 user) of these stipulated that these would only
be useful if they were not prescriptive and if they were applied flexibly. The reasons for guidelines being helpful varied as shown below.

“Yes. Well I think they would need to be flexible, to take account of local conditions and the kinds of learning opportunities that the local environment presents. ...I think it should be a collaborative effort from both within the medical school and various stakeholders outside” (R3: Communication teacher)

“Some, but I think I would be more interested in how it might be taught... ... I think it would depend on the nature of the advice... It needs to be short, it needs to be focused, it needs to be realistic, in that it needs to be something that would show how this can be integrated into existing teaching, what its links are with all the teaching and if it also had ideas about how you might do it, practical suggestions and examples of practice, things like that, then I think that alongside a few achievable objectives and learning outcomes would be really useful, but what I don’t want is a sort of 50 page document with pages of objectives and no real possibility of delivering” (R8: Curriculum head)

Diversity teachers in particular saw guidelines as serving a supportive function, and a policymaker saw them as a benchmark against which schools can compare themselves with one another.

“Yes. I think ultimately what needs to happen is that medical schools as a whole need to get together... ...at the moment it is so disparate. I think it is also very reliant on individuals and as one of those individuals, I find it’s a constant sticking your neck out. When it’s the flavour of the month then it’s safe to stick your neck out and other times it is very, very wearing” (R26: Diversity teacher)

Others saw guidelines increasing the credibility of this area and enabling the curriculum to be more coherent.

“Probably yes. I can see that sometimes topics we choose may seem kind of random. Maybe guidelines, but maybe more getting together of module leaders to look at the whole curriculum and how it works because I think one thing students do think, is about its repetition. Whereas I think some of that is poor planning but also because maybe they
don't understand that sometimes something like chronic illness you don't just do once; you might kind of need several perspectives. On the other hand, there maybe something real going on as well in terms of covering topics and I think there isn't enough co-ordination across the curriculum” (R14: Diversity teacher)

Five (1 curricula head; 2 policymakers and 2 students) respondents were unsure if guidelines would be helpful or not, and a policymaker felt they were only for those who did not know the subject.

“It would be great if this was an exemplar of a way that a national guidance framework could be agreed. I know that schools on the one hand are resistant to being told what to do... ... some of the stuff in Tomorrow’s Doctors is absolutely right, there is a certain amount of educational fashion about it” (R37: Policymaker)

Four (1 communication teacher; 1 diversity teacher and 2 policymakers) respondents felt that new guidelines would not be useful, as they already existed in some form. Both these policymakers held senior positions with medical educational bodies.

“I don’t really think that there should be anything more specific than an overall aim of why they should teach this. I think it should be left to individual medical schools to work out how they are going to serve that end” (R4: Communication teacher)

Only a student felt that guidelines should be prescriptive, as this was the only situation in which medical schools would take them seriously.

“Yes, actually. I think the GMC have been very, very vague in its Tomorrows Doctors document. They wanted key learning outcomes and I can’t remember what the exact words were said on it, but I certainly don’t remember them being terribly prescriptive and I think they should be I think they should perhaps for example give examples of the key things to do with cultural diversity, the key areas like race, ethnicity, colour, disability”(R53: Student)
8.5.1 Developing the guidelines

When the question was asked about who should be involved in the development of guidelines, just over one-half of respondents (32; 4 communication teachers; 3 curricula heads; 7 diversity teachers; 7 policymakers; 1 researcher; 5 students and 5 users) felt that a range of individuals needed to contribute. There was a view that guidelines should be developed through consensus. No-one mentioned evidence-based medicine and the use of guidelines to highlight support for different approaches. There was a recognition that those involved with developing guidelines would need to be aware of their own biases by individuals from different groups. One curriculum head suggested that someone who was too involved might not necessarily be constructive.

"I think people who are interested (should develop them). I think what we need to do is to be aware of the people with a bee in their bonnet. There are people who come with baggage and I think we need to have a, people who are taking an overview about this, not, you know, I went to somewhere and they were awful to me, we want to get away from that" (R12: Curriculum head)

A communication teacher expressed the view that someone with expertise in several areas, e.g. clinical practice and sociology should lead the development of guidelines as this might help achieve a better balance.

"I think that one way that you can achieve this is by a group of people who are very committed and who are involved in this teaching, could advise the GMC on putting together guidelines, so it's consistent" (R15: Diversity teacher)

"The guidelines for the teaching would have to involve the educators and the practitioners, multi-professional stakeholders. If it's got to be delivered in this region we have got to bring people from this region and locality into the play, into the development and then into the implementation strategy" (R17: Diversity teacher)

There was also a view (from 1 curricular head and 2 policymakers) that teaching diversity was perhaps not so different from other teaching and that course and curriculum designers might benefit from some reassurance that this was not a totally new subject or approach.
"It would have to be collaboration between medical students and medical academics and bodies that represent different cultures and patients associations... ... I think one of the real starting points would be to bring students together and ask them what the difficulties they face are, because I know that we could come up with a list as a starting point straightaway about things we are so ignorant about we don’t know how to handle and then perhaps all these questions could be actually answered by the bodies that represent those difficulties” (R49: Student)

This and some other responses hoped that representative bodies will be able to dissolve away clinical uncertainties. This is consistent with ‘cultural expertise’. Another student expressed an altogether different view:

“It's got to be working together, it's the whole thing about ownership; you have got to have all the stakeholders involved and their voices heard and they and there has got to be ownership, because if there isn't ownership, and that's about from the highest level down, when it gets down to actually being in the classroom, when it's been watered down somewhat” (R54: Student)

Two (1 communication teacher and 1 diversity teacher) respondents suggested that the Royal Society of Medicine model that was used for the development of guidelines for communication teaching could be applied to ‘cultural diversity’.

“We use the RSM just because they have a forum on communication, which is already up and running and there are lots of people from different universities who are all involved in that. Now I originally took on the role with my colleagues in A about trying to co-ordinate development of a curriculum, so we took the lead on it to begin with and so we just went to all the medical schools and said what are you kind of teaching, and what do you think you should be teaching?” (R19: Diversity teacher)

Four diversity teachers felt that guidelines would highlight good practice and offer support to those assigned with responsibility for developing such teaching. Another important issue that was not apparent from the responses was the lack of effective leadership in this area because it is not the professional or academic territory of any one group or discipline which no-one felt it should be. Three respondents suggested specific
organisations to take the lead including the British Sociological Association (a diversity teacher with sociology background), the Commission for Racial Equality (a user) and the General Medical Council (a user). Two policymakers were not sure which organisation might be appropriate. A further 2 felt that doctors should lead the development and another suggested local initiatives but was unsure how this might progress. The responses perhaps confirm the uncertainty about what medical schools are doing, and also anxieties about a top down approach by the development of a national curriculum. In summary there was support for the development of guidelines if they were developed through a multidisciplinary forum involving a range of stakeholders.

8.6 Analysis of the organisation of ‘cultural diversity’ teaching

This section proposes that that there is confusion about the place of ‘cultural diversity’ in the curriculum and this has led to the organisation of such teaching being unsystematic. It also argues that as individuals have led the origins, there is no strategic overview and that leads to a great variability of educational programmes. The variability leads to inconsistent and unclear organisation. There is no clear evidence for supporting the current organisation of programmes. There is also a mismatch between what is happening and what respondents thought should be happening and possible explanations for this are discussed.

8.6.1 The place of ‘cultural diversity’ in the curriculum

Whilst most respondents were committed to ‘cultural diversity’ teaching in the curriculum, the idea that ‘cultural diversity’ is always welcomed into the curriculum was challenged:

“One question is, how much sort of resistance is there to embracing this really, either within a medical school curriculum, or within... [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, bringing it into the curriculum and how much again is it viewed negatively within the wider health community itself” (R4: Communication teacher)
Curriculum design issues raised the debate about the balance of science and humanities. No respondent suggested that basic sciences were irrelevant to medical education but there was a view that the so-called “soft skills” were valued less. The naming of them as “soft skills” is also unhelpful. It is useful to consider whether or not those heading curriculum design are leaders or facilitators. Those leads who believe that the curriculum should reflect their personal vision are likely to exclude those who do not share their visions and do not welcome different perspectives. What or who constitutes expertise in medical curriculum design remains unasked and unanswered. There was some concern that poor curriculum design and planning often leads to repetition in the curriculum and further undermined teachers:

“I think, because we did several, [modules] and the three really overlap in some areas so you end up doing some things three times. We did health in the community, some of it was really paternalistic, you know, sort of learning what Muslims eat, and it was very sort of actually it was a bit sort of patronising and also sort of generalist and doing it three times. I remember there were other areas as well and, one of them particularly was dealing with terminal patients which we never actually got down to but we touched on so many times and it's like you know, certain areas of it were explored about 5 or 6 times but we never actually engaged with it as something specific” (R5: Student)

“I worry that medicine teaches prejudice in lots of ways by the nature and the structures because we are taught to look at, OK what's this patient got? You know use all the stuff that's around and all the rest of it but then come down to, OK what's the most likely thing that's coming on. And we are taught to do pattern recognition, and I worry in some ways that by doing that, by saying this person, if they have come from abroad recently have they got an infectious disease or something, and I worry that sometimes, and I think that it's the way that people interpret it rather than it being taught, but I think that partly it is that people teaching it aren't always aware” (R54: Student)

This respondent saw that ‘cultural expertise’ fits more easily with the general way of teaching medicine, which is pattern recognition. To move away from this will involve recognising the ways in which medicine is taught generally before other ways of teaching can be considered. Historically, medical curricula have developed in ad hoc fashions (Engel, 1995; Dennick, 1998)). ‘Cultural diversity’ teaching is in limbo – on the one hand
it is not considered only as part of the ‘behavioural sciences’ but on the other that is
where it is mostly taught. Through this placement, ‘cultural diversity’ takes on the history
of the behavioural sciences and becomes associated with lower status.

There was also concern that students respond less well to social sciences and to the view
that it is necessary to accommodate student wishes. Students are not asked about if
anatomy is relevant to them. Feedback tends to be about whether or not the teaching
methods are appropriate, etc. The content of the social sciences and psychology modules
needs defending in ways that so much else in the curriculum does not. It is worth
questioning why social sciences are still not accepted as relevant to medical education
compared with the biomedical sciences. Whilst it is very appropriate to listen to what
students have to say, it is also important to be aware of the context. Students are perhaps
given implicit messages by teaching staff that it is unacceptable to fail biomedical
components but that it is impossible, and perhaps even irrelevant if they fail so called
‘soft options’ of social sciences and behavioural sciences. Whether or not this is what
faculties believe, there has to be consideration of where students form the impression that
the ‘soft options’ are less important and why they have even acquired such a name. The
view appears to be that social sciences are just ‘common sense’ and the acceptance of this
view means that curricula try to accommodate this perspective rather than challenge it. It
is possible that senior medical staff and faculty deliberately and/or inadvertently collude
with students.

8.6.2 The lack of a systematic approach

Some schools may find it difficult to identify exactly where ‘cultural diversity’ is taught
when it is taught in an integrated curriculum. A member of staff had reservations that
their problem-based learning course covered ‘cultural diversity’ at all, and if it did, it was
being addressed only superficially. There was also concern where to place ‘cultural
diversity’ in different types of curricula. To date, medical schools are clear about the
curriculum they have developed. However, they are less clear that different types of
curricula might suit different types of learners, and by implication different types of
students. Whatever the type of curriculum, the learning outcomes should still be the same
- to be an effective practitioner as defined by the GMC (1993). As there was considerable
confusion about where ‘cultural diversity’ should be taught, it is unsurprising that there is
no evidence of any systematic approach regarding the organisation of ‘cultural diversity’ teaching. A systematic approach is needed as suggested by:

“There needs to be this ongoing working party where we sit down and share practice so what would be ultimately really good was like if all PBL courses got together and looked at PBL cases and how you wrote PBL cases and integrated, and got that language because so often people who are PBL writers say, OK we’ll put in another black, or put in a trigger then and I’ll do this, do you see what I mean” (R26: Diversity 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’ and is highly relevant especially if the aim of integration of diversity into clinical practice is to be achieved. This is a particularly pertinent issue, given Beagan’s (2003) finding that ‘cultural diversity’ teaching when taught early in the curriculum was largely forgotten or presumed to be irrelevant by the time students went into their clinical years.

The rationale for early learning in diversity came from the intention of preparing students appropriately for clinical training, to get in early and challenge students before they became medicalised, to maximise learning opportunities. No-one touched on whether or not any evidence was available to determine when such teaching is likely to have the greatest effect. However, the impression was that ‘cultural diversity’ teaching should actually occur throughout the curriculum. Policymakers, students and users were less likely to state explicitly that the teaching should be integrated. This may be because they are less likely to be aware of different types of curriculum or delivery of educational objectives or outcomes. It is less likely but a possibility that they regard integration as less important than those delivering the curriculum. The GMC is certainly less clear on how it expects curricula to be delivered but is clear about what should be delivered.

There was, however, less clarity about how integration might be achieved. Again the respondents revealed their views about ‘cultural diversity’ generally through the question on whether ‘cultural diversity’ should be taught separately or not. Their views were also revealed through their justification of why it needed to be taught separately or together because they had to consider the way they viewed the subject as a whole. There is also
another reason that integration is important. If diversity is only taught in the early phases of the curriculum students may not fully realise its relevance to clinical practice.

On the whole, 'cultural diversity' teaching was not integrated in medical school curricula, either vertically through the years or horizontally across different modules, although there are programmes aiming to develop this especially in Professional Personal Development strands. There were views that 'cultural diversity' teaching should be developed in the same way as other parts of the curriculum. Many accepted that it should be an integral part of practice. Pragmatically, however, they considered that if it was not addressed as a separate discrete issue, it was unlikely to be taught. Many felt that there is currently little formal evaluation of teaching in this area and little evidence whether teaching this actually makes a difference (Betancourt, 2003). 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 using the limited evidence-base rather than reacting to political pressures which is currently the case.

### 8.6.3 Making ‘cultural diversity’ teaching credible

As discussed in Chapter Three, teaching within universities has lower status than research. Within medicine the 'soft skills' teachers are least valued. Teachers of ‘cultural diversity’ at medical schools did not generally feel valued. As shown in this study, those currently teaching ‘cultural diversity’, i.e. general practitioner and psychiatrists are somehow less credible than other doctors. This confirmed the findings of Loudon et al (2001) and is also demonstrated through the literature (e.g. Conning et al, 2001, Thistlethwaite and Ewart, 2003 were general practice based (although involved multidisciplinary staff) and the programme described by Dogra, 2001 run by a psychiatrist but again involved a range of staff). This mirrors the development in communication skills. Male and female staff and white and non-white staff have championed the teaching in medical schools.

"I think, who should lead the teaching, someone who has some sort of exposure and experience of that. So maybe it will be somebody who has some clinical experience. I think the students value that a lot more than the kind of pure social scientist to come and
talk to them and give them an overall analysis of studies. Important though that information is, I think students would value somebody who has actually been in the frontline of that as well, because I think they are able to bring up many more sort of examples from their own experience and relate them to the student teaching points, and also encourage students to look at their own examples and try and fit them into those frameworks as well” (R4: Communication teacher)

This then raises the issues of support for ‘cultural diversity’ teaching by medical schools. Perhaps it is time to recruit senior, medically-qualified staff to lead teaching in these areas. The appointment of non-medical staff to the behavioural sciences but medically qualified staff in other areas may give students very contradictory messages – on the one hand lip service is paid on the importance of the issue and on the other hand it is not so important that it warrants the involvement of senior medical staff. There were also others who felt that the job needed to be undertaken by people with responsibility for that role, rather than it being one of several roles. However, 2 respondents specifically did not feel a ‘diversity officer’ was the answer.

“Taken seriously, it does need posts allocated to them, rather than getting, we look at it, you give us the post we would do an even better job, but I think it’s also unfair on my colleagues who are on short-term contracts” (R46: Researcher)

A policymaker talked about creating doctors who could do their job in terms of core competencies. This may be different from medical schools that want to create doctors who can think and apply their learning in different contexts as highlighted by Fazackerley (2003) on the debate whether or not the Department of Health or Department of Education should be responsible for medical education. Students were felt to be concerned with being prepared for clinical practice. The inference is that, despite whatever efforts are being made to apply Tomorrow’s Doctors (GMC, 1993) by changing the curriculum, students still hold an essentialist view of medicine, with greater respect for biomedical than for social sciences. There was a perspective that teachers of social sciences and associated subjects have to work harder to prove the relevance of their subject to both students and other faculty staff.
Training and staff support are important issues. Sociologists may not have the clinical experience to appreciate fully the nuances of clinical practice and clinical issues. Indeed, a sociologist with some clinical experience commented on the credibility of theorists teaching about clinical issues that they had never themselves faced. In contrast, clinicians may not fully appreciate the complexity of some sociological issues and end up simplifying them. These teachers may be unaware of their own biases. Given the lack of a systematic approach, it is arguable whether or not teachers are aware of their biases and why they have chosen a specific approach. The wider view was that both social sciences and clinical medicine had a role, but that the involvement of the latter was crucial if students were to be convinced of the subject’s relevance to clinical practice.

“Well, if I was being really honest with you I would say, probably just because of my own situation in life, I am more likely to want to separate cultural diversity, which I think in this way, is a polite way of saying let’s talk about racism, but that’s because of my personal situation really... so I am more sensitive to it, although intellectually and academically I take your point of view of if you remove it rather than integrate it maybe becomes part of oppression, then I don’t think it is particularly helpful, so I ought to move on to that one, maybe one time I will be mature and do something (R21: Diversity teacher)

Whilst there was a desire for more clinical teachers, most were pragmatic in thinking that this was unlikely to happen. However, it may be possible that medical schools could give more public support to those teachers currently struggling with credibility. Schools and other organisations could demonstrate their commitment by supporting high-quality research in this area. There is implied criticism that medical education research in general and especially in this area, tends to be of poor quality so there perhaps needs to be a fresh approach to addressing this.

Guidelines were seen as potentially positive, as long as they were flexible. They were viewed as one way in which teaching in ‘cultural diversity’ might gain some credibility. No-one commented on the possibility that too much variety in teaching programmes might be disadvantageous. There may be an impression that when it comes to teaching diversity ‘anything goes’ and that is acceptable. The majority of respondents felt that a multidisciplinary consensus was required, although 4 participants mentioned interested
teachers as potential leads. It is useful to consider the implication of reservations about guidelines in an area with little track record of quality teaching. It is possible that, if there were guidelines, more programmes might be shown to be somewhat lacking and that this would further undermine the already weak positions of many teachers in this field. There was a fear that guidelines would reduce innovation so that, for example, if a particular programme were highlighted, then new programmes or developments would be deemed unnecessary. However, this is a rather static view of education. Coles (Lowry 1993) stated that education is an evolutionary process: even quality programmes need to be developed continually especially in fields which like diversity are subject to constant change. The existence of a few programmes that set the benchmark may be a useful step forward; schools unable to meet the basic standards would have opportunities to consider the limitations to their progress. Teachers may also feel that guidelines would serve to undermine their already unclear value.

There appears to be a mismatch between what is actually happening and what respondents generally felt should be happening with respect to the organisation of ‘cultural diversity’. It is likely that this mismatch has occurred in the absence of any clear educational agenda or some strategic direction. The development of programmes has been rather fragmented and unsystematic. It may also be that a mismatch results if ‘cultural diversity’ is included to comply with external pressures but with little belief of its’ relevance. In this case, the subject may be introduced into the curriculum but little regard paid to its organisation. The mismatch may also be present because of the lack of clear educational models to support those trying to develop teaching in this area.

8.7 Conclusion

Whilst the respondents were enthusiastic for inclusion of ‘cultural diversity’ in the curriculum, there was a view that this did not necessarily reflect the views of others within medical schools. There was consensus that ‘cultural diversity’ needed to be taught early and most felt it should incorporate more than ethnicity. Most felt that it should be integrated into all aspects of the curriculum. Whilst there was general enthusiasm for the development of guidelines, there were reservations that these might be restrictive and applied without any sensitivity to local contexts. There is no evidence to suggest that the approaches to developing ‘cultural diversity’ teaching have been systematic. This has
created a mismatch between the reality of what is happening and what respondents felt should be happening. It has been argued that the origins of ‘cultural diversity’ have led to its place within the curriculum being unclear which had led to an unsystematic approach. Teachers within this area do not feel valued and as much of the development has been through individuals, they have not been involved in strategy. This also means that the place and organisation of ‘cultural diversity’ remains unclear and variable and the subject lacks credibility with staff and students. This then affects the contents and delivery, which are discussed in the next chapter.
Chapter 9: Findings and discussion on the contents and delivery of ‘cultural diversity’ learning and teaching

Chapter Nine reports on respondents views about the contents of ‘cultural diversity’ programmes and how these might be delivered. Teaching strategies, including the involvement of the community, are discussed. Chapter Nine argues that the contents of ‘cultural diversity’ programmes may focus more on process rather contents. This is inconsistent with the philosophies identified. It is also proposed that the lack of coherent educational models effects the contents of programmes delivered. The origins and organisation of ‘cultural diversity’ learning and teaching may also mean that there is a sense that teaching in this area is merely an application of common sense. There are contradictory pressures on what is taught within ‘cultural diversity’ in that teachers may need to balance their perspectives with what is desired by curriculum heads, students and/or policymakers. However, the pressures are different for different disciplines and some are related to professional status within and outside of medical schools.

9.1 The influences of the organisation of the curriculum on the contents of programmes

Educationalists recognise that there is a link between educational philosophy, educational process and the contents of educational programmes (e.g. Toohey, 1999). Few of the respondents appeared to recognise this with regard to ‘cultural diversity’. There was a perspective by some students and policymakers that much of the philosophy and thereby the contents behind the teaching is merely ‘common sense’ and students just need to be pointed in the right direction. This is consistent with the literature reviewed in Chapters Two – Five. However, some respondents warned against this approach.

"...But on the other hand I also think it is incredibly useful right at the beginning of the students training in medicine, to start thinking about the impact of cultural diversity on both your own values and also how society treats other people. So I think that kind of awareness does need to be built into the curriculum. It’s finding the balance between, a sort of understanding that people might have some, the way that students talk about it is it’s often a common sense notion, which I think is dangerous in some ways, because it implies they don’t need to learn it anymore, that they know it all, and there is some truth
in that. So I think it’s getting some balance. I think it is very important to teach it in really quite a structured way and mix of quite sort of knowledge-base and academic research, academic learning, but also the kind of group work which is actually about exploring people’s own attitudes” (R14: Diversity teacher)

“I have Caucasian-based views, which will surface, and unless I am conscious of them they will hang around and equally all our tutors are similar to me, then all of that is going to be playing a part. I mean clearly we need to have some training sessions for tutors, but we need to do that on everything and we can’t. So we kind of run with the fact that they are conscious, reflective clinicians” (R21: Diversity teacher)

This makes the assumption that people of the same origin share the same beliefs and values. However, it also openly acknowledges that teachers’ perspectives colour the contents. This was not widely recognised. There was some limited understanding that the lack of educational clarity has affected the contents and delivery of specific programmes.

9.2 Learning outcomes

In this section respondents’ views about the learning outcomes are reported and these were divided into those focusing on communication, knowledge based and mixed. Many (23; 2 communication teachers; 3 curricula heads; 3 diversity teachers; 7 policymakers; 1 researcher; 2 students and 5 users) respondents focused on communication-based learning and responses were spread evenly across the sample between the ‘cultural sensibility’ and ‘cultural expertise’ approaches. Seven of the 14 who considered the understanding of self as the main focus, which is consistent with the ‘cultural sensibility’ model, were diversity teachers both clinical and non-clinical:

“I think we ought to ideally be thinking about identity and what we actually mean by it, but that has implications of, you know, social sciences resources and how much do we bring into the curriculum and all that, and how we integrate it. But that’s the crux of it, it’s identity, and the other labels sort of spin off from that and you can build on that”

(R17: Diversity teacher)
"The other big bit I think is about learning, about being non-judgemental and not discriminating and really that’s part of being a professional doctor” (R27: Diversity teacher)

Implied in both these responses are that ‘cultural diversity’ components are an integral part of all training. The others who felt learning should be about one’s own understanding were a communication teacher, a curriculum head, 3 policymakers and 2 students.

"Teach principles around effective communication skills. Alternative ways of looking at different perspectives whether [teaching] is clinical communication or any other kind of communication” (R2: Communication teacher)

"Making education patient-centred and making it individual-based treatment. Make medical students see that individuals have different perspectives, see the world from their own perspective and understand there are other perspectives so student/doctor perspective not only perspective” (R34: Policymaker)

One communication teacher and 1 policymaker felt that communication teaching and ‘cultural diversity’ were the same and thereby should have similar outcomes. Thirteen (2 communication teachers; 2 curricula heads; 3 diversity teachers; 4 policymakers and 2 students saw it more as essentially knowledge about other groups, in line with the ‘cultural expertise’ approach. Eleven (1 communication teacher; 1 curriculum head; 1 diversity teacher; 4 policymakers; 1 researcher; 1 students and 2 users) gave responses that were not in line with ‘cultural expertise’ but rather a general kind of cultural sensitivity:

“I think it’s much more important to give people competence in the differences about cultural diversity, to deal with culture, to find out, to have a degree of sensitivity about it, rather than to have learned a, b, and c about the three most important cultures of this country” (R41: Policymaker)

In summary, nearly one third of respondents viewed the learning outcomes as based on the process of acquiring communication skills. This is more consistent with ‘cultural
sensibility’ than ‘cultural expertise’ and demonstrates that respondents move between the models, highlighting the lack of a coherent model.

9.3 Course content
Many respondents gave a fairly broad response to the question “What do you think should be taught at undergraduate level about cultural diversity?” and also said how they thought ‘cultural diversity’ should be taught. No respondent separated the response into knowledge, skills and attitudes. Responses included:

- Externalised the teaching of ‘cultural diversity’ and perceived it as learning about groups of others (22; 2 communication teachers; 2 curricular heads; 4 diversity teachers; 8 policymakers; 5 students and a user)
- Unsure (5; 1 policymaker; 2 students; 2 users)
- Sociological issues (3 all non-clinical)
- Contradictory answers (6)

Many respondents (24; 2 communication teachers; 3 curricular heads; 7 diversity teachers; 5 policymakers; 1 researcher; 2 students and 4 users) focused on the process; 1 of these felt it might be unhelpful to focus too strongly on process without considering outcomes. The processes mentioned included an understanding of self in relation to others and also an understanding of patient rather than service-centred approaches. Six respondents from across the sample were very clear that students should be learning about people as individuals and 2 of these were users who were keen for patients to be seen as people rather than bodies.

“Everyone has got their own cultural background or they are bringing their cultural baggage and beliefs to the doctor patient interaction and it’s obviously important to consider that issue with every single patient you see not just the ethnic minority patient”
(R22: Diversity teacher)

This highlights the perspective that all patients have a sense of culture, which may need exploration and is consistent with ‘cultural sensibility’.
"Can you have courses which say well people with a particular ethnic origin are going to have this, that and the other experiences, is that just stereotyping those people? So, I'm not sure. I think it still needs a lot of thinking about. Probably what is needed is a general awareness of actually listening to people's personal experiences and not categorising them. It might be as simple as that. I can see that it could be a really big problem, if medical students think they know everything about say what an Asian woman's experience is and then placed that on to a particular Asian woman who may not have had that experience. They may just think that they know a lot, and actually still not be prepared to open their ears and listen. The diversity of any particular group members and their experience can be enormous, their parents, and how long they have been in this country, whether they have ever lived in their country of origin. The individual differences will be greater than the actual differences that you can attribute to cultural diversity, cultural origin. It's incredibly complicated" (R58: User)

One curriculum head and 1 policymaker believed that, in many contexts, the contents could just be ‘picked up’ (e.g. through living in a multicultural area); that it did not need to be directly covered with another respondent, suggesting that parts needed to be taught but the rest could be observed as part of everyday life. This supports those perspectives who believe ‘cultural diversity’ teaching is merely common sense.

“One is to make sure that, particularly in areas where they may not know to pick this up naturally, then there is a didactic element to it, to learn to that extent, be taught” (R30: Policymaker)

In terms of philosophy regarding what should be taught, there was often a struggle to be precise. There was a concern that focusing on groups may lead to stereotyping, but equally there seemed a need to provide information about groups to feel reassured that teaching aims had been achieved.

In response to the more specific question as to “What main topics do you think that cultural diversity teaching should encompass at undergraduate level?” responses included:
- Race and other aspects of diversity (35; 3 communication teachers; 5 curricular heads; 11 diversity teachers; 8 policymakers; 1 researcher; 4 students and 3 users)
• An awareness of the issue (15; 1 communication teacher; 4 curricula heads; 3 diversity teachers; 4 policymakers; 2 students and 2 users)

• Communication skills (13; 3 curricula heads; 1 diversity teacher; 2 policymakers; 1 researcher, 3 students; and 1 user)

• Self-reflection specifically (9; 3 diversity teachers; 4 policymakers; 1 researcher and 1 student)

• Learn to ask the right kinds of questions (3; 1 communication teacher and 2 curricula heads)

Five respondents were specific about what should not be taught. Three (a communication teacher, a curriculum head and a diversity teacher) felt it was not just about giving information about specific groups, a student felt that it should not be a forum for religious education, and a policymaker felt that using a cookbook approach would be unhelpful. Only a communication teacher mentioned just race and ethnicity. Those that focused on process suggested issues rather than groups and did not focus on the details about groups:

"I think, at undergraduate level, you need to start getting people to think about who they are, where they come from, looking at their own cultural conditioning, although the background they're from, but looking at their own cultural conditioning and how that affects the way they respond to individuals. Now it might affect the way you respond to other cultures, to class differences, gender, whatever, but that's the start, learning who they are and how to affect the way they respond and their attitudes and everything. The other big bit I think is about learning, about being non-judgemental and not discriminating and really that's part of being a professional doctor" (R27: Diversity teacher)

"I think I would see it more as encouraging and questioning attitude rather than some kind of rote learning of facts...I think there is a danger in, there is a difficult balance between giving people enough information that they feel sort of confident, but without giving them so much information they feel they understand other people just by virtue of the fact they can check a list of facts about them. So I think it would be more the approach that says 'you're the expert in you so tell me about you'" (R8: Curriculum head)
The issue of what constitutes the right information and how much is enough, remains open. Four respondents felt that ‘cultural diversity’ needs to be given a priority in the curriculum and that the contents should build on what students bring, while 2 stated that this may also involve some unlearning. In some ways, this can be viewed as a slight contradiction, i.e. we build on what they bring, but we also help them unlearn what they have brought. In practice, however, the starting point may need to be students understanding what they bring; unless there is first clarity about this, other learning processes are unlikely to occur effectively (Gagne, 1971).

“I think people are brought up from different origins to believe different things so there is quite a lot of learning and unlearning to do in achieving a view of the society we are trying to create and comparing that with the society we have got and endeavouring to narrow the gap... ... I don’t think, there was not much of this in my undergraduate course, but I think we almost need a kind of grounder in the humanities broadly put as a part of our introduction to the medical curriculum. Now again that doesn’t mean stamping views on people, but it does mean introducing them to a range of material so they are able to pick and choose what it is they take with them into their clinical practice”
(R45: Policymaker)

This implies that clinicians are aware of the different factors that influence their practice. Even when awareness was suggested, there was a sense that some of it was still about the context of us (our values) versus them (their values). However, whilst there was often a sense of them, in all but 1 case this did not appear to reflect a pejorative or negative or disrespectful perspective of them but more of a difference and an oversimplification. There was little consideration about what actually constitutes the other. There was no mention of similarities. Only 1 diversity teacher included legalisation issues as part of the contents because this reflected the local course although; 2 other diversity teachers mentioned it. The Race Relations Amendment Act (Home Office, 2000) places statutory responsibility on organisations to ensure they are proactive in addressing issues of racism.

Only a diversity teacher suggested that students could read texts to obtain background knowledge. These issues are particularly relevant if transformative or self-reflective models of learning are applied. In these models, students are guided towards learning rather than being taught what they might need. Here there needs to be clarity about what
students are taught in a formal setting and what they might be expected to achieve through self-learning. However, it is unclear whether effective communication can be achieved in the absence of self-reflection as effective communication needs an individual to acknowledge their personal influence on an interaction.

Concerns were expressed by the same communication teacher who thought teaching should focus on facts about specific ethnic groups, about students needing to learn what were seen as potential gaffes:

"...Patients beliefs are very important aren't they and we are always encouraged to look at patients’ beliefs and understandings. And in fairness, the practice that I’m at, we don’t have a lot of issues with different cultures. Most are Caucasian people, so there is not a problem from that point of view but when you do come across it I personally find it difficult because you are not familiar with all their cultural beliefs and habits. That can be a disadvantage, particularly if you are working in that kind of environment. What needs to be taught? I’ve said their beliefs, a bit about their culture so that you can understand what is appropriate and what is not appropriate within certain cultures. I mean at one practice I went to it is inappropriate to offer a handshake. That’s an insult apparently, but I don’t know that as fact, that’s what I was told. I think it may be important about how you, ways it’s appropriate to examine and who to examine and who has to be there. I’ve no idea about that. Those are the sort of things that I’m thinking about, everyday contact with different cultures and knowing what’s appropriate and what’s not appropriate and what behaviour they think is reasonable behaviour." (R1: Communication teacher)

This kind of response raises the question of how many of our own ‘norms’ do we suspend to accept other ‘norms’. Are we teaching students not to shake hands with non-white people because they may find that offensive? Should we perhaps be asking students to consider how they might manage the situation, as there is unlikely to be a single correct response? Also, what information about ‘their’ cultures is important and who makes that decision. The need to create expert students who never make mistakes is consistent with the ‘cultural expertise’ model. However, some respondents replaced different types of ethnic groups with different types of diversity so that, whilst the range was broader, the focus was still largely information about groups, for example:
"I think it should try and cover them all, cultural differences by ethnicity, sexuality, disability, social class. Social class I think is ignored quite a lot and it is interesting in a couple of weeks we are actually going to run a session on, which was suggested by the students and I think, reading the suggestions, seems like that student's from a working class background so that is quite interesting" (R16: Diversity teacher)

There was mention that there can be too much emphasis on ticking boxes to imply that teaching had been undertaken rather than a commitment to the subject. Interestingly, there were times that medical staff were criticised for using a group-based approach. However, medical staff were not the only ones to do this, as evidenced by the fact that those from other clinical and non-clinical backgrounds also mentioned group-based approaches.

There were few respondents who viewed 'cultural diversity' consistent with the 'cultural sensibility' model but still felt under pressure to give students factual information.

"...I think certainly what we sort of talk to students about is the fact that prejudice is a normal almost phenomenon and everybody has prejudices and it's important to be reflective about those and to understand them, not to let them as enshrined in good medical practice, the GMC's good medical practice, not to let them get in the way, you are entitled to your attitude, but you mustn't manifest it in behaviour, it could disadvantage somebody. So I think a lot of what we should be teaching about diversity is to do with attitudes and reflective practice, and then there are factual things I suppose, or broad kind of factual issues. I mean, you may want to come on to this, but I will say it now, one of the things that we struggle with is the students are always asking us for detail. How do you relate to a Muslim? What do you do if somebody is wearing a funny hat or a sari? And we've tried to set back from that and say that is actually missing the point. Notwithstanding that, it is important for a student or a doctor working in an area with a particular ethnic minority groups, or working with particular minority groups, to understand something about the culture" (R23: Diversity teacher)

Only a few (5; 2 communication teachers; 1 curriculum head and 2 diversity teachers) of the respondents were happy not providing facts in diversity teaching. There is less emphasis in the contents on individuals challenging their own perspectives about doctors
and the tendency to view them as a homogenous group. There was also a view that part of the focus may be on normalising prejudice (that is acknowledging that most individuals have prejudices and that it is not abnormal to have them) and not preaching at students. This respondent was also aware of the difficulties in resisting the pressure from students to provide clear-cut answers and focus on information about groups. There was less discussion about student ideas could be challenged.

Some ideas about the contents were practical rather than based in any clear philosophy:

"I don't think we can really expect every student to know everything about say different cultures, religiously and socially. I think it's getting them aware that there are differences and as doctors they have got to respond to those and they have got to look at their own prejudices and communication skills within those groups" (R25: Diversity teacher)

This implies that time and curriculum space were the issues that limited what could be taught. There does not appear to be a philosophy that learning facts about groups may be unhelpful. There was also a perceived hierarchy of needs of groups, i.e. large groups of minorities warranted more curriculum space, suggesting that the needs of those from other groups are less of a priority:

"...Because there could be some basics and some main groups because there are large groups of certain ethnic groups and certain cultural groups" (R35: Policymaker)

This approach is consistent with 'cultural expertise', which focuses on the local needs and may be taught in a way that reinforces student stereotypes. Focusing on teaching about minorities serves to marginalise this area and to create unhelpful divisions that fuel the 'them and us' lobbyists. The approach is still one-sided and few questions are asked about the unhelpful stereotypes that might be held about 'whites'; for example, whites do not look after their elderly relatives, or pejorative views about perceived promiscuity of 'western' lifestyles. In summary, there was superficially some similarity in what respondents considered needed to be taught with just over one-third focusing on the process and a similar number on students learning about groups. Only one-fifth of respondents focused on the specific skills of self-reflection and/or modes of questioning.
However, when this was explored there was greater variety, which may reflect individual concerns and priorities.

9.3.1 Other contents

As well as teaching about race and other aspects of diversity, other specific suggestions were also made. A student and a policymaker mentioned working with interpreters and a further 4 (3 of whom were students) mentioned learning minority languages. This is different to the US where working with interpreters is a common feature of ‘cultural diversity’ learning (AMA, 1999: 94). There was also some confusion between diversity and international health. This implies that to some diversity equates with foreignness and difference. It also becomes a study of preparing students to work with medical illnesses related to different climates and social contexts but does not necessarily challenge students do consider their own impact on the consultation process.

“I really think needs to be expanded is our experience of international health which in a way is an automatic follow on from cultural diversity. But of course then you have got to be going abroad and because you can’t practice medicine any more on national boundaries. I wouldn’t say I could stipulate now how much of the curriculum, I think if learning about, if all this learning could be integrated throughout the curriculum then there doesn’t need to be a set time. I definitely think that we need to have very sort of specific lectures and teachings on this, religions, on the efforts you make within those religions, from people with experience of the main ethnic differences, and cultural differences and they should be a set period. I really can’t see any less than a week spread over the entire degree, specifically on cultural teaching. But, ideally I would like to see it integrated throughout the medical curriculum” (R49: Student)

A communication teacher, 2 curriculum heads and a diversity teacher specifically commented that teaching should not be on what specific groups did as highlighted below:

“What I don’t think should happen is that people learn that this is what Muslims do on a Thursday or whatever” (R27: Diversity teacher)
Programme contents did not necessarily relate to overall curriculum design or policies, which were often unclear about 'cultural diversity' teaching. In terms of what should be taught and how, there was little reference to any formal evidence-base. Few held a 'cultural sensibility' approach, conversely many did not hold a clearly 'cultural expertise' approach either as discussed in chapter seven. Students were more likely to hold a 'cultural expertise' approach especially with respect to religions. Teachers expressed the conflicts with which they are presented, in that they sometimes gave students wanted what students wanted rather than what they as teachers believed was necessary. This, in turn, suggests that there is a need to help students learn about learning, and that insufficient time is being spent on ensuring students address their biases and understand how these may influence their behaviour in clinical practice.

Overall, there was no consistency in the views about educational content that aligned specifically with either 'cultural expertise' or 'cultural sensibility'. However, most respondents gave responses that were consistent with 'cultural expertise', that is the contents should be specific to local needs and that facts needed to be learned about others. Communities tended to be seen as made of groups rather than individuals. Those who intimated a group-focus seemed less aware that the limitations and difficulties of teaching about different 'ethnic' groups apply equally to groups identified by criteria other than ethnicity. There was little awareness that 'cultural diversity' might be addressed effectively if it were taught as a conceptual process. This might enable it to be generalised to aspects of diversity beyond ethnicity, consistent not only with 'cultural sensibility' but also with the spirit of Tomorrow's Doctors (GMC, 1993 and 2002). If not, the content may merely reflect the topics currently high on the political agenda and be viewed in abstract.

9.4 Teaching methods

When asked about teaching methods most respondents (30; 4 communication teachers; 8 diversity teachers; 10 policymakers; 1 researcher; 5 students and 2 users) gave between 3 and 5 teaching strategies that might be useful, and 27 (2 communication teachers; 5 curricula heads; 6 diversity teachers; 7 policymaker; 2 students and 5 users) gave 1-2 methods, with only 1 respondent giving just one method. Two curricula heads and 1
researcher gave more than 5 teaching strategies. Reflected in those who suggested fewer methods was less teaching experience.

The following was a fairly typical response.

"I would say I think in a number of different ways. I mean there are obviously things that can be put across, large group kind of lecture type of format but I think one would hope that that kind of thing would be kept to a minimum although possibly increasing student numbers and diminishing resource, that’s probably rather a big wish, but I think also through exposure... I think also use role play so that the students can actually sort of engage in some of the issues and anything really that involves the students to a greater extent than merely sitting, listening and taking notes in the sort of traditional didactic way. I mean the students do have quite a lot of community exposure. I know in Year 2 it’s always a particular issue on the diversity side of things" (R3: Communication teacher)

The variety of teaching methods implies moving beyond giving students factual information; this is more consistent with ‘cultural sensibility’. It is perhaps also useful to consider approaches and issues that were felt to be unhelpful in teaching ‘cultural diversity’. Perhaps surprisingly only 4 respondents commented on this:

“They were talking about things like should call coffee black or white and, it made some of the people so angry that they were just OFF race awareness forever and they thought it was a load of crap. It trivialises it” (R27: Diversity teacher)

“The thing was, it really pissed me off to be honest, was, and it was forceful, and I don’t feel guilty about saying it was forceful because I remember one specific session which pissed me off. It was about how powerful language is, which it is, but you can’t use terms such as brainstorming any more because epileptics are going to be offended, and actually one of the facilitators said keeping abreast of the idea could be very damaging to patients who have had a mastectomy, because the word breast comes up and yeah that could happen, but we can’t go round living in this kind of paranoid state” (R51: Student)

These were seen as inappropriately focusing on language at the expense of the more important issues at hand. This is consistent with the findings of the SCMH (2002), which
found that these approaches gave ammunition to those who wanted to remove training from the agenda. It can be inferred that respondents found it difficult when marginalisation occurred in training that was supposed to explore different perspectives and value them. However, there were clear messages about whose perspectives were ‘right’ and certain perspectives more valid than others. This is contradictory to the philosophy behind a ‘cultural sensibility’ approach educational model. Legally, certain behaviours are unacceptable but in the context of learning, facilitators need to be open to exploring all perspectives.

9.4.1 Specific teaching strategies

Respondents were asked to state which teaching strategies they might use and more than one response was possible. Thirty (4 communication teachers; 4 curricula heads; 11 diversity teachers; 7 policymakers; 3 students and 1 user) justified the use of small group work to help students explore and discuss the issues. Some felt that lectures and other didactic teaching should support this but some (a diversity teacher, a policymaker and a student) felt that lectures had no place in ‘cultural diversity’ teaching. Nineteen respondents (1 communication teacher; 7 diversity teachers; 9 policymakers; 1 researcher and 1 student) included lectures suggesting that they wanted some facts or information to be taught although no-one said only lectures. Seven of these policymakers were clinicians.

Twenty respondents (2 communication teachers; 3 curricula heads; 2 diversity teachers; 6 policymakers; 4 students and 3 users) suggested community placements. However, the justification for this was variable ranging from talking to individuals representatives of their community (1 policymaker and 1 student), to talking to those that are different from oneself in order to give students experience of the wider community (2 users). Seventeen respondents (2 communication teachers; 2 curricula heads; 5 diversity teachers; 4 policymakers; 3 students and 1 user) felt that students had to have experience of actually talking to diverse communities or dealing with it clinically. A student felt that experience can be good or bad and that experience in itself was not enough. He particularly wanted time for discussion and reflection. Clinical contexts were suggested by 18 respondents (3 communication teachers; 2 curricula heads; 4 diversity teachers; 3 policymakers; 2 researchers, 2 students and 2 users). Of these 9 were clinicians.
"I think they have actually got to DO it. They have got to practice doing difficult consultations. They have got to get feedback on their practice. They need to be supported and encouraged to feel confident and OK about themselves in order to be able to operate better with anybody" (R2: Communication teacher)

This is consistent with students wanting an experiential approach. Students, however, did not mention theoretical underpinnings or other teaching to perhaps support the experiential learning. Two communication teachers, 2 diversity teachers and 1 student mentioned role-play which could be a safer method of offering experience. A communication teacher and a diversity teacher, both of whom had much experience of working with simulated patients in communication skills, touched on the expense of using simulated patients. One of these discussed the skills needed by simulated patients, and why they might be more appropriate than real patients in detail:

"Well I will see a professional actor undergo they will usually have some formal training, during which a lot of the focus from the training practice is in terms of, is actually an increased awareness of yourself. As a trained actor you get an increased awareness of yourself, so you work out what is you, the way you react and the way you impact on others, because through understanding that you can then learn how to take on somebody else and leave the bits of yourself behind so you can then take on others, so you also do a lot of work on empathy and being real and being believed, whereas if you take a lay person who has never done acting training usually they will just stick on a hat and, it's not quite the same as believing...Actors allow them [students] to struggle enough so that the teaching points are there, but not so they are completely destroyed" (R19: Diversity teacher)

This suggests that those participating know how to be effective facilitators as this may influence ‘cultural diversity’ teaching. Effective facilitators are more likely to engage students in constructive debate and encourage them to self-reflect and share their perspective than tutors who are didactic. Interestingly at a time when interdisciplinary education is high on both political and educational agendas, only three respondents, all policymakers, mentioned this. This may reflect the uncertainty there is about the agenda behind the political support for interdisciplinary education. There have been concerns
expressed that part of the agenda is about covertly changing health professions and producing generic health workers with less professionalisation (Hale, 2004). In summary a variety of teaching strategies were identified as being in use and viewed as appropriate.

9.5 Community involvement

In this study, most respondents discussed the community in relation to the community’s role as potential teachers. Given the high priority of public involvement on the political agenda (DoH, 2003), it is unsurprising that many (33) respondents suggested community involvement as well as involvement of others in the teaching of ‘cultural diversity’ although only 6 (1 diversity teacher; 2 policymakers; 1 student and 2 users) gave only the community as a response. Who in the community should be involved and what the nature of such involvement should be was less clear:

“I think representatives from many different cultures, both at a teacher trainer level and at a patient carer level and a community leader level” (R44: Policymaker)

“There are people who belong to the [any minority] culture who have the teaching skills, that’s not necessarily easy to identify, but people who can provide information and understanding. Then there are people who are outside the culture who have become interested in it and can provide an outside view of it and how it impacts on them. You need both, and of course unless you get people who are able and skilled as teachers then you could end up with a disaster, but you, if you like, you don’t want it taught as an anthropological exercise by somebody who has just been an observer from outside. That would not be good. Although there is an element, I think we need to get across some basic facts because it’s amazing how little some people know” (R40: Policymaker)

“Well, we take advantage of being fashionable, you know to have patient groups involved, we take full advantage of that, we would be silly not to” (R60: User), but questioned whether an individual could really be representative of broad heterogeneous groups.
“It could be being a member of a particular cultural group, and coming with that hat on [belonging to a particular culture], so coming in from the community” (R24: Diversity teacher)

All these have the ‘ethnic’ community member in the role of expert, which is consistent with ‘cultural expertise’. One respondent wondered whether or not groups were really served by individuals with their own interest at heart.

“Well they used to say that the person who did the least help to help the career of the ordinary woman was Maggie Thatcher, so there will be an element of that, so that any particular group often don’t have mainstream troops” (R30: Policymaker)

This implies that those perceived to be similar because of one characteristic may have little else in common as highlighted below:

“I would have them, not so much taught, but actually have so many people come in from different ethnic groups, from different categories, whether that be mental health, whether that be chronic heart disease, or whatever, and have them give their experience of culture, the varying diversities. No two black people are the same, and trying to pigeon-hole me as a black person, I would say, no I’m black British and yet somebody who is born in Britain would class themselves as black Caribbean, and identify with that first. So it would having that actually at play in front of them so a little exercise for them. There are 2 people here from the same, look the same or the same colour, but they are saying something totally different” (R57: User)

A few respondents mentioned religious and community leaders, with only 1 considering any potential difficulties or disadvantages of this approach. This is more consistent with ‘cultural expertise’. However, some respondents did state that there was a need to ensure that community involvement was considered carefully and only used when appropriate. There was awareness that community participants might, like any other individual, have specific agendas and not relate them to learning outcomes or student needs. Interestingly, no-one suggested that community involvement could be used to provide examples of when patients had felt their ‘cultural needs’ had been met and how this had happened. In
summary, there was consensus that the community should be involved in ‘cultural diversity’ teaching although the exact role was not clear.

9.6 Analysis of the contents and delivery of ‘cultural diversity’ learning and teaching

Chapter Seven presented the argument that political agendas have driven ‘cultural diversity’ teaching rather than educational ones. There has been a tendency to view individuals as members of discrete groups who have similar needs because of a shared ethnic origin. However, respondents wanted the contents of programmes to be process based. The lack of any coherent educational models to date has led to a lack of clarity about what needs to be taught let alone how it should be taught. There are those approaches that want students to feel comfortable and armed with knowledge about how to work with those perceived to be different based on ethnicity or skin colour but there are also those who feel students would be helped most by realising the realities of clinical practice. This section argues that unclear educational agendas have led to muddled teaching strategies which have, in turn, led to programmes that serve to reduce student anxiety. They also lead to ‘cultural diversity’ teachers delivering information despite their view that this is inappropriate.

9.6.1 Teaching strategies

The teaching strategies were not always consistent with the educational philosophy, the organisation or the desired learning outcomes. Those who believed that ‘cultural diversity’ teaching needs to be principle rather than fact-based were also likely to believe that students needed to learn about how to learn and that this was fundamental to their beliefs. Yet this is not something they felt was being delivered by many schools. Despite claims by many schools that they focus on learning about learning, this usually means learning about how to use libraries and computers (e.g. University of Leicester and University of Sheffield websites). Kaufman et al (2000) argued that if educational theory is applied, students need to be given opportunities to consider their learning. This is not happening in practice as far as the respondents were concerned. This again reflects inconsistencies that have arisen.
Some respondents perceive experience is in itself an effective educational tool. However, there are inherent difficulties with this approach, which is often welcomed by students because it feels ‘real’ and is like being on the job. But if medical students can be thrown into the deep end and start interviewing patients on the basis of fulfilling admission criteria, then why train them at all? Experience without a context or clarity of purpose may mean students enjoy themselves as they feel they are role-playing their future but it does not ensure that they are necessarily learning what they need to learn (Dogra, 1999). This reflects the confusion that exists in this area and raises the question why is there so much confusion? The answer may lie in the lack of a systematic approach and coherent educational plans.

It was unclear why respondents thought patients are better able to train in ‘cultural diversity’, although this may relate to a perception that belonging to a group constitutes expertise. No-one questioned whether patients have considered their own biases and prejudices and how this might affect the teaching. One respondent felt that community representatives should teach. This respondent had earlier stated that no two individuals from the same community were likely to be the same and the idea of an individual representing ethnicity was unhelpful. Community members are often perceived as representatives of their group, although it is difficult to see how one individual can represent diversity. They can certainly share their perspective but whether they can be considered representative of a heterogeneous group is questionable. To view an individual as being a representative of heterogeneous groups runs the risk of the groups being viewed homogenously and confirming stereotyping, e.g. exposing a student to a Bangladeshi family as their exposure to diversity implies that other Bangladeshi families will be the same. That is not to say that community involvement in this way is not useful, but rather that it has only limited use. One respondent suggested comparing two individuals, who outwardly came from the same group, but presented different perspectives to emphasise the fact that no two people will be exactly the same.

Individuals may be seen as representative of ‘their community’ as though individuals have only one facet to their identity. There is also a reification of that individual perspective of an objective presentation of the reality in the community. User involvement is currently very fashionable, but whilst some initial findings are helpful in that patients valued their role in teaching (Walters et al, 2003), the issue needs to be
applied clearly and carefully. Like all other strategies, it needs to be used in the correct way, situations and context. Those planning curricula need to think carefully about what patients/users are asked to do and whether or not they have the appropriate training to participate and any ethical issues that may need addressing. It may be useful to have examples of patients who found that their needs were met, so that students can begin to identify the skills of a good practitioner, and what patients find helpful and unhelpful. No-one raised the issue of patients being used partly because they are often unpaid and may help keep teaching costs down. It is important that user involvement does not have for reasons of expediency and cost effectiveness at the expense of the subject in hand. An issue not raised was how the community members who participate are selected. It could be argued that a male from an ethnic background may present a very different perspective from a female, or an educated male present a different perspective from one less well educated. Whose perspective is the most valid? Certainly, if there were coherent educational models, the roles of community experts might be questioned and this might be politically unacceptable especially to those who have a vested interest in representing certain perspectives. There was little emphasis in any of the programmes examined towards transformative learning approaches. The organisation and contents of ‘cultural diversity’ are inconsistent with the desired outcomes of being able to deliver individually tailored care.

9.6.2 Inconsistencies in the contents of ‘cultural diversity’ programmes

There were some inconsistencies between the educational process, the learning outcomes and the final contents of programmes. The issue of a knowledge-based education is a difficult one. From students’ responses and some teacher responses it is clear that students often want or need information, which they can recall to feel safe. Few respondents, or the literature, stressed the importance of learning about the ambiguities and uncertainties in clinical practice. Even when some respondents said small groups teaching to promote discussion about students’ own beliefs, there was a sense that the bringing in of an external ‘expert’ supported enabled such discussion. This ‘expert’ related to the issue at hand whether it be ethnic, sexual practice or whatever. This has the potential to externalise diversity and not necessarily challenge the assumptions of teachers or students. It is arguable that the idea of experts in diversity meets political rather than educational aims. No-one raised the issue whether or not teaching in ‘cultural diversity’ is
synonymous with teaching about equality. ‘Cultural diversity’ teaching was seen as playing a part in improving health care through improved communications and not necessarily about better understanding individual patient need. Few teachers felt comfortable letting students struggle.

“So, it doesn’t worry me too much when the students struggle... I think we tread a tightrope between that sort of experiential learning, which in a way is my background, and the students’ desperate need for certainty. I suppose it’s like I’m sort of saying in the back of that book. Experiential learning and confidence in knowing yourself, and that security that they need... here’s a person who is clearly from a different religious background and ethnic background from me, you know, that clothing what does that symbolise, what toes am I going to tread on? And there is a danger of, you know, if they sort of learn half a recipe, it’s worse, learn nothing, then just find out” (R24: Diversity teacher)

“Uncertainty, paradoxical things, chaos is very close to us and existing in that zone of uncertainty is actually what we are asked to do as doctors...” (R45: Policymaker)

Students particularly felt that teaching about religions was important. However, this is easily accessible from written texts. Basic principles can be read about, but it is still preferable to ask what patients want rather than make assumptions. In practice it may be difficult to resist student pressure because to some extent, successes of educational outputs are judged through their feedback. Students wanting facts and certainty are consistent with what is provided in the rest of the curriculum. There is perhaps also a need to ensure that medical curricula do not just focus on the needs or wishes of the most vocal. The way the policies currently stand is as though the needs on non-minorities are being well met so services just have to focus on the needs of minorities.

The view that ‘cultural diversity’ teaching is merely common sense places teachers in a difficult position regarding the contents of such programmes. Given the low status of ‘cultural diversity’ teachers and the lack of credibility of the subject, teachers may feel that by not acquiescing to student demand in providing certainty, their positions are further undermined. Political pressure (including pressure groups) may also force teachers to include contents, which are inconsistent with their educational philosophy thus leading
to educationally incoherent programmes. Leaders of minority groups may not feel that a principle-based approach sufficiently addressed their concerns, so teachers may feel pressured to include information about several groups to demonstrate collaboration. Again political agendas may influence the educational programme more than educational ideas. Stating that all patients are individuals but then teaching about people as belonging to groups might also undermine credibility.

9.7 Conclusion

In summary, there were two main trains of thought regarding the content of ‘cultural diversity’ teaching, which to some extent, reflect the models of ‘cultural expertise’ and ‘cultural sensibility’. The first focused on principles and exploration of student understanding of key issues. The second focused on contents and consideration of group needs. A wide range of teaching strategies was felt to be potentially useful. There was consensus that the community should be involved in ‘cultural diversity’ teaching although the exact role was not clear. Inclusion of community participation appears to be more for political rather than educational reasons. There are sound educational reasons for involving the community but these were not articulated.

Again there is a mismatch between what is being taught and what should be taught. This may relate to the lack of any educational models. Teachers may unknowingly borrow from different approaches and end up with contents that are inconsistent with the educational philosophy. The literature and this research show that the contents of most programmes are based on the basic principle that individuals belong to groups who, on the basis of a shared characteristic such as ethnicity, have similar needs. Yet whilst this is the driving force, there is also a wish to develop a process-based approach. There was little emphasis in any of the programmes examined towards transformative learning approaches. The organisation and contents of ‘cultural diversity’ are inconsistent with the desired outcomes of being able to deliver individually tailored care. As there is variability in the contents of the programmes and their delivery, this is likely to affect the outcomes, which are discussed next.
Chapter 10: Findings and discussion relating to assessment and outcomes

Chapter Ten focuses on the findings relating to assessment and outcomes as well as considering issues raised for students as a result of ‘cultural diversity’ teaching. The chapter then presents the argument that concern about student feedback may override a coherent educational approach. Teachers’ concerns about negative student feedback may lead them to devise teaching that is inconsistent with the educational philosophy or model that drives other aspects of the teaching. It is proposed that ambivalence about how to assess students and what should happen to students who fail ‘cultural diversity’ gives mixed messages and undermines those who are trying to teach it. The effect on clinical practice is unclear and yet ‘cultural diversity’ education is being advocated for inclusion in the curriculum (contrary to evidence-based approach)

10.1 Assessment

This section reports on the findings relating to whether or not respondents felt students should be assessed about cultural ‘diversity’ and how they might be assessed. Justifications for their reasoning are also given. Fifty-four (6 communication teachers; 7 curricula heads; 13 diversity teachers; 15 policymakers, 2 researchers, 4 students and 7 users) of the participants stated that students should be assessed on ‘cultural diversity’. Of these 3 communication teachers; 4 curricular heads; 6 diversity teachers; 4 policymakers; 1 researcher, 2 students and 1 user felt the subject needed to be examined if students were going to take it as seriously as other parts of the curriculum. Five respondents from different groups felt assessment in ‘cultural diversity’ should carry the same weight as other assessments. There was greater variation regarding the rationale for assessing students, ranging from pragmatic (that is assessments still drive learning) to helping students learn how to learn. There were educationally-based responses too, such as the need to ensure that learning outcomes are successfully being met, to impress upon students the relevance and merit of the subject.

“Things they are not assessed on, they don’t learn” (R47: Researcher)
"Yes. They are assessed about every other part of their learning and this seems to me one of the most important areas. I think we are too hung up with students about assessing purely theoretical knowledge, we don't spend enough time thinking about how we assess their attitudes and the way they go about doing things" (R44: Policymaker)

Of the remaining 7 (3 diversity teachers; 2 policymakers and 2 students) 2 were unsure, a diversity teacher felt that assessment should be formative rather than summative, 1 did not think students should be assessed, and 2 students gave a mixed response.

"I think perhaps not summative assessment, but formative perhaps, you know, so that you, for example, could perhaps have a video for the consultation, with an interpreter, perhaps that's something that can be done, fairly far on through the medical curriculum, and feedback on that, but helpful positive feedback about their strengths" (R27: Diversity teacher)

"Exams have a slightly negative effect I think, and I just see it as being, if I've got to learn about, let's say Mormons, does that make me feel empathetic towards them, or rather angry that I have got to learn about them because I am being assessed about it. I actually think it might have an adverse effect" (R40: Policymaker)

"Officially, probably yes. Unofficially, no, it's probably a waste of time to an extent, in a way that, the way that medical education is moving onto there isn't the space for anything other than multiple-choices and tick boxes and stuff like that and I think in some ways it reduces the importance if all you are going to do is have an MCQ. I mean I agree if you come up with good questions, then it could be worthwhile, but having things like, should you be exceptionally rude to someone based on their race, and unfortunately the questions that I've seen that are being used tend to be that sort of thing, are not very well structured, rather than actually showing any reflection" (R54: Student)

"I think some basic understanding of certain, say key religious groups, isn't an unreasonable expectation to have of students and you could do that quite easily in an MCQ. If students know it will come up in an exam they might actually make an effort". (R53: Student)
This last response suggests a ‘cultural expertise’ approach and suggests that the respondent accepts that knowing key facts about religions on a general basis means that the student is aware of the effect of this on individual lives. The respondent who did not feel an assessment was appropriate gave an interesting response.

“No, I don’t [because] I think it is very difficult to assess. I think it is wrong to assess someone’s views. I think it is right to assess how somebody would act on their views if they were in a difficult situation, so maybe you know, I mean the standard thing is if you are in a difficult situation with a patient, whatever reason, you go to your next senior person or you hand over to somebody else, and that’s not something you can assess in any kind of generalised assessment. But I think sort of a formal exam is wrong and I think it gives the wrong impression about the way you are teaching” (R51: Student)

This suggests that an assessment supporting a ‘cultural expertise’ approach is inappropriate, and that no assessment is better than a poor one. There was less consistency on how students might be assessed and what assessment methods had been proven effective. Six respondents were unsure about the types of assessments that might be most appropriate, and 2 felt that formative assessments were more appropriate. Fifteen gave more than one suggestion. The following suggestions were made:

- OSCES (28; 2 communication teachers; 7 curricula heads; 9 diversity teachers; 5 policymakers and 1 student)
- Test knowledge through multiple-choice question (MCQ) and short answer question (SAQ) (15; 4 curricula heads; 6 diversity teachers; 4 policymakers and 1 researcher)
- Clinical scenarios (15; 1 communication teacher; 2 curricula heads; 1 diversity teacher; 4 policymakers; 2 students and 5 users)
- Written paper or portfolio to assess reflection (11; 3 communication teachers; 2 curricula heads; 4 diversity teachers; 1 policymaker and 1 researcher)
- Critical thinking (1); non-specific assessments (2) and continuous assessment (1)

There was a tendency for respondents to relate it to their own experience. All those who said MCQs and SAQ stated that these were reasonable methods to test knowledge. The OSCE situation received the most favourable comments. This was especially for those
who felt diversity should not be assessed as a stand-alone subject as such, but rather in the context of communicating with patients. There were, however, those who felt essays and portfolio or reflective diaries might be better in assessing what learning had taken place. There was a view that with OSCEs (more than perhaps in an essay) students might be more able to give the impression they were sensitive to diversity issues in the exam context. However, there was a concern that what students actually believed was that they needed to do enough to jump the hurdles, rather than undertake learning. In summary the majority of respondents felt that ‘cultural diversity’ should be assessed and the OSCE cited as the most appropriate assessment method although a quarter also cited MCQs and SAQs and clinical scenarios (as distinct from OSCEs).

10.2 Student Feedback

All 61 respondents stated that student feedback should be collected although 5 expressed concern that it might be overdone, and that students may not always give useful feedback as illustrated below.

“I do think you need to listen to it and if there are common things that come out, then it's giving you a message, but they are not always at the level, they don’t appreciate the importance or the impact of what you are expecting them to do and it’s often not until much later that they are going, “Ah, I get it now”. But if we just respond to student feedback initially we could have done ourselves an enormous amount of disservice, because afterwards they go, “Oh, I realise now why you did that and why you did that and now I understand what it's about”” (R2: Communication teacher)

“Yes. It should be gathered if the feedback is going to be used. There is an evaluation culture, just to tick off, I’m not saying this happens particularly in this medical school, but the whole world is questionnaire crazy, and I’m sure it makes not the blindest bit of difference to the outcome” (R4: Communication teacher)

“Yes. I mean, I have got very mixed views on student feedback on teaching because most people don’t fill in the forms and they are usually multiple-choice and people just can’t be bothered and they just sort of go through randomly. I mean I’ve never, I think if I was a
teacher I would never look at student feedback forms to be honest, because I know the way they are filled in" (R51: Student)

In terms of how student feedback might be collected, the following responses were given with many respondents giving more than one response:

- Questionnaires (29; 5 communication teachers; 3 curricula heads; 11 diversity teachers; 4 policymakers; 4 students and 2 users)
- Focus groups (18; 1 communication teacher; 5 curricular heads; 7 diversity teachers; 1 policymaker; 1 researcher; 2 students and 1 user)
- Student representation on committees (12; 2 communication teachers; 3 curricula heads; 1 diversity teacher; 5 policymakers and 1 student)
- Computer feedback (6; 1 communication teacher; 1 curriculum head; 2 diversity teachers; 1 policymaker and 1 student)
- Verbal feedback on one-to-one level (5; 1 in each of curriculum head, diversity teacher; policymaker; student and user)
- Observation of clinical practice (4; 3 policymakers and 1 student)
- Students devise evaluation (2; 1 diversity teacher and 1 policymaker)
- Suggestion box (1 policymaker)
- Pre- and post-measures (1 policymaker)

Feedback was seen to be useful for the following reasons:

- Helps course design (22; 1 communication teacher; 3 curricula heads; 6 diversity teachers; 5 policymakers; 1 researcher; 3 students and 3 users)
- Improves quality of teaching (21; 3 communication teachers; 2 curricular heads; 5 diversity teachers; 7 policymakers; 1 researcher and 3 users)
- Checks whether course aims are being met (9; 2 policymakers and 2 users and 1 in each of the other groups)
- Checks whether the course actually helps students (6; 1 communication teacher; 3 policymakers and 2 students)
- Identifies when things did not go well (5; 2 diversity teachers; 2 students and 1 user)
- Identifies when things went well (2; 1 diversity teacher and 1 policymaker)
- An opportunity to reflect on the course (3 diversity teachers)
• Check on facilities such as rooms etc (1 diversity teacher)
• Enables the creation of a safe learning environment (1 diversity teacher)
• Established whether student needs are being met (1 policymaker).

In summary, all respondents thought that student feedback should be collected and that good feedback supported course design and could improve the quality of teaching.

10.3 In clinical practice

When asked if respondents thought ‘cultural diversity’ teaching actually had an effect on practice, no-one said thought it did not. Thirty-five respondents (2 communication teachers; 3 curricular heads; 9 diversity teachers; 9 policymakers; 1 researcher; 6 students and 5 users) felt that it did improve practice with 2 of these saying only if it was taught properly. Another thought it might, but had some reservations. One respondent gave an affirmative response based on her experience of delivering a postgraduate programme. Another felt that success was dependent on the ethos of the organisation. This is in the absence of any clear evidence that this is the case.

“It is inevitably bound to have, both in terms of how you relate to colleagues and staff as well as how you relate to patients. I think it actually, I think if it is well done it spins off beyond the obvious interface. You get to start seeing people as individuals, not as white or black, or whatever else, but actually as real people and not classify them as Catholics or Irish or whatever. Yes, I think it changes your perspective” (R30: Policymaker)

The desired outcome here is consistent with ‘cultural sensibility’ not only in terms of an individual-based approach, but also in terms of acquiring a method that can be generalised.

“Well I would hope that it would mean that patients would feel that they were valued, that they were listened to, and that they were understood and that hopefully when those things happen patients respond better to whatever advice or however they are treated. Certainly a lot of evidence suggests that when patients feel that they are understood and listened to they comply better to medication for example. I think it would have a huge impact on clinical practice” (R5: Communication teacher)
"I can only talk about our pack because that’s the only one I have got experience of, it’s the only one I have evaluated. In fact people reported quite a lot of things that they changed as a result of being on that. For example a lot of people said that they would find an interpreter, whereas before they might have muddled through. People said they would never use a child to interpret ever again. One nurse said she went and got posters that were more appropriate for the outpatients department. A physiotherapist reported that she changed the graphics used for parents so that some of these graphics had black children in them, so they were acceptable for everybody really. A couple of other people said they felt confident to challenge racism when they saw it. Someone else said he or she had changed the language they used to describe black clients, which was quite interesting. Someone else had gone on to do an audit of his or her service. I think if you do win people over all kinds of things can happen really” (R27: Diversity teacher)

This suggests minor behavioural changes may have significant clinical implications even without any change in attitudes. Ten (1 communication teacher; 2 curricular heads; 1 diversity teacher; 4 policymakers; 1 researcher and 1 user) hoped it made a difference. Nine (2 communication teachers; 1 curricular head; 3 diversity teachers and 3 policymakers did not know. Five (1 communication teacher, 1 curricular head, 2 policymakers and 1 user) were unsure and 1 diversity teacher and 1 student thought it was too early to say. Respondents were also asked how the teaching might affect practice.

"I’m not sure but in my heart I think it must make a difference...I say that because I see some patients here who are Italian or Chinese. Their attitude to life and to disease, and their understanding of what we are saying, even though through an interpreter, it’s not right, so I always feel that I am failing these people [using an interpreter] It’s not the same as them talking to you, it depends how the interpreter understands your question, but that is the only way we can do it at the moment, you know, we can’t have 200 hundred languages” (R29: Policymaker)

In terms of the ways in which ‘cultural diversity’ teaching could affect practice, 6 gave a number of ways in which ‘cultural diversity’ teaching might make an impact and 4 were unsure. Responses included:
- Improved doctor/patient communication (27; 2 communication teachers; 2 curricular heads; 5 diversity teachers; 12 policymakers; 2 students and 4 users)
- Student awareness would be improved about issues related to patients with I stating that this would lead to better communication (16; 1 communication teacher; 2 curricular heads; 6 diversity teachers; 4 policymakers; 1 researcher and 2 students)
- Patient satisfaction might be improved through feeling better heard, valued and understood (5; 1 from 5 different groups; 2 of these also commented on doctor/patient communication and 1 on student awareness)
- Improved sensitivity to patient issues (5; 1 curriculum head; 1 researcher; 1 student and 2 users)
- Teaching in conjunction with role models in practice would lead to better health care (1 diversity teacher and 1 policymaker)
- Better access to care (1 policymaker)

Interestingly, the outcomes in clinical practice were related to a process as opposed to better knowledge with which to serve patients. Few expanded on how ‘cultural diversity’ teaching might improve the doctor-patient relationship that is whether it was through improved knowledge of the patient’s background or through a collaborative partnership with the patient. Students and users were more confident that ‘cultural diversity’ teaching did improve clinical practice. The desired outcomes are more consistent with ‘cultural sensibility’.

Question 25 asked, “In your opinion, how do you think programmes that endeavour to teach cultural diversity might be evaluated?” and was followed by Question 26: “In your opinion, how the impact on clinical practice might be measured?” Respondents often (42) gave one response, which negated the need to ask question 26. Respondents made the following responses to question 25:

- Thought that students needed to be observed in practice to effectively evaluate whether learning outcomes had been successfully met (15; 4 curricula heads; 5 diversity teachers; 3 policymakers; 2 students and 1 user).
- Assessment (14; 1 communication teacher; 1 curricular head; 4 diversity teachers and 3 policymakers. Five of these explicitly stated test knowledge)
• Longer-term evaluations were needed (8; 3 communication teachers; 3 diversity teachers; 1 policymaker and 1 student)
• Evaluation should be related back to the learning outcomes (8; 4 curricular heads; 1 diversity teacher and 3 policymakers)
• Student evaluation forms (5; 1 diversity teacher; 2 policymakers; 1 student and 1 user)
• Asking users (4; 1 communication teacher; 1 diversity teacher; 1 policymaker and 1 student)
• Unsure and thought this would actually be quite difficult (3; 2 policymakers and 1 student)
• Proper research was needed in this area (3; 2 diversity teachers and 1 policymaker)
• Asking employers (2; 1 curricular head and 1 diversity teacher)
• Reflective portfolios (1 diversity teacher and 1 researcher)
• Focus groups (1 communication teacher)

Some examples of responses were:

"Ultimately they have got to be evaluated by whether you get the outcomes that were specified, but of course those outcomes are expressed in practice... I would suspect that the main focus would have to be on I mean senior SHO type of positions where you could get, people have had a chance to reflect. Somehow or another try to get at whether there has been an actual change, but of course you can’t do any of the things you want to do; you can’t do any trials, or anything else. It’s very difficult to try and identify groups who have not been exposed to intervention or randomising in any way, but that’s what you would be looking for...The difficulty here is that senior SHO level is quite a late point at which to offer remedial help" (R10: Curriculum head)

“They could be evaluated by people from culturally diverse backgrounds evaluating them as well. I think it would be important to have their input into the development, rather than just the evaluation” (R11: Curriculum head)

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This statement implied that simply because patients come from the non-majority they are going to be able to effectively decide whether care is appropriate for a range of people some of whom may be very different from them. It does not acknowledge that patients may bring their own biases and prejudices. A patient of Indian origin may rate a ‘black doctor’ as insensitive because the patient does not believe that blacks can be as good doctors as whites or Asians.

“I think that’s, I think this kind of measuring of outcomes is so difficult with something that’s not scientific when all the starting points are going to be different so I think the measuring outcomes has to be looking at it from the perspective of portfolio learning and building up a portfolio. I think it’s a very problematic area and it’s one that needs to be examined more” (R26: Diversity teacher)

This reflects a need for outcomes to be measured in several ways and then triangulated to see whether the initial outcomes have been met.

When asked how the impact on practice might be measured, 32 respondents (4 communication teacher; 2 curricula heads; 8 diversity teachers; 8 policymakers; 6 students and 4 users) thought that user involvement was important. This might be through questionnaires, focus groups or interviews. One respondent felt it important that this be contextualised, and that we needed to be careful, as there may be difference between what patients and doctors regard as effective. Nine (1 curriculum head; 4 diversity teachers; 3 policymakers and I student) thought that students should be observed in practice and a further 2 linked this to the process of revalidation. Four (1 communication teacher; 1 curricular head and 2 diversity teachers) felt that longer-term outcomes were needed and 6 (3 diversity teachers; 2 policymakers and 1 researcher) that effective research was needed. Other responses were: health outcomes but none were specified (4); ask employers (3); unsure (3); self-reflection (3); complaints register (3); OSCES (2); ask students if felt prepared (2); patient care improves (1); audit (1); improved compliance (1) and comparing services with the National Service Framework (1).

One respondent linked undergraduate teaching with the pre-registration house officer years and made suggestions on the effectiveness of teaching in practice, but also that consultants willing to learn could present excellent role modelling opportunities.
"You could say, 'right, regarding Doctor X, how do you think they perform in these particular aspects', so that you would actually have 360° assessment of every single member of the team by everybody else. You could then analyse that because that would give you really quite a strong, because you would be having multiple observations, so that everybody would be feeding back about me, not to me directly, about me, to somebody else, albeit anonymously. It would be scored anonymously. And then at the end of the day if you wished to, you could probably build in a 'if you would like to receive feedback about your own perception of you in this respect, tick here, or not interested, tick here'...
I think questionnaires are hopeless, they just don't fill them in, they are getting questionnaires all the time, people come to them every week, every day, and say can we send a questionnaire about this or this" (R36: Policymaker)

The response below indicates some consistency with an evidence-based approach, and suggests that there is a need for different teaching approaches to be implemented and compared.

"Ideally to have trial evidence for any teaching that we do, but that's obviously difficult, but we don't have to have randomised trials, we can have comparative trials, non-randomised, with one half a year taking a particular model and the other group taking the Model B, and seeing what the outcomes were" (R17: Diversity teacher)

Long-term follow-up of students will not only allow educators to assess whether or not learning outcomes are met, but will also show how learning outcomes are applied in practice. However, this approach is not always practical.

"I suppose it is possible to sample clinical encounters of some kind during pre-registration and beyond to ask patients really whether they felt that their particular concerns or features were listened to and taken seriously. I think it's quite difficult, because even if they are taken seriously it doesn't mean to say that they are properly treated. The thing is, you know Dr Smith is a really good doctor because he refers me to the best specialist, Dr Smith is a really good doctor because he never refers me, he does all the tests himself, I mean you know, what is effective criteria" (R37: Policymaker)
This demonstrates how good clinical care may have different meanings to different patients and is consistent with ‘cultural sensibility’. No-one referred to any external or objective evidence to suggest that beyond students’ own evaluations that learning had made a difference. The ‘cultural sensibility’ model relies heavily on student’s self-assessment of their learning.

“I think, for instance it might be possible during the PRHO year to look at students to see, I mean that would have, the first time that they are in a real context for a prolonged period of time, but actually assessment during a PRHO year could very well focus on how well people have been prepared for this as individuals and how they react as individuals within the PRHO assessment” (R33: Policymaker)

This section has highlighted that despite the lack of evidence available, many respondents felt that clinical practice was improved through ‘cultural diversity teaching’ and this was mostly through improved doctor-patient communication. Just over half of the respondents felt it was necessary to involve users in deciding on whether practice was improved. Several different types of evaluation were suggested.

10.4 Student issues
A number of issues pertaining to students were identified. These included student perspectives on the relevance of ‘cultural diversity’ teaching to their medical training, peer learning, racism within medical student groups, student wishes for a more experiential approach, and to receive information about different groups, especially religions (despite the fact that much of this is accessible in written texts). Student perspectives about their clinical teachers’ understanding of ‘cultural diversity’ were also raised.

10.4.1 Responses if ‘cultural diversity’ teaching perceived as unnecessary
In response to the question “What might be the respondent’s perspectives if students considered teaching in cultural diversity as unnecessary?” the following responses were made (some respondents gave more than one response):
Explore and discuss the issue (26; 4 communication teachers; 3 curricula heads; 7 diversity teachers; 9 policymakers; 2 students and 1 user)

Worry about the type of students being accepted to study medicine (12; 2 curricula heads; 6 policymakers; 1 researcher and 3 users)

Demonstrate the usefulness of the teaching in clinical practice (9; 2 communication teachers; 2 curricular heads, 3 diversity teachers; 1 policymaker and 1 student)

Review the teaching (5; 1 communication teachers; 1 curricular head; 2 policymakers and 1 student. One policymaker stated if the students said there was too much teaching in 'cultural diversity' he would cut back on what was taught

Hard luck and students have to learn to live with it (6; 2 policymakers; 2 students and 2 users)

Consider offering those students more support and teaching (4; 3 diversity teachers and 1 policymaker)

Students had said this (6; 2 curricular heads; 2 diversity teachers and 2 students)

Would be surprised to hear that (3 each from different groups)

View the students as arrogant or short sighted (4; 2 diversity teacher; 1 student and 1 user)

Relate the teaching to the GMC (3; 2 curricular heads and 1 diversity teacher)

Ask students to prove their case (3; 2 communication teachers and 1 researcher)

Justify the teaching position (2; 1 diversity teacher and 1 student)

If said by occasional student then that student has the problem but if said by more, then the course would need to be considered (2; 1 curriculum head and 1 diversity teacher)

Examples of the types of responses were:

“I would say well tough luck chum, we know better than you.......we can use the opportunity [of a student council] to discuss various changes to the course etc, because the staff-student relationship is very important” (R32: Policymaker)

“That's difficult, because when you believe something is, and I am a student myself, you know, I would find the other students like me and say yes it was really good. It's difficult
because it's almost saying well we are saying it is so therefore you should do it, and actually sometimes I think it's OK to say actually you are just students and actually it is important. If they come back in 10 years time and say you know, I've never used any of this cultural crap you taught us, then fair enough, but I don't actually. I still believe that teachers know best ... some of the time” (R51: Student)

The issue of suitability to practice was also raised, for example:

"To be very blunt, I would say they shouldn't be in this class. Attitude is crucial. In undergraduates one always has to have this learning and if one feels that one knows everything, then I think you are limiting yourself" (R55: User)

"Well I'd have deep worries about their ability to be a doctor...I would have thought that those people should have been picked up for many reasons, and worked with, to think on an individual basis about their beliefs and attitudes and why they are saying what they are saying. Not in a confrontational way but in a way which tries to break down some of the problems and work with them on it, because I think that sort of rigidity is probably going to be a reflection of other problems as well” (R44: Policymaker)

Only 1 respondent, a student, said he would be sympathetic to students who felt ‘cultural diversity’ teaching was unnecessary but that it was likely to come from students who needed this teaching, which implied that, others did not.

“\nI might have some sympathy with that. I think it's unlikely to come from the right people. People who say that are people who actually aren't aware of how diverse society is and those who really are into this as a subject, are interested, they can never get enough of it. They really want to learn more about it.” (R53: Student)

Another respondent similarly felt that negative comments about diversity teaching were likely to come from white students whilst 1 respondent was concerned that students might not voice dissenting opinions, for example:

“If a student explicitly said cultural issues did not matter I think that as such would be such an interesting statement that I would invite him again to discuss that. I think it would
be very brave to say that, and there's probably something behind it, and that's something I would like to find out. I haven't come across that so far. What I'm more afraid of is someone who would not be brave enough to stand up against politically correct and get lost with all that cultural stuff” (R41: Policymaker)

There were those who sought to justify its inclusion to students in a variety of ways:

“...if they have really not found it helpful, I would probably be interested to, if I was running the OSCE I would probably say well OK, let's not do it this year, let's run the patient in the OSCE and see how they perform. Let's prove that it's of no value. I'd probably go down that route I think” (R1: Communication teacher)

“I think they would have to be shown examples for it, because we have to obviously convince them. We are in a society and we don't know where they are going to work, and there are problems with diversity. Also disease process in an African and an Indian, it is different and they also suffer from specific conditions, which is not prevalent among the white people. They need to be exposed directly to those conditions then they will see how interesting it is, that I didn't know that, and I think that you have to expose them to the situations” (R29: Policymaker)

Only 1 male policymaker suggested cutting back on teaching if students indicated they felt too much time was being spent on the subject. A male researcher expressed the view that students who least needed teaching in 'cultural diversity' were the ones who selected SSSMs when these were offered.

10.4.2 Learning from peers

Students learning from other students was put forward as a positive way of peer learning by a communication teacher, a curriculum head and 2 students but there was little clarity how they might be effectively used. The curricula head and 1 of the students implied that this meant minority students leading the teaching for majority white students as both commented on needing to use the diversity of ethnicity available. For the student, this was one justification for having ethnic diversity within medical student bodies.
"I think the people you probably learn from the best are your peers. I think it is probably somebody that doesn’t have a direct academic hierarchical standing over you because they can talk to you on a more, you are allowed an opinion, you are allowed to interact, I mean there is some sort of power gradient between lecturers and students." (R52: Student)

This response suggests students may worry about saying the wrong thing in front of teachers; teachers are not viewed as facilitators but more as judges.

"I certainly think that students should be encouraged to go away and explore for themselves what they believe cultural diversity means bearing in mind that a lot of medical students cohorts are very cultural diverse in themselves and it’s often as peer learning, I think that’s very important” (R5: Communication teacher)

Whilst peer learning may be useful, it may be more useful as an adjunct to more formal structured teaching otherwise students may be unclear about what they are expected to learn from their peers. The advantage of learning from peers as a two-way learning opportunity has yet to be exploited. That is, not only are majority students expected to learn about minorities but vice versa. This would support perspectives that ‘cultural diversity’ education is needed for all students as suggested by the ‘cultural sensibility’ model and by Tervalon (2003). There also needs to be some purposive learning. Living in a multicultural society does not in itself breed awareness of our own biases and prejudices or respect for other perspectives.

"I think the first thing I’d like to say is we have a very diverse student body in every sense. Both in terms of ethnicity and gender, not so much age, they’re mostly younger, but in every sense, so I think there is a lot of peer learning so when you say who should teach it I think that’s the first point to make, is that, particularly in seminars they do learn a lot from each other, and they challenge each other and explain things to each other and put each other right and all this sort of thing.” (R15: Diversity teacher)
10.4.3 **Racism within the student body**

Whilst few respondents raised peer learning, only 2 (1 policymaker within a medical school and 1 student) discussed the issue of racism within the student body. One student (R50) saw it more in the context of students from different groups not mixing well with each other, although this varied across academic years.

"You do notice actually that you are in the minority [being white]. I mean I like it because I have got a lot of friends from different areas and I love learning. One of my friends is Muslim and her views are so black and white and so. It is scary to an extent but then you realise as well how you... How you talk to your friends and not think about them as being black, I think that's what the curriculum” (R50: Student)

This suggested that students from minority backgrounds also needed to learn respect for perspectives different from their own.

"... [She] interjected we ought to be doing some work on ethnicity in our own medical students, because there is such a lot of racism within the medical student community within X. It's actually very difficult to teach diversity in a comfortable and effective way. One of the problems I think that has developed in these large medical schools is that nobody, people go into ghettos, so you've got your white, upper crust, male, resident players of golf, the third generation, BMW-owning, clubbing Asian boys, and you've got the south-east Asian people who don't hold a view with anything very much. Some of these groups don't socialise and so the kind of teaching that they need, curiously is different... I think there are a lot of very different cultural backgrounds that play in medicine, so a programme has to be, teaching has to be sensitive to that. That's probably the main thing I've thought about here” (R37: Policymaker)

The issue of racism within medical has been widely discussed in political contexts (e.g. Bhopal, 2001; Esmail, 2001; Esmail, 2003) but little is written about it in educational contexts.

10.4.4 **Training of clinical staff**

The issue of clinical staff needing to be trained for a variety of reasons was raised.
“Well, I think the medical students see a great deal of bad practice in terms of diversity when they are on the wards, I know they do and I think if they are going to have any confidence to either reject that or perhaps some of them may even be brave enough to challenge it, it’s something that needs reinforcing and they need to know there is a team that they can go back to that they know that they are going to meet again to look at issues in a bit more depth. I just don’t think it’s something you can shovel in as if it doesn’t relate to anything else they do” (R27: Diversity teacher)

“No, except that if ever you start this to be a curriculum in some stage in medical education there is a huge volume of doctors who are already there, 25-30,000 who have very little idea about the ethnic problem, very little idea, so it will have to be addressed at both levels. While you do the undergraduate training for the future generation, for better understanding etc, there is a need for immediately starting something, to give best patient care, absolutely at postgraduate level and in fact it should be a part of GP BPS training, and postgraduate education, be it done by seminar, conference, it doesn’t matter” (R29: Policymaker)

“You really should take the longer term view, you need to see what’s going on 10-15 years down the line. And that is an issue for us, is all the input we are giving going to go like water into a desert sort of thing, when a student comes into contact with their first consultant who says you can forget about all of that that you were taught in your so-called pre-clinical years, you’re in real medicine now and all the kinds of issues and topics we have covered get forgotten about” (R22: Diversity teacher)

In summary, several issues that related to students were raised including peer learning, racism and the training of clinical staff. These issues are important to be aware of as unless they are addressed, the agenda for ‘cultural diversity’ may remain sidelined.

10.5 Analysis of the outcomes of ‘cultural diversity’ learning and teaching
This section discusses student perspectives and their influence on how ‘cultural diversity’ teaching is organised and taught. It also argues that unless the place of ‘cultural diversity’
in the curriculum is made clear, ambivalence about whether students should be failed or not if they fail to demonstrate appropriate attitudes will remain.

10.5.1 Student influences on the development of 'cultural diversity' teaching

Student perspectives were considered very important. As discussed in Chapter Nine, there was concern about the students’ desire for certainty where certainty does not exist. This was also illustrated by views that medical students needed to understand the realities of medical practice and recognise the ambiguities that are inherent in practice. This suggested that this was not happening at earlier stages in their education despite the development of different types of curricula.

"Dealing with uncertainty in medicine is a big issue. We do discuss some of this in our session, about dealing with uncertainty and sort of trying to get students to understand that actually most of their professional life they are going to be dealing with uncertainty, sadly.. But dealing with uncertainty is one of the things I am really interested in and of course cultural diversity just increases that uncertainty. I don’t think it, in a sense for me, when, we are now thinking of teaching, not that we do a lot of teaching, hopefully the students do a lot of learning. I don’t think we necessarily do a lot of teaching. It’s very much a sort of facilitated programme that we operate from, but dealing with differences, whether they are cultural differences, however you define, because of course we haven’t decided, on a consensus about what this means anyway” (R2: Communication teacher)

It is, therefore, pertinent that ‘cultural diversity’ as a subject and its’ teaching is justified to students in the curriculum. As few clinicians have themselves been trained in diversity, how students integrate their preclinical or formal context teaching with observation in practice needs consideration. There was a strong feeling, especially among users and policymakers that, if students did not realise the relevance of such teaching, the question of whether or not they are fit to practice in the UK is legitimate. Student feedback was perceived to be relevant and its potential impact considerable. However, concern was raised that too much feedback is sought for bureaucratic rather than educational reasons. Whilst teachers were less likely to worry about negative comments, perhaps because they are more used to hearing them and defending their teaching, they were aware that criticisms did influence them to include factual information even if it was inappropriate to
appease students. One teacher commented on the difficulty of addressing negative comments, as they are often made anonymously but can carry considerable weight.

Students are keen to have practical exposure and experience and perceived to view the theoretical underpinnings as less relevant. Again, too much weight may be given to what students say without giving it context. One student respondent actually stated that sometimes students need to learn to put up with being told and have some faith in their teachers. There was concern by 1 female ‘cultural diversity’ teacher that the issues raised by some student groups are given greater credibility than issues raised by other groups although this contradicts the experience of 1 white policymaker who felt that at his school, the needs of the vocal minority groups received the most attention. A white student at a different medical school agreed with this perspective and raised the issues of racism within the minority groups.

"In my experience people who say we don’t need it are the people who do need it and therefore there are a number of techniques that I think you can use in order to show people that they do need it... So when we did it at X we found that there was proportion of white students who said that diversity education was irrelevant and a waste of time and the black students gave very positive feedback. The interesting thing, although negative feedback, the white students was then often the one that was heard the loudest" (R26: Diversity teacher)

The experience of this respondent is similar to the finding by Robins et al (1998), who found that majority men initially rated teaching on diversity as least relevant compared to their peers. The response of the majority men was in part related to feeling marginalised in the way the teaching was targeted. There was an expectation by respondents that some students would not value the relevance of ‘cultural diversity’ or social sciences. A few sympathised with this view, whilst others felt students should have to learn to live with some components of the undergraduate curriculum, whether they agreed with it or not. Most respondents, however, felt that students openly voicing their disagreements was constructive as this enabled exploration of the issue. They might be persuaded through discussion or demonstration of its relevance to clinical practice.
10.5.2 Outcomes of inappropriate student attitudes

Some respondents questioned that, if students could not see the relevance of ‘cultural diversity’ teaching given today’s society, were they really the kind of students we needed to be attracting to medical school? Such students might also have difficulties in progressing through medical school. This raised questions about admission criteria and processes. The impression was that, in many ways, medicine is still being sold as a ‘hard’ science and perhaps attracting students with outstanding scientific backgrounds but lacking an interest in people. The question was raised of how to deal with those who are academically able but lack appropriate working or ‘people skills’. There is the argument that students could qualify with a medical degree but not the right to practice if they lack ‘people skills’. This would however, contradict the outcomes suggested by the GMC (1993 and 2002), which are clear in relation to effective communication skills. It is unclear whether or not students can graduate with a medical degree given the learning outcomes of the GMC and most medical schools if they fail to demonstrate effective respect for diverse perspectives. Medical schools need to decide whether or not to fail students who are unable to demonstrate respect for difference irrespective of their academic backgrounds. If they decide not to fail students, it undermines the message that is already struggling to be heard; that is communication is central to effective clinical practice. The medical degree is often heralded as a gateway to many career options including non-clinical ones; nevertheless it would be difficult to justify the rationale for passing students who fail to show competence in communication skills.

There is a lack of conviction and confidence that staff in medical schools are able to identify students who display inappropriate attitudes in general but especially with respect to ‘cultural diversity’. Whilst reflective journals and projects were mentioned, a great deal of confidence was placed in the OSCE. In part, this may reflect the fact that the OSCE is widely used and has been found to be effective for other clinical contexts (Rennie, 2003). This may be because OSCEs can generate a sense of objectivity in examiners and imply that the prejudices of examiners play no part in the way in which they assess student performances. Students may find that the duration of OSCEs is short enough to be able to perform adequately without raising staff concerns. The potential look of an OSCE that assessed ‘cultural diversity’ either separately or as part of a clinical problem was unclear and there was concern this might be tokenistic. One communication teacher was particularly resistant to the idea that specific religious facts needed to be elicited from the
patient to demonstrate ‘cultural expertise’. Wass et al (2003) found that Asian male students communicated particularly poorly in OSCE stations. The authors concluded that medical schools needed to be aware of this cultural difference. The suggestion appeared to be that allowances needed to be made for their poor performances. No questions were asked as to whether or not Asian males might perform less well than their peers because they failed to treat patients with respect or that they felt it was unnecessary to comply with medical school standards of equality on the basis of their cultural background. Hierarchy of race over gender and other factors may mean that racism is less well tolerated than sexism or other prejudices. Therefore, the OSCE may not be as objective as it is perceived. The use of OSCEs indicate an underlying adherence to the ‘cultural expertise’ model and suggest there is a view that expertise in ‘cultural diversity’ can be demonstrated in the same way as expertise in undertaking a neurological or cardiovascular exam.

There was real ambivalence by some about whether or not students should be examined. Some expressed disappointment in needing to examine in this area but their experience of students meant that they felt they must. Some expressed strong ambivalence whether students should be failed overall in their degree, if were unable to demonstrate appropriate behaviours and attitudes. Some felt this was justifiable, others did not feel it was a sufficient enough reason to fail students. The feeling appeared to be that students were more likely to challenge for failing if they had inappropriate attitudes, than if failed their knowledge-based exams. There was also a perception that doctors could be competent even without demonstrating appropriate skills in addressing issues of diversity which supports the position held by Toynbee (2002). This suggests that considerably more work is needed in the area of how to assess students in this area. When forced to make a choice, educators choose assessment models that support the ‘cultural expertise’ model because of a lack of other methods. The ambivalence about whether students should be examined may reflect an unconscious belief that being able to determine the relevance of cultural aspects is not as relevant to effective clinical care as being able to determine physical symptoms. Whilst this may be true for the diagnosis component, it is not necessarily true for the management of a problem (Levinson et al, 1997). Respondent were aware that students might not take the subject as seriously if it were not assessed. They seemed less aware that examining it poorly or superficially might also undermine the subject and teachers with students.
A ‘cultural diversity’ teacher gave an example that highlighted how students may behave appropriately in exam situations but fail to do so in clinical practice.

"A girl in her final year has just said that she is very concerned because she has got a number of acquaintances who are real hard core evangelical Christians who quite openly in conversation say that when they are qualified and practising they will not be prepared to care for certain kinds of people including gay people. She just wanted to come and talk about it and I just want to give her that sympathetic ear, I’m not sure that I will be able to anything about it. But I think that is always going to bedevil both assessment and evaluation of outcomes because people will tell you “Oh yes it was wonderful and I do this and I do that”, but they may not. Also there is this problem about the gap between competence and performance. People may do wonderfully well in the end of the year OSCE on diversity, but a week later when they are practising may have terrible attitudes" (R23: Diversity teacher)

There was a concern that students often paid lip service to diversity teaching. They said what they thought teachers wanted to hear but privately planned to dismiss most of the teaching. This may link in with views that learning about diversity is about changing student beliefs and forcing the acceptance of ‘rightness’ of other perspectives. Some students with strong religious convictions are unlikely to accept even the most charismatic of teachers saying that homosexuality is acceptable, as they may believe that it contradicts their religious learning. More progress is likely to be made by enabling students to understand that whatever their personal beliefs, all patients need to be valued and respected. If students cannot undertake this, then their clinical practice may be questionable.

Students and users were most critical of students who dismissed ‘cultural diversity’ teaching. This may reflect a greater naivety on how possible it actually is to identify students who display inappropriate attitudes and how to resolve the ambivalence about whether or not students not meeting certain standards could or should be failed. Faculty staff and teachers may be less comfortable in addressing non-academic student issues as these may not be supported through university appeals processes. Failing a student for not having sufficient knowledge is relatively straightforward; failing a student for displaying
appropriate attitudes is not the same. The lack of appropriate methods to comfortably and confidently assess student attitudes increases the problems that educationalists face. There is also the dilemma of universities being under pressure to increase the number of graduates and widening access at the same time as there is a pressure for medicine as a profession to improve the standards of care. It is possible that whilst universities may give borderline students the benefit of the doubt, once in practice these doctors are more difficult to deal with.

When pushed, the bottom line appeared to be that students not meeting the outcomes for diversity should probably not be failed. However, it can be more difficult to identify these doctors in later years and address their problems then. Universities are in an almost impossible position. On the one hand few students are expected to fail courses once enrolled in higher education and termination of courses is seen as a negative outcome. On the other hand, the GMC is under pressure to ensure doctors are able to meet the needs of a diverse population.

10.5.3 Measures of effectiveness of ‘cultural diversity’ teaching

Despite the lack of evidence of any clear effect on clinical practice, there are many advocates for the inclusion of ‘cultural diversity’ in the curriculum, which is contrary to evidence-based approach. The issue of assessing student progress is made more difficult by the lack of agreed or validated appropriate measures compounding the difficulties in this area. The sample interviewed was more likely to be positive about ‘cultural diversity’ for reasons discussed in Chapter Six. If there is a belief that cultural factors affect the way health is perceived in general, then the logical step is to believe that learning about the subject is important. The work is undermined if any doubt is expressed regarding its effectiveness. Politically it may be unacceptable to say there is very little evidence that the teaching of ‘cultural diversity’ makes any differences, especially if organisations have invested money on its teaching. However, the views that it does make a difference are made in the absence of any firm evidence to support this perspective.

Research needs to be undertaken on the effectiveness of teaching and of assessment methods to measure the effectiveness of ‘cultural diversity’ teaching. This would help improve the credibility of the subject. There is also clearly a need to make teaching
clinically relevant because after all, medical schools have a responsibility to educate doctors fit to practise. However, it is also important that students understand the need for some theoretical underpinnings. The subject, though, is let down by the lack of effective research to demonstrate this to students.

In addition, the subject has little credibility when clinicians themselves have not been trained and so cannot support students once they are in clinical practice. The ambivalence that clinicians may express about ‘cultural diversity’ training (AAMC, 1999; Tang et al, 2003) may be related to the lack of any evidence base. It may also relate either to the fact that clinicians may not receive any training or perceive training received as poor. Either way there is little effect on clinical practice.

10.6 Conclusion

The assessment process is driven by ideas that are consistent with ‘cultural expertise’ but the desired outcomes in clinical practice and for students as learners are consistent with ‘cultural sensibility’. The assessment aims were inconsistent with assessment methods. The majority view was that assessments are important, and yet there was ambivalence about failing students who failed to demonstrate appropriate attitudes regarding ‘cultural diversity’. OSCEs were considered by most to be an effective assessment method, although some felt that reflective journals were an important assessment tool in this area. Several student-related issues were raised including peer learning and racism. There is hope, rather than there a belief, that ‘cultural diversity’ improves clinical care, given the lack of available evidence. The analysis argued that student perspectives may override other perspectives. The ambivalence towards assessment in this area, and how to manage students who demonstrate inappropriate attitudes needs resolution because the current position undermines the development of the subject. Clinical contexts also need to start addressing diversity in more meaningful ways than they have to date which includes the training of staff who are already in practice.
Chapter 11: Conclusion

This chapter begins by stating the main research objectives and the key findings and relating them to what is already known. The lessons to be learned from this study’s method and methodology are discussed before the implications for practice and policy are considered. This is followed with suggestions to support the development, organisation, delivery and outcomes of ‘cultural diversity teaching before making specific recommendations for the stakeholders who participated in this research. The chapter concludes with ideas for further research.

11.1 Introduction

The aim of this thesis was to identify and analyse the origins, organisation, contents, delivery and outcomes of the teaching and learning of ‘cultural diversity’ in undergraduate medical education in the UK. The main research question aim was to investigate how medical stakeholders (such as policymakers, teachers and students) conceptualise the term ‘cultural diversity’ and issues that related to the teaching and learning of ‘cultural diversity’ in undergraduate medical education.

To understand the origins of ‘cultural diversity’ teaching, the history of medical education in the UK was explored and showed that medical education is inextricably linked to the development of the medical profession itself. The medical profession developed with surgeons at the forefront; although physicians had been prominent, the focus on the Anatomical Method at the end of the eighteenth century paved the way for dominance by surgeons. This dominance perhaps made them the most advantaged and most powerful group of doctors with significant impact on what and how medical students are taught. The status of the ‘behavioural sciences’ is low in the medical curriculum as compared with ‘biomedical sciences’. Whilst there are justifications for the inclusion of ‘cultural diversity’ in the medical school curriculum, to date, there is little evidence to suggest that teaching ‘cultural diversity’ has an effect on the service delivered. Policies especially Tomorrow’s Doctors (GMC, 1993) set the agenda for teaching of ‘cultural diversity’ in undergraduate medical education. However, the document does not appear to have influenced the development of specific programmes. The need for healthcare professionals to meet the needs of all the population professionally and equitably has
come at the same time as the medical profession has been challenged in almost every aspect of its work; that is with regard to training of doctors, direct clinical care, self-regulation and continued professional development (for example Fitzpatrick, 2001; Gray and Finlayson 2002). The threats the profession may perceive itself under may mean that there is little real commitment to lasting change in issues such as ‘cultural diversity’. The issues may only be superficially addressed to satisfy external agencies rather than because there is any real belief on their relevance to clinical practice. The relationship between behavioural sciences and ‘cultural diversity’ has given rise to difficulties when including ‘cultural diversity’ in medical education.

Kaufman et al (2000) indicated that medical education has not effectively made the link between educational theory and practice, which was the case for ‘cultural diversity’ teaching in the UK. The literature review showed that there is also a lack of clarity and systematic approach towards the teaching. It is unclear whether or not this is the case just for ‘cultural diversity’ or is reflective of medical education generally.

To date, various approaches to teach ‘cultural diversity’ have been proposed by a range of academics and clinicians; such as ‘cultural competence’, ‘cultural sensitivity’, and ‘cultural safety’. However, most approaches, except for ‘cultural competence’, have not used a coherent educational model. The approach of ‘cultural competence’ presents particular difficulties in the way that it uses culture and a sense of ‘us’ the majority and ‘them’ the minorities. This led to considering new ways of thinking about the educational frameworks.

The thesis developed two ideal type models of ‘cultural diversity’ educational programmes referred to as ‘cultural expertise’ and ‘cultural sensibility’. Expertise is expert skill, knowledge or judgement with expert being defined as having special skill at a task or knowledge in a subject. Sensibility is an openness to emotional impressions, susceptibility, and sensitiveness. It relates to a person’s moral, emotional or aesthetic ideas or standards. The ‘cultural sensibility’ approach was developed to enable an educational approach that focuses on concepts and principles in line with Tomorrow’s Doctors (GMC, 1993). Philosophically, the model is more inclusive and based on individuals rather than specific groups. This is particularly relevant for clinicians who provide individual care.
The ‘cultural expertise’ model enables ‘medicalisation’ of ‘cultural diversity’ and this is perhaps something with which doctors may be more comfortable. For doctors to acknowledge uncertainty and not knowing in ‘cultural diversity’ amongst other things may be asking them to risk too much too quickly. It may be easier for established medical practice to fall in line with ‘cultural expertise’ than to consider ‘cultural sensibility’. Student preference for the expertise model may dissuade educators from trying alternative approaches, despite the fact that there is no strong evidence that any training to date has met the main target set of reducing healthcare inequalities.

A review of specific educational programmes demonstrated that programmes are not always explicit about the way they use terms and the philosophies and principles that guide the teaching. There is a tendency for programmes to adopt the ‘cultural expertise’ approach although this influence is not always transparent. Whilst the field of medical education is aware of established educational theory, there is little evidence to show that this evidence is utilised effectively as shown through the review of specific educational programmes. There is little clarity on the educational theories that influence those developing curricula and if this links in with what teachers teach. This may possibly relate to the lack of coherent educational models available. ‘Low status’ staff in medical schools undertake much of the teaching and this may in part explain the fragmented nature of the programmes reviewed.

From the literature review it is unclear how Tomorrow’s Doctors (GMC, 1999 and 2002) has been implemented, how those delivering ‘cultural diversity’ education interpret the policy, what influences their philosophies regarding what is taught and what teaching strategies are applied. It is also unclear the extent to which schools are assessing and evaluating their programmes. The literature demonstrates a lack of clarity about what ‘cultural diversity’ means, what should be taught and how it should be taught. It is also unclear how medical education utilises the work that exists in the body of educational theories and how teaching in diversity is conceptualised and then delivered. To begin to understand this, it is necessary to identify the views and perspectives of the various stakeholders in medical education towards the teaching and learning of ‘cultural diversity’ in undergraduate medical education which was the main research objective.
The research strategy designed to answer these questions constituted the following objectives:

1. To apply the ideal types of ‘cultural expertise’ and ‘cultural sensibility’ to the review and analysis of ‘cultural diversity’ educational programmes in UK medical schools
2. To identify the process by which Tomorrow’s Doctors (GMC, 1993) came to be include aspects of diversity
3. To identify perceptions and evaluations of ‘cultural diversity’ and its teaching held by policy makers in the UK
4. To identify perceptions and evaluations of ‘cultural diversity’ and its teaching held by medical faculty staff in the UK
5. To identify perceptions and evaluations of ‘cultural diversity’ and its teaching held by teachers in the UK
6. To identify perceptions and evaluations of ‘cultural diversity’ and its teaching held by medical students in the UK
7. To identify perceptions and evaluations of ‘cultural diversity’ and its teaching held by service users and advocates in the UK
8. To identify how the perceptions of ‘cultural diversity’ identified in objectives 3-7 align with the models of ‘cultural expertise’ and ‘cultural sensibility’
9. To analyse the literature and findings to identify the origins, organisation, contents and outcomes of ‘cultural diversity’ teaching in UK undergraduate medical education

11.2 Key findings

In general, the findings show no discernable pattern between sections of the sample, which is perhaps somewhat surprising. Overall, there is a mismatch between what respondents thought should be happening and what was happening in practice. There is little evidence to suggest that ‘cultural diversity’ teaching in the undergraduate curriculum has used the limited evidence-base or any coherent educational model.
11.2.1 Origins

- Most of the respondents were aware of Tomorrow’s Doctors (1993) and viewed the document favourably and perceived it as having been a major factor in placing ‘cultural diversity’ on the medical education agenda. Most were positive about the role of the GMC and the intention regarding ‘cultural diversity’; doctors conveyed the most cynical views which may reflect their broader dissatisfaction with the GMC (Fitzpatrick, 2001).

- Respondents were aware of ‘cultural diversity’ teaching especially by those in medical schools but the nature and extent of the teaching was rather unclear.

- There was uncertainty about how programmes had originated but it was largely felt to be through the efforts of individuals. Although there was sometimes involvement from curricular bodies, this did not appear to be strategic.

- Only just under one-fifth of the sample had received any formal training in ‘cultural diversity’, most of whom were students.

- Views about how ‘cultural diversity’ was conceptualised were consistent with ‘cultural expertise’ and a more group-based identity view of individuals. The majority perceived diversity as relating to group differences, but this was not applied consistently and they slipped into talking about individuals. ‘Cultural diversity’ teachers were more likely than other groups of respondents to have educational philosophy consistent with ‘cultural sensibility’. However, each of the sample groups revealed a range of views indicating that educational philosophy is not dependent solely on the status or position of specific stakeholders.

- Other commonly used terms such as ethnicity, race and multiculturalism were no more clearly understood than ‘cultural diversity’. There was recognition that this is a complex issue, and that debate is needed to improve clarity because the current confusion is unhelpful.

- Most respondents felt there was confusion about the terms used in this field but only 11 stated that they felt this confusion might influence the programmes developed.

- Different types of expertise were identified but only a minority felt that expertise constituted a combination of academic, practical and personal experience.
11.2.2 Organisation

- The content analysis revealed that the websites of the majority of UK medical schools gave equal attention to behavioural sciences and biomedical sciences.
- The consensus was that ‘cultural diversity’ is not the province of any specific discipline and should be integrated into the curriculum although it was less clear how this might happen in practice.
- There was less agreement about the number of hours spent on teaching ‘cultural diversity’. There was, however, clarity in that ‘cultural diversity’ should be part of the core curriculum and warranted more than a one-off teaching slot or being an add-on to other modules.
- The consensus that ‘cultural diversity’ teaching should be undertaken early in the curriculum and integrated in all aspects is more compatible with the ‘cultural sensibility’ model.
- Whilst the majority of respondents had a philosophy more consistent with ‘cultural expertise’, the way they viewed the organisation of ‘cultural diversity’ teaching was more consistent with ‘cultural sensibility’.
- The general perspective was that although ‘cultural diversity’ would best be taught by a multidisciplinary team, senior practising medical doctors must be a visible part of this team, so that students have confidence in the medical school’s commitment.
- There was also a strong view that teaching skills were perhaps more relevant than ‘expertise’ in diversity, especially if students were to be asked to explore their own perspectives.
- Staff support was felt to be lacking and teachers involved in this area were generally perceived as holding low status.
- The views relating to the educational process are less clearly aligned with either ‘cultural expertise’ or ‘cultural sensibility’.
- There was support for the development of guidelines if they were developed through a multidisciplinary forum involving a range of stakeholders.
11.2.3 Contents and delivery

- Programme contents did not necessarily relate to overall curriculum design or policies, which were often unclear about ‘cultural diversity’ teaching.
- There was little reference to any formal evidence base when considering what should be taught and how it should be taught.
- There was no consistency in the views about educational content that aligned specifically with either ‘cultural expertise’ or ‘cultural sensibility’.
- A variety of teaching strategies were identified as being used and as being appropriate.
- Most respondents gave responses consistent with ‘cultural expertise’, that is, the contents should be specific to local needs and that facts needed to be learned about others.
- There was consensus that the community should be involved in ‘cultural diversity’ teaching although the precise role was unclear.

11.2.4 Outcomes

- The majority of respondents felt that ‘cultural diversity’ should be assessed and the OSCE cited as the most appropriate assessment method although one-quarter of respondents also cited MCQs and SAQs and clinical scenarios (as distinct from OSCEs).
- All respondents thought that student feedback should be collected and that good feedback supported course design and improve the quality of teaching.
- Despite the lack of evidence available, many respondents felt that clinical practice was improved through ‘cultural diversity teaching’ and this was mostly as a result of improved doctor-patient communication.
- Just over one-half of the respondents felt it necessary to involve users in deciding on if practice had improved.
- Several different types of evaluation were suggested.

The confusion and inconsistency about ‘cultural diversity’ in undergraduate medical education were common issues that arose in exploring the outcomes.
11.3 Lessons learned and limitations of the study

The research used semi-structured interviews and interviewed 61 individuals with a stake in medical education such as policymakers, curriculum heads, teachers, students and users. It is important to acknowledge the constraints of trying to select the ‘right’ people to meet the research objectives. It may be 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. 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. In this project the researcher could be viewed by some as an insider as she was both a teacher and doctor. In contrast, other interviewees, such as students and users who were perhaps the least empowered of the groups interviewed, may have perceived her as an outsider.

The interview was an effective research tool, but it is possible that it may have been too structured for some participants. The clear focus on education may also have deterred non-educationalists from expressing their thoughts in case they were perceived to be ‘wrong’ or ‘politically incorrect’. A broader sample may have provided a more representative picture of what happens within organisations, especially medical schools. This might have revealed the rivalries existing between different subject teachers in an ever-expanding curriculum. The interview data might have been usefully triangulated with a questionnaire survey for additional breadth and depth. Whilst the data may have been limited more perspectives might have been explored. A more detailed interim analysis may also have been useful, as it may have led to changes in the interview schedule. As Benson (2000: 461) states, manual analysis is subject to analyst deficiencies, but computers too have their limitations. Analysis of qualitative data is bedevilled with issues of validity, and this has been met by being explicit about the basis on which interpretations were made. In addition, content analysis was undertaken on information available on the Internet for each UK medical curriculum. This was severely limited by the information available on the website, with some schools giving detailed information and others giving very little. This method is used increasingly to obtain information but there are questions regarding the quality of information.
11.4 Implications for future policy and practice

11.4.1 Development

The GMC has demonstrated willingness to address some of the difficult issues that face the medical profession. It is ideally placed to take the lead in the development of teaching guidelines that are coherent and consistent with its policy. The GMC may need to lead rather than follow policy (e.g. Department of Health policy is often poorly articulated and ironically not patient-centred); there is a need for policies to direct teaching away from a superficial checklist approach and ensure the teaching delivers doctors who are able to meet the needs of individual patients and their families. Policies could perhaps be more explicit in that the concept of equality is applicable to everyone and not just for minority groups. The GMC has recently revised its quality assurance procedures to ensure that medical schools are delivering the curriculum they claim to be delivering. This process is likely to support the ethos around diversity introduced by the GMC (GMC, 2004).

The GMC could also take a clearer stand with supporting staff in medical schools who are given the responsibility for developing ‘cultural diversity’ teaching. They could play a major role in ensuring that issues such as diversity are clear and integrated through all levels rather than left to individuals.

There is also a role for networks, such as proposed by the Diversity Interest Group, to become more developed in a formal manner so that teaching in this area can be developed with academic rigour and an evidence-base be established to ensure that future developments are educationally-based, even though they may remain politically informed or motivated. These actions would enable the credibility of ‘cultural diversity’ teaching to be raised. This is relevant because, unless those at different levels of medical education perceive ‘cultural diversity’ as important, it may fail to move the subject which would make it an unsustainable part of the curriculum.

There is a need for a wider and more open debate about developing models of ‘cultural diversity’ teaching appropriate to the UK context. This research has shown that whilst many respondents viewed culture as a group-based identity, they remained open to other possibilities.
11.4.2 Organisation of ‘cultural diversity’ teaching

Educationalists have yet to address their own values and their potential impact on decisions regarding the curriculum, including the time and support given to teachers. It is also necessary to decide whether or not valuing diversity means that there are no common expectations of the community as a whole. Educationalists need to remember the context of medical training, the legal frameworks within which doctors work, and the nature of the population with diverse health care providers and patients. These all need to be addressed at curricular level if all patients are to be given respectful and courteous care acknowledging their views and engaging them as effective partners in their healthcare.

From the views given it would be appropriate to start with ‘cultural diversity’ teaching early in student careers. The rationale for a discrete module is to ensure that the issue is addressed clearly. The topic could then be revisited at different stages but the teaching needs to be coordinated otherwise, some aspects may be repeated and others not addressed at all. A way of implementing this option is for an individual to co-ordinate the different components. However, if the post holder is to suggest how other staff can introduce ‘cultural diversity’ into their modules or teaching components without necessarily taking over their valuable curriculum time, the post holder requires the support of their curriculum lead. It would be important that the coordinator would support other staff working with them, rather than have sole responsibility for the teaching. The same co-ordinator (especially if clinically qualified) should consider engaging with clinical teachers, because of the need of ‘cultural diversity’ teaching at ward and community level.

The findings of this study suggest that the role of coordinator would need to be undertaken by someone with credibility and seniority and not someone considered to have a personal agenda about a specific issue or the needs of a particular group. This would help make ‘cultural diversity’ an integral part of all teaching and a mainstream activity. This should, perhaps, be a long-term goal to enable ‘cultural diversity’ teaching to become integrated into all aspects of the curriculum. At this stage, however, it is too early for such a step as little is known about what makes effective teaching in ‘cultural diversity’. At present, ‘cultural diversity’ may need to be taught as a discrete module to provide a theoretical foundation, and for research to be undertaken in establishing what works with respect to teaching ‘cultural diversity’. This is perhaps where a national set of
guidelines might be useful. The findings suggest that guidelines, set by a credible group made up of various stakeholders, would be well received and implemented.

Guidelines could frame the issue more educationally and move the teaching of 'cultural diversity' from a political to an educational framework. This is especially relevant as politics and political agendas have influenced the philosophy and contents of 'cultural diversity' programmes to date. What is politically expedient may not be educationally coherent; given the concerns raised, it may be most useful to develop guidelines and consult widely with all stakeholders. It would, therefore, be important for stakeholder representatives to consult widely within their group to ensure that as many perspectives as possible are sought. Given the common difficulty in receiving feedback, it may be more useful to attach a questionnaire to the consultation document and also provide some space for free comments. This could be followed-up by selected focus groups. Initially, this may be labour intensive, it has the advantage of being inclusive and, thereby, more likely that the outcomes will be deemed relevant and implemented successfully. The guidelines could also act as evidence of good practice by being clear about their underlying philosophy, their relationship with policy, educational process (including the evidence on which this is based and acknowledging where evidence does not exist or is limited) and their contents and outcomes.

The guidelines need to give examples of 'good practice'. The guidelines should not suggest that there is only one way of teaching diversity. The guidelines also need to refer to some educational theory to frame them in an educationally coherent way. Any endorsement for a particular model needs to be clear about the evaluation that the model has undergone.

There is also a clear need to support staff given the responsibility for developing 'cultural diversity' teaching within medical schools. Tied with this is the need to establish credibility for the teaching of 'cultural diversity', related to which is the issue of ensuring that everyone who teaches medical students is aware of the relevance of 'cultural diversity'. Given the major changes that are proposed for postgraduate medical education, it is less clear how this can be achieved. However, given the GMC's commitment to revalidation, it is possible that the issue of the ability of clinical staff to address the needs of diverse patients could be included in that process. If clinical medical staff highlighted
the relevance of social sciences to their clinical work, this would allow for students to self-reflect and to relate the concepts to themselves as individuals and to them as future practitioners.

The move to have a single body responsible for postgraduate medical examination and for this body to become part of the National Health Service University (NHSU) enables greater coherence between undergraduate and postgraduate education. It would also enable longer-term follow-up of students to extend evaluation into the clinical years. However, the NHSU has been developed in a political context and it is crucial that political agendas remain separate from educational agendas, otherwise ‘cultural diversity’ teaching will continue to be more about being seen to do the right thing rather than commitment to staff development and improvement of patient care. The NHSU (NHSU 2003) views communication skills as a high priority identified through two approaches, one helping staff in their interactions with patients and colleagues, and the other developing communication with patients in a specialised field of practice. The NHSU website is unclear about how the diverse needs of patients will be met but, if consistent with NHS policy, the focus is more likely to be on groups than on individuals, and implicitly the NHSU will apply a ‘cultural expertise’ model.

11.4.3 Contents and delivery of ‘cultural diversity’

There are several issues that need to be addressed when considering the contents and delivery of ‘cultural diversity’ teaching. Clinical practice is neither always safe nor predictable. Ambiguity and uncertainty are inherent in clinical practice; even the hardedge discipline of neurosurgery has considerable uncertainty. For example, in the case of Michael Watson who following a head injury sustained in a boxing match was expected to die and at most survive in a vegetative state. Eleven years later Watson completed the marathon, albeit in a week (Anthony, 2003). This was not something that doctors had predicted. To collude with students and imply that ‘cultural diversity’ is about having the right information to hand or knowing who to contact to obtain the information is ultimately failing to help them learn. ‘Cultural diversity’ teaching cannot be about being able to reel off facts about groups, whether or not the facts are about ethnic groups or groups based on other criteria if clinical care to individuals is to be improved. Someone is not able to provide better clinical care by knowing general information about groups of
people but this was not something about which respondents seemed concerned. Effective 'cultural diversity' teaching in medicine has to be about making sure that patients are treated on the basis of their individual stories. No matter how the rhetoric is phrased, ultimately all patients need to be treated with respect, have their perspective valued, and receive the care that is appropriate for them in their particular context at that particular time (GMC, 1998).

One approach to challenge student perceptions about a group-based approach with the acquisition of facts may be to ask students to use an interview similar to the one used at Leicester (Dogra, 2001). In this programme, students were asked what they would say was universally applicable about a group they felt they belonged to. Even if one example contradicted this the case is proven: it may be that very example of a patient that consults you as a practitioner. The contents of specific programmes need to have coherence with educational philosophy and process.

11.4.4 Outcomes

'Cultural diversity' is not alone as a subject requiring a more coherent approach towards assessment. However, in an age of increasing emphasis on core competencies (e.g. GMC, 1997), it is important that these are considered in the context of a coherent educational model.

Engaging students and the community may effectively involve both groups in considering how they view 'cultural diversity' and its' teaching. However, it is important that medical educators take responsibility for leading the development in this field to ensure that the progress takes robust educational practices into account.

There needs to be more critical analysis of some training that is widely available given the perspective that some of it was considered to be very attacking and humiliating. Training needs to engage and encourage people to be prepared to openness about new ways of thinking. The biases of all those planning teaching need to be explored, and not just those of the white majority. Training also needs to be evaluated in terms of its affect on clinical practice.
11.5 Specific recommendations to the participant stakeholders

Policymakers should:

- Be clear about their expectations regarding ‘cultural diversity’ teaching and in their use of terms associated with it
- Be explicit about the philosophies behind the policies
- Ensure that quality assurance mechanisms go beyond tick box checks
- Ensure that the statements about what is undertaken in the area of ‘cultural diversity’ teaching is demonstrated
- Support ‘cultural diversity’ teachers in justifying teaching in this area
- Support educational research in this area

Curriculum leaders should:

- Consult actively with teachers, students and users if the process of evaluation and refinement of ‘cultural diversity’ programmes is to happen
- Improved communication between curriculum heads and teachers to increase coherence in the overall curriculum and prevent replication of some topics which reduces student confidence
- Actively support ‘cultural diversity’ teachers especially those who feel marginalised in their teaching roles
- Consider how the subject can be mainstreamed and integrated into the curriculum while still being clear to teachers and students and not become lost in courses with a problem-based learning approach
- Develop strategies about learning that can be applied to medical students

Teachers should:

- Continue with the agenda but seek to use the work that already exists and be willing to challenge political agendas (including their own agendas) which are inconsistent with sound educational practice
- Work on devising better assessment methods
- Develop coherence in the educational models they use
- Be willing to critically evaluate the effect of their teaching on clinical practice

Students should:
Consider their resistance to the behavioural sciences generally but especially in this area

Consider their understanding of clinical practice being black and white rather than shades of grey and their need for certainties in all areas of medical practice

Consider the skills needed to deliver quality patient-centred clinical care

User groups should:

- Consider what perspectives and advice they provide to policymakers
- Consider if their ways of conceptualising ‘cultural diversity’ are consistent with the clinical outcomes they want
- Consider whether or not they want their doctors to be experts in ‘cultural diversity’ by being armed with facts about groups or to ask them as individuals what meanings they have for their own lives

11.6 Further research

In exploring the origins, organisations, contents and outcomes of the learning and teaching of ‘cultural diversity’ in undergraduate medical education, some common themes have emerged. There is a great deal of contradiction and confusion about the teaching that has been developed. The expertise that exists in education and medical education appears not to have been utilised in ‘cultural diversity’ teaching. In devising the ideal type models of ‘cultural expertise’ and ‘cultural sensibility’, an analysis of current educational programmes was possible. This has identified the confusion and mismatch between what perhaps should be happening and what actually is happening. This research may form the foundation for future research.

The subject of ‘cultural diversity’ urgently requires effective tools that can evaluate the outcomes of ‘cultural diversity’ teaching. This could be derived from research in other areas, but measuring changes in attitudes and ways of thinking is fraught with difficulties. However, this should not mean that the subject should be avoided. The subject would benefit from intervention studies exploring the outcomes of different models and their impact on clinical practice.
There is also a need to investigate how teaching in the earlier parts of the curriculum is integrated into what students experience in the clinical settings. Again, this is not a problem just for ‘cultural diversity’ but students may find that what they have learned earlier is dismissed as irrelevant ‘touch-feely’ teaching. This could be achieved by training clinical staff but also by medical schools considering very carefully who teaches medical students and how this is monitored. Pragmatically, whoever is available and willing is often the person who teaches medical students, so supporting these staff to deliver effective teaching may be the most viable option.

There is also a need to investigate the steps to be taken to raise the credibility of ‘cultural diversity’ as a subject within medical schools and the profession as a whole. This is where the rather vague links between undergraduate and postgraduate education could be explored to investigate the continuity of medical education, especially in issues of professional and personal development. Currently, whilst consistency within educational models is suggested, it is not possible to state which educational model effectively provides the desired outcomes. Implementing and comparing the outcomes of different educational models to deliver ‘cultural diversity’ teaching may also help provide the educational clarity that is needed. Different models could be useful to meet different learning objectives and this may be helpful for teachers to know when they are devising educational programmes.

11.7 Conclusion

In summary, this research has identified that there are a range of perspectives on what constitutes ‘cultural diversity’ and how this should be taught. It has engaged high profile individuals, which, to some extent demonstrates a commitment to this field. Most of those involved in the research identified that clear conceptual and educational models are lacking. The ‘cultural sensibility’ approach presents an alternative to ‘cultural expertise’ type approaches. Now it is appropriate to implement and evaluate different educational approaches, so that ‘cultural diversity’ teaching develops rigour and an evidence-base. Unless this is achieved, it will continue to be a path laid with good intentions but one that ultimately fails to educate students to meet patients’ individual needs irrespective of their background or sense of identity.
Appendices

Appendix One: Table 8: The presence of departments of medical education within medical schools

Appendix Two: Review of different approaches to teach diversity

Table 9: Review of specific undergraduate programmes to teach cultural diversity to medical students

Appendix Three: Examples of correspondence with sample

Appendix Four: Interview schedule

Appendix Five: Table 10: Information on medical schools according to diversity programmes, Times ranking and minority populations

Appendix Six: Characteristics of participants and non-respondents

Table 11: Characteristics of participants

Table 12: Characteristics of those who responded but declined to participate

Table 13: Characteristics of non-respondents

Appendix Seven: Table 14: Summary of content analysis undertaken on the information available from UK medical school websites as at June 2003

Appendix Eight: Questions from reading transcripts and key words
Appendix One: Table 8: The presence of departments of medical education within medical schools as at June 2003

<table>
<thead>
<tr>
<th>Medical School</th>
<th>Department of Medical Education</th>
<th>Professor of Medical Education</th>
</tr>
</thead>
<tbody>
<tr>
<td>University of Aberdeen</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Barts and the London School</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>University of Birmingham</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>University of Bristol</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>University of Cambridge</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>University of Dundee</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>University of East Anglia (medical school opened in 2001)</td>
<td>Not formally established</td>
<td>Yes</td>
</tr>
<tr>
<td>University of Edinburgh</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>University of Glasgow</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>The Guy’s, King’s College and St Thomas’ Hospitals’ Medical</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Imperial College</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>University of Leeds</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Leicester Warwick University</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>University of Liverpool</td>
<td>Yes</td>
<td>Yes</td>
</tr>
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<td>University of Manchester</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>University of Newcastle</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>University of Nottingham</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>University of Oxford</td>
<td>No but have curriculum leads</td>
<td></td>
</tr>
<tr>
<td>University</td>
<td>1st year</td>
<td>2nd year</td>
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<tr>
<td>------------------------------------------------</td>
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</tr>
<tr>
<td>Peninsula Medical School</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>The Queen’s University of Belfast</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Royal Free and University College</td>
<td>Yes (International health and medical education centre)</td>
<td>Yes</td>
</tr>
<tr>
<td>University of Sheffield</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>University of Southampton</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>University of St Andrews (Bute)</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>St George’s Hospital Medical School</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>University of Wales College of Medicine</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>
Appendix Two: Part One: The teaching and learning of ‘cultural diversity’

Different approaches to teaching ‘cultural diversity’: Preparing Peace Corps volunteers for overseas service

Albert (1986) described the inter-cultural sensitiser or culture assimilator as a method for cross-cultural orientation. Cross-cultural orientation was to teach individuals from one culture to see and interpret situations from the perspective of members of the other culture. The basic idea was to present to the learner or trainer a series of situations or critical incidents, which depicted interactions between persons from his/her culture and persons from another culture, and to ask the trainee to interpret the situation as members of the target culture would. The goal was to present to the learner as much information about critical differences between his/her culture and the target culture as possible in a short period of time and to do so in a way that stimulated the experience of interacting with the members of the other culture and fosters active learning. Incidents were based on actual or reconstructed experiences of persons from the two cultures and were obtained from interviews, observations, literature reviews and other methods. They usually portrayed situations, which were likely to cause misunderstandings between persons from the two cultures. They were followed by 3 – 4 attributions or alternative interpretations of the situation. Typically 2 – 3 interpretations were from the learner’s own culture and 1 – 2 from the target culture. The learner’s task was to select the interpretation given by a person from the target culture. After each selection the learner was given feedback about his/her choice. He/she was told whether the interpretation selected was the one preferred by the target culture or not, and was given an explanation and additional information about the alternative selected. The inter-cultural sensitiser was seen to be advantageous because:

1. It actively engages the learner
2. Programmed learning approach
3. Individuals can progress at their own rate
4. Repeated use
5. Individual or group use
6. Conjunction with other approaches
7. Potential to use as a process for learning about cultural differences
8. Effective in evaluation studies
However, Albert (1986) did not discuss the stereotyping that this kind of learning might reinforce and cultures appear to be perceived as discrete and homogenous.

Bennett (1986) described a developmental approach to training for inter-cultural sensitivity, suggesting a continuum of stages of personal growth that allows trainers to diagnose the level of sensitivity of individuals and groups and to sequence material according to a developmental plan. The developmental continuum moved from ethnocentrism to ethnorelativism.

The stages were:
- Defence – denigration of difference
  assumption of cultural superiority
  reversal (denigration of own culture and taking on superiority of other)
- Minimisation – bury differences
- Acceptance – achieve move from ethnocentrism to ethnorelativism
- Adaptation – empathy
- Integration

The second part of the paper discussed training applications of the model. The model as presented appeared to be a simplistic view of quite a complex process.

McCaffery (1986) asserted that cross-cultural orientation and training programmes are all too often ineffective because of unintended outcomes such as acquiring stereotypes which may lead to unrealistic expectations. McCaffery (1986) argued for a model, which moves people toward developing/enhancing skill and becoming independently effective cross cultural sojourners. He proposed focusing on ‘learning how to learn’ rather than on learning a particular fact or set of information. He stated that there are many objectives in cross-cultural training and some of these can be quite concrete e.g. language mastery, or to steer people towards assimilation and these can be quite limiting. The model he proposed is holistic and systematic and for this reason, he argued, it will increase ability to identify and achieve important explicit outcomes or reduce the number of unwanted inadvertent ones. The model had three components, which must be integrated.
1. A basic and clear cross-cultural training aim needs to be identified.
2. An educational methodology needs to be described which is consistent with the aim.

3. Educators and trainers need to design and deliver their programmes in a style that is congruent with and that reinforces the methodology and educational aim.

There is a skill and knowledge base. The former included everyday life skills and communication skills. The latter was gathering information through refining and adapting skills in areas of observation, question asking, simple researching and developing data from reflection on actual experience. There was also a process of filtering/validating information by identifying and using alternative sources of information, checking and measuring the perspective of information sources, dealing with conflicting data, recognising when two or more 'truths' may exist simultaneously and making reasonably valid judgements based on imperfect and/or incomplete data.

McCaffery (1986) said that for most cross-cultural orientation and training programmes there tends to be an over-reliance on lectures, presentations, question and answer sessions, reliance on 'experts' and dissemination of written materials. These approaches supported student need for specifics and certainty in areas where certainty may not exist. McCaffery (1986) felt there is a focus on information dissemination rather than skill development. He, however, believed that information could be very valuable. He suggested interactive teaching approaches and making goals relevant to learners. These are part of an adult educational model'. The rest of the model focused on learning and teaching styles. It was acknowledged that the model might be western in approach but that limited use in international forums has been effective. However, the philosophy behind what is taught was not discussed or made explicit.

Ptak et al (1995) used interviews and survey to collect data about Peace Corps trainer experience in cross-cultural training. There was little data on needs assessment except to say that thorough needs assessment were helpful. They found little consistency on evaluation of programmes. The purpose and goals of training needed to be relevant, clear and achievable to participants. It was important for trainers to recognise their own cultural biases when planning and designing programmes. In general, experienced trainers did not support pre-packaged, off the shelf programmes. Efficient and flexible training was
valued. The views varied about using intellectual or experiential approaches but there was little supportive evidence. Training techniques such as cultural immersion, guiding participants to take ownership were suggested. Trainers considered that trainers should know their field, be professional, have experience and recognise their biases. Trainer characteristics that were valued included being supportive of participants, of themselves, humility, humour, flexibility, ability to work with diversity, and presentation skills. An example of working with diversity is to recognise diversity. They commented it could be easy to neutralise cultural issues by saying “It is not a cultural issue, this guy is just rude”. However, they do not discuss that in some cases this may actually be the case.
Appendix Two: Table 9: Review of specific medical undergraduate educational programmes to teach ‘cultural diversity’

*CE = ‘cultural expertise’ model approach dominant; CS = ‘cultural sensibility’ model approach dominant*

<table>
<thead>
<tr>
<th>Study</th>
<th>Setting</th>
<th>Program and length</th>
<th>Teaching staff</th>
<th>Learning outcomes</th>
<th>Teaching methods</th>
<th>Other comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>US</td>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>
| Brainin-Rodriguez, 2001| University of California, San Francisco, year 3 | 4 sessions during the obstetric and gynaecology | Department of Psychiatry | Enhance students’ ability to assess the roles of race, ethnicity, socioeconomic difference, gender and sexual preference in clinical presentations | Videos, student case material, topic based teaching, discussion groups | Student evaluation show it to be well received  
*CE approach* |
| Crandall et al (2003)  | Wake Forest University School of Medicine  
Year 2 Pilot Elective | 20x 2-3 hour sessions | Range of experts | Core competencies specifically in effective communication, self-directed independent learning, critical thinking and problem solving, and facility with technology | Variety including interactive lectures, videos, role-plays, workshops, patient interviews | Student self-evaluation showed change in knowledge, skills and attitudes.  
Predominantly *CE approach* |
Table 9: Review of specific medical undergraduate educational programmes to teach ‘cultural diversity’ continued

<table>
<thead>
<tr>
<th>Study (US)</th>
<th>Setting</th>
<th>Program and length</th>
<th>Teaching staff</th>
<th>Learning outcomes</th>
<th>Teaching methods</th>
<th>Other comments</th>
</tr>
</thead>
</table>
| Deloney et al, 2000 | University of Arkansas                  | Single teaching session                | Teachers on Introduction to Clinical Medicine     | To explain ways in which patients’ cultural and spiritual beliefs affect their disease process and illness experiences  
To describe how spiritual and cultural factors influence the doctor-patient relationship  
To conduct a spiritual assessment using predefined tools | Didactic teaching and expert panel      | Student evaluation show it to be well received  
*CE* approach                                                  |
| Godkin and Weinreb, 2001 | University of Massachusetts Medical School, years 1-4. Elective | Longitudinal over four years            | Community health                                 | Linguistic, cultural and clinical experiences with newcomer groups both in their countries of origin and the United States  
Cultural immersion with a local newcomer family and a summer cultural or language immersion experience  
Discussion groups | Preceptorship                                      | Early report but student evaluation shows summer immersion experiences well received. Family immersion assignment felt to be artificial  
*CE* approach                                                |
Table 9: Review of specific medical undergraduate educational programmes to teach ‘cultural diversity’ continued

<table>
<thead>
<tr>
<th>Study (US)</th>
<th>Setting</th>
<th>Program and length</th>
<th>Teaching staff</th>
<th>Learning outcomes</th>
<th>Teaching methods</th>
<th>Other comments</th>
</tr>
</thead>
</table>
| Goldstone and Drake   | University of California, San Francisco, orientation week for entering students | 2-hour session     | Orientation facilitators | Heighten the students’ awareness of their own cultural backgrounds and those of their peers, so that they can develop and/or strengthen respect and tolerance for differences in others                                                                                                                                                                                      | Discussion groups and exercises | Highest rated session of orientation week. Time increased for session as years progress  
                          |                                                                          |                    |                |                                                                                                                                                                                                                                                                                                                                                       |                  | CS approach                                                                                                                                                   |
| Mao *et al*, 1988     | University of Southern California School of Medicine, Year 2 Mandatory | A 4-hour workshop part of: Introduction to clinical medicine course | Students as facilitators | Influence of ethnic and socio-cultural differences in physician and patients on consultation                                                                                                                                                                                                                                                   | Videotaped vignettes, discussions, role playing | Early pre-test and post-test questionnaires showed improvement in understanding but no significant difference. Student initiated programme  
                          |                                                                          |                    |                |                                                                                                                                                                                                                                                                                                                                                       |                  | CE approach                                                                                                                                                   |
| O’ Brien *et al*, 2000 | University of Colorado medical school Year 3 | Within the family medicine clerkship | Family medicine department staff | Aim of programme to improve medical students’ competency in the care of Hispanic patients  
Demonstrate specific cultural competencies including the use if interpreters                                                                                                                                                                                                                                               | Didactic, group discussion, cultural immersion | Student performance evaluated by use of a Spanish speaking standardised patient. Early stages  
                          |                                                                          |                    |                |                                                                                                                                                                                                                                                                                                                                                       |                  | CE approach                                                                                                                                                   |
Table 9: Review of specific medical undergraduate educational programmes to teach ‘cultural diversity’ continued

<table>
<thead>
<tr>
<th>Study (US)</th>
<th>Setting</th>
<th>Program and length</th>
<th>Teaching staff</th>
<th>Learning outcomes</th>
<th>Teaching methods</th>
<th>Other comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Robins et al, 1998</td>
<td>University of Michigan Medical School Year 1 Mandatory</td>
<td></td>
<td></td>
<td>Focus on students exploring their own perspectives, and recognising the diversity within their own cohort, engaging in non-judgmental discussions about cultural beliefs, attitudes and behaviour and to discuss how the delivery of culturally competent care might result in improved satisfaction and clinical care</td>
<td>Discussion groups Exercises</td>
<td>Initially majority men gave the lowest average ratings but changes rectified this C5S approach</td>
</tr>
<tr>
<td>Sifri et al, 2001</td>
<td>Jefferson Medical School, Thomas Jefferson University, Year 3 90-minute seminar Family medicine staff</td>
<td></td>
<td></td>
<td>Discuss student experience of prejudice Consider their own prejudices and the impact of these on the delivery of health care</td>
<td>Discussion groups and exercises, use clinical experience to draw on</td>
<td>Well received C5 approach</td>
</tr>
</tbody>
</table>
Table 9: Review of specific medical undergraduate educational programmes to teach ‘cultural diversity’ continued

<table>
<thead>
<tr>
<th>Study (UK)</th>
<th>Setting</th>
<th>Program and length</th>
<th>Teaching staff</th>
<th>Learning outcomes</th>
<th>Teaching methods</th>
<th>Other comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conning et al, 2001</td>
<td>Guys, King’s St Thomas’ Medical School Year 2 Mandatory</td>
<td>5 day community based course part of a wider programme</td>
<td>Department of Family Medicine as part of Practice of Medicine (Clinical and non-clinical staff)</td>
<td>Develop knowledge of the health care needs of various groups (including minority ethnic and cultural groups) Describe community resources available to meet these needs and identify the gaps Develop awareness of their own values and attitudes and how these impact on communication skills</td>
<td>Visits to community placements Formal teaching Small group discussions</td>
<td>Assessed using a group project. OSCE, integrated short answer questions Early evaluation has found the course to be challenging and useful More CE</td>
</tr>
<tr>
<td>Study (UK)</td>
<td>Setting</td>
<td>Program and length</td>
<td>Teaching staff</td>
<td>Learning outcomes</td>
<td>Teaching methods</td>
<td>Other comments</td>
</tr>
<tr>
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</tbody>
</table>
| Dogra, 2001 | Leicester Medical School, year 2 | Cultural diversity consisted of 2x three-hour sessions with four hours of student self study. Part of a wider module called Human Diversity and separate from teaching on health inequalities and public policy | Range of clinical and non-clinical staff | Outline the legislation that exists to prevent discrimination  
Describe at least two cultures different from your own  
Recognise the limitations of your knowledge and seek appropriate advice with respect to your understanding of someone else’s perspective  
Apply the principles you have learned from the exercises to other similar situations  
Evaluate your own attitudes and perceptions of different groups within society  
Assess the impact of your attitudes on your future practice as a doctor  
Demonstrate respect for patients and colleagues that encompasses without prejudice, diversity of background and opportunity, language, culture and way of life | Discussion groups  
Didactic teaching (on legal aspects not cultures)  
Exercises  
Students interviewed those they perceived to be similar and different to them culturally | Subjective student evaluation showed it to be well received  
Pre- and post-measures showed that the teaching had enabled the learning objectives to be met with significant pre- and post-findings  
Assessed through self-study interviews, reflective essay, aspects integrated into the final integrated exams in years 3 and 5  
More CS |
<table>
<thead>
<tr>
<th>Study (UK)</th>
<th>Setting</th>
<th>Program and length</th>
<th>Teaching staff</th>
<th>Learning outcomes</th>
<th>Teaching methods</th>
<th>Other comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Loudon et al, 2001</td>
<td>Birmingham Medical School</td>
<td>Health inequalities year 1, Race, ethnicity and health in year 2, Patterns and stereotypes year 3, Global health year 3, Communication skills year 5</td>
<td>Range of clinical and non-clinical staff</td>
<td>Range of topics such as health inequalities, genetics, cultural issues in health, communication skills, health beliefs and culture, family attachment scheme</td>
<td>Lectures, small group work, self-study, role-play and community placements, Cultural immersion with a minority family</td>
<td>Subjective evaluation found programme to be well received, Assessed, CE approach</td>
</tr>
<tr>
<td>Study (UK)</td>
<td>Setting</td>
<td>Program and length</td>
<td>Teaching staff</td>
<td>Learning outcomes</td>
<td>Teaching methods</td>
<td>Other comments</td>
</tr>
<tr>
<td>------------------------------------</td>
<td>----------------------------------------------</td>
<td>-------------------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------------------------------------</td>
<td>-----------------------------------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| Thistlethwaite and Ewart, 2003     | Leeds Medical School                         | Year 1 – various lectures on aspects of diversity                                    | Clinical and non-clinical staff with range of community contributors including patients | To understand some of the ways in which age, gender, culture, sexuality, educational levels and self-esteem affect how events are experienced or perceived  
To be able to characterise and give value to differences that arise through gender, age, cultural background, ethnicity, disability and sexuality  
To develop insight into your own beliefs, attitudes and behaviours and learn to reflect on how they are influenced by your own behaviour | Seminar based learning with some formal presentations.                                                                                     | Recently reviewed – positively evaluated  
Students have some choice about groups they attend. Have to attend three  
Some topics were suggested by students  
Assessment through portfolio  
CE approach                                                                 |
Appendix Three: Examples of correspondence with sample

Dear Sir/Madam

Participation in PhD study

My name is Dr Nisha Dogra and I am a senior lecturer/honorary consultant in child and adolescent psychiatry at the University of Leicester. I am currently undertaking a PhD entitled “Cultural Diversity and Medical Education”. One of the PhD objectives is to explore the perspectives of key policymakers regarding issues in this area.

In order to do this I am hoping to obtain the views of policymakers in key roles/organisations as well as members of any undergraduate education or equal opportunities committees the organisation has. I am hoping that with the perspectives of key stakeholders in medical education I will be able to build on educational models that I have already explored. The project outcomes would be to develop guidelines or principles to ensure that cultural diversity teaching developed for medical students is educationally sound (that is it has a theoretical and evidence-base) but is also relevant to them as future practitioners. The principles should be transferable across the disciplines and potentially beyond healthcare.

I have developed a semi-structured interview, which I would like to administer to key staff, of which you are one. Ideally I would like to undertake the interviews face to face at a time and place that is convenient to you. However I accept that this may be difficult and would be happy to undertake the interview by phone if you would prefer. The interview will take approximately 45 minutes and will be taped for later analysis. I would also like to assure you that you are granted anonymity and none of your statements will be linked or attributed directly to you or the organisation through which your participation has been sought.

I am writing to ask if you would be willing to participate in this study, which has been passed by the local ethics committee as not requiring ethical approval as it does not directly involve patients.

I would also be happy to discuss any queries you may have and look forward to hearing from you.

Yours faithfully

Dr Nisha Dogra
Senior Lecturer and Consultant Psychiatrist
Child and Adolescent Psychiatry

Email: nd13@le.ac.uk
22nd November 2002

Dear Dr X

Participation in PhD study

My name is Dr Nisha Dogra and I am a senior lecturer/honorary consultant in child and adolescent psychiatry at the University of Leicester. I am currently undertaking a PhD entitled “Cultural Diversity and Medical Education”. One of the PhD objectives is to explore the perspectives of key policymakers regarding issues in this area.

I should be most grateful if you as Chair of the Ethnic Issues Committee of the Royal College of Psychiatrists could forward the letter of invitation to participate in my study to the committee members if you agree that this is an appropriate project for this committee to be involved in given its influence regarding issues of ethnicity. I would also like to invite you to participate in the study as the chair of this committee.

I hope that you agree to participation in this project and look forward to hearing from you soon.

Kind regards
Yours sincerely

Dr Nisha Dogra
Senior Lecturer and Consultant Psychiatrist
Child and Adolescent Psychiatry
Email: nd13@le.ac.uk
27th February 2003

Dear

Participation in PhD study

Further to my letter dated 19 January 2003 I have not heard from you and I just wondered whether you were now in any position to make a response.

I look forward to hearing from you.

Yours sincerely

Dr Nisha Dogra
Senior Lecturer and Consultant Psychiatrist
Child and Adolescent Psychiatry
Email: nd13@le.ac.uk
Our Ref: ND/lcm

26 February 2003

Dear

**Participation in PhD Study**

I am writing to thank you for taking the time to participate in my PhD project.

I look forward to writing to you again with a summary of the findings by the end of the year.

Once again, many thanks for your input.

Kind regards.

Yours sincerely

Dr Nisha Dogra
Senior Lecturer and Consultant Psychiatrist
Child and Adolescent Psychiatry
Email: nd13@le.ac.uk
Appendix Four: Interview schedule

"Cultural Diversity" and Medical Education:

Interview schedule for PhD of Nisha Dogra
Introduction
My name is Dr Nisha Dogra and I am a senior lecturer/honorary consultant in child and adolescent psychiatry at the University of Leicester. I am currently undertaking a PhD entitled “Cultural Diversity and Medical Education”. In this interview schedule the issue of ethnicity will be used as a principle example of “cultural diversity” and the issues that this may raise. One of the PhD objectives is to explore the perspectives of key policymakers/heads of medical education/curriculum designers/teachers regarding issues in this area.

This interview should last about 45 minutes. I am hoping that with the perspectives of key stakeholders in medical education I will be able to build on educational models that I have already explored. I would like to assure you that you are granted anonymity and no statements will be linked or attributed directly to you or your organisation. I will be taking notes as well as taping the interview with your permission for later detailed analysis.

Semi-structured interview:

I would like to begin by just checking some of the information I have about you and your role.

PART I
1. Name:

2. Organisation:

Background information of interviewee:

3. Education:

4. Clinical experience

5. Job title:

6. Role of post:

7. Gender

Male    Female

Age:
Under 30  30-35  36-40  41-45  46-50
51-55  56-60  over 60
PART II

I would like to now move on to discuss your personal views or views in your role regarding what you think should happen about teaching “Cultural diversity” to medical students.

8. How do you understand the term “cultural diversity”?

9. What do you think should be taught at undergraduate level about cultural diversity?

10. What main topics do you think that cultural diversity teaching should encompass at undergraduate level?

11. How do you think cultural diversity should be taught?

12. Other areas of human diversity – from your perspective where do they fit in?

13. Should they be taught with cultural diversity or should cultural diversity be a separate course?

   Religion
   Gender
   Sexuality
   Disability
   Social class

I am now going to focus on specific questions about teaching of cultural diversity.

14. At which stage of the medical student’s career should this teaching take place?

   Year 1   Year 2   Year 3   Year 4

   Year 5   Integrated throughout curriculum

Get justification for response.

15. How much time do you think needs to be spent in this area?

Prompts:
0-2 hours  3-5 hours  5-7 hours  8-10 hours  11-12 hours
More than 12 hours
Get justification for response

16. What kinds of learning outcomes would you like to see established for this area?
How might these be phrased?

17. What teaching strategies might be usefully employed?
Prompts:
Discussions  Lectures  Workshops
Small groups  Problem-base or case based learning
Clinical placement (specify with whom)
Community placement (specify with whom please)  Other (please specify)

18. Who do you think should teach cultural diversity? (Prompts: Experts; only those from minority groups; any one who understands the issues and is skilled to teach; any particular clinical disciplines)
If they say experts, ask what to them constitutes someone having expertise in cultural diversity?
On what basis have you formed your opinion? (Opinion/advice from experts; evidence-base; literature; own experience)

I would now like to move on to student assessment and student perspectives.

19. Should students be assessed about cultural diversity?
Get reasons for response

20. How might they be assessed?
Prompts:
Essay  Project  Short answer questions
21. 
   a. Should student feedback be gathered?
   b. If so how might this be done?
   c. How might student feedback be effectively used?
   d. What might be your perspective if students said that they did not feel this kind of teaching was necessary?

22. 
   a. Would it be helpful to have guidelines on what should be taught?
   b. What form might these take and who might develop them?

I would now like to move on to specific programmes you may be aware of.

23. What specific training programmes to teach cultural diversity are you aware of?

24. In your view, could these form models of best practice. (Prompt: have they used an evidence-based approach/been subject to critical evaluation?

25. In your opinion, how do you think programmes that endeavour to teach cultural diversity might be evaluated?

26. In your opinion, how might their impact on clinical practice be measured?

27. 
   a. Are you aware of the GMC perspective on this issue? If so, what is your understanding of it?
   b. What is your perspective on the GMC including this issue in Tomorrow’s Doctors?
(Use this if asked what is the GMC position. GMC statement is “at the end of the course of undergraduate medical education the student will have acquired and will demonstrate attitudes essential to the practice of medicine including respect for patients and colleagues that encompasses, without prejudice, diversity of background and opportunity, language, culture and way of life”?)

28. In your view, does the teaching of cultural diversity have an impact on clinical practice?

29. If no, can you think of reasons why this might be the case?

30. If yes, can you think of how it impacts on practice?

For medical schools only

31. a. Does your medical school have “Cultural Diversity” on the curriculum?

   b. How did this come about?

   c. Who influenced its development?

PART III
I would now like to move on to ask you your understanding of some key terms in this area. I should say that there is no right or wrong answer as such. I am just interested in your views?

What is your understanding of the following terms?

32. Culture

33. Ethnicity

34. Multiculturalism

35. Race

36. Cultural diversity

37. How do you think that the way that these terms are used and understood might influence medical education?

38. Do you have any personal training/experience in cultural diversity issues?
39. How would you classify your own ethnicity?

**Ethnic group**

- **ASIAN**
  - INDIAN
  - PAKISTANI
  - BANGLADESHI
  - OTHER (PLEASE SPECIFY)

- **BLACK**
  - AFRICAN
  - CARIBBEAN
  - OTHER (PLEASE SPECIFY)

- **CHINESE**
  - CHINESE
  - OTHER (PLEASE SPECIFY)

- **WHITE**
  - ENGLISH
  - SCOTTISH
  - WELSH
  - OTHER BRITISH
  - IRISH
  - OTHER (PLEASE SPECIFY)

- **MIXED (PLEASE SPECIFY)**

- **ANY OTHER ETHNIC GROUP (PLEASE SPECIFY)**

Is there anything else that you would like to add – either more about what we have covered or anything you feel I may have left out?

Finally, is there anyone else you think it would be useful for me to meet?

Thank you very much for your help with this project. Would you like to receive a summary of the final project report?
Appendix Five: Table 10: Information on medical schools according to diversity programmes, Times ranking and minority populations as at June 2003

<table>
<thead>
<tr>
<th>School</th>
<th>Teach diversity</th>
<th>Times Ranking</th>
<th>Numbers of minorities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aberdeen</td>
<td>Not explicit</td>
<td>Middle</td>
<td>Low</td>
</tr>
<tr>
<td>Barts/London/Queen Mary</td>
<td>Yes</td>
<td>Bottom</td>
<td>High</td>
</tr>
<tr>
<td>Birmingham</td>
<td>Yes</td>
<td>Bottom</td>
<td>High</td>
</tr>
<tr>
<td>Bristol</td>
<td>No</td>
<td>Bottom</td>
<td>Low</td>
</tr>
<tr>
<td>Cambridge</td>
<td>No</td>
<td>Top</td>
<td>Low/Moderate</td>
</tr>
<tr>
<td>Dundee</td>
<td>No</td>
<td>Middle</td>
<td>Low</td>
</tr>
<tr>
<td>East Anglia</td>
<td>Not clear</td>
<td>N/a</td>
<td>Low/moderate</td>
</tr>
<tr>
<td>Edinburgh</td>
<td>No</td>
<td>Top</td>
<td>Low</td>
</tr>
<tr>
<td>Glasgow</td>
<td>No</td>
<td>Top</td>
<td>Low</td>
</tr>
<tr>
<td>Guy’s, King’s and St Thomas’</td>
<td>Yes</td>
<td>Middle</td>
<td>High</td>
</tr>
<tr>
<td>Imperial</td>
<td>Not clear</td>
<td>Middle</td>
<td>High</td>
</tr>
<tr>
<td>Leeds</td>
<td>Yes</td>
<td>Bottom</td>
<td>High</td>
</tr>
<tr>
<td>Leicester</td>
<td>Yes</td>
<td>Middle</td>
<td>Moderate/High</td>
</tr>
<tr>
<td>Liverpool</td>
<td>Not explicit</td>
<td>Top</td>
<td>Low</td>
</tr>
<tr>
<td>Manchester</td>
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<td>Top</td>
<td>High</td>
</tr>
<tr>
<td>Nottingham</td>
<td>Not clear</td>
<td>Bottom</td>
<td>Moderate</td>
</tr>
<tr>
<td>Newcastle</td>
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<td>Top</td>
<td>Low</td>
</tr>
<tr>
<td>Oxford</td>
<td>Not explicit</td>
<td>Top</td>
<td>Low</td>
</tr>
<tr>
<td>Peninsula</td>
<td>Not clear</td>
<td>N/a</td>
<td>Low</td>
</tr>
<tr>
<td>Queens Belfast</td>
<td>Yes</td>
<td>Bottom</td>
<td>Low</td>
</tr>
<tr>
<td>Royal Free and University College</td>
<td>Yes</td>
<td>Middle</td>
<td>High</td>
</tr>
<tr>
<td>Sheffield</td>
<td>Yes</td>
<td>Bottom</td>
<td>Low</td>
</tr>
<tr>
<td>Southampton</td>
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<tr>
<td>St Andrews</td>
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<td>Low</td>
</tr>
<tr>
<td>St Georges</td>
<td>Yes</td>
<td>Middle</td>
<td>High</td>
</tr>
<tr>
<td>University College of Wales</td>
<td>Yes</td>
<td>Middle</td>
<td>Low</td>
</tr>
</tbody>
</table>
Teach diversity (information from website and or prospectus)

1 Teach diversity and aligns with ‘cultural expertise’
2 Teach diversity and consistent with ‘cultural sensibility’
3 Do not actually formally teach diversity

Ranking (The Times Archives ranking)

1 Top 8
2 Middle 8
3 Bottom 8

Local Ethnic population (hcna.radcliffe-online.com)

1 Low (less than 2.0%)
2 Moderate (between 2.1 and 4.9%)
3 High (more than 5%)
Appendix Six: Characteristics of participants and non-respondents

Table 11: Characteristics of participants

<table>
<thead>
<tr>
<th>Number</th>
<th>Ethnicity as described verbatim by interviewees</th>
<th>Gender</th>
<th>Age</th>
<th>Medical school connection</th>
<th>In clinical practice</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Communication teachers</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.</td>
<td>White Caucasian - white English</td>
<td>M</td>
<td>46-50</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>2.</td>
<td>White, British, multi-dieted</td>
<td>F</td>
<td>46-50</td>
<td>Yes</td>
<td>Non med</td>
</tr>
<tr>
<td>3.</td>
<td>White British</td>
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<td>51-55</td>
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<tr>
<td>4.</td>
<td>Mixed</td>
<td>M</td>
<td>46-50</td>
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<td>Yes</td>
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<td>5.</td>
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<td>36-40</td>
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<td>Yes</td>
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<tr>
<td>6.</td>
<td>White English</td>
<td>M</td>
<td>41-45 (43)</td>
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<td>Yes</td>
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<tr>
<td></td>
<td>Curriculum heads</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td>7.</td>
<td>White English, East Anglian</td>
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<td>46-50 (47)</td>
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<td>8.</td>
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<td>9.</td>
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<td>Diversity teachers</td>
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<td>30-35 (34)</td>
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<td>Age</td>
<td>Medical school connection</td>
<td>In clinical practice</td>
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<td>M</td>
<td>56-60</td>
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<td>White European</td>
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<td>23.</td>
<td>I'm WASP I suppose. Greying hippy</td>
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<td>Yes</td>
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<td>Yes</td>
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<tr>
<td></td>
<td>Policymakers</td>
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<td></td>
<td></td>
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<td>Over 60</td>
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<td>Scottish – am white but would not describe myself as such</td>
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<td>31.</td>
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<td>33.</td>
<td>English. Am white but would not describe myself as such</td>
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<td>No</td>
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<tr>
<td>34.</td>
<td>White English</td>
<td>M</td>
<td>36-40</td>
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<td>Karnataka</td>
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<td>30-35</td>
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<tr>
<td>36.</td>
<td>White, British, English</td>
<td>M</td>
<td>41-45</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>37.</td>
<td>White English</td>
<td>M</td>
<td>51-55</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>38.</td>
<td>White English</td>
<td>M</td>
<td>46-50</td>
<td>Yes</td>
<td>Yes</td>
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<tr>
<td>Number</td>
<td>Ethnicity as described verbatim by interviewees</td>
<td>Gender</td>
<td>Age</td>
<td>Medical school connection</td>
<td>In clinical practice</td>
</tr>
<tr>
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<td>--------</td>
<td>-----</td>
<td>---------------------------</td>
<td>---------------------</td>
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<td>White British</td>
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<td>46-50</td>
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<td>No</td>
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<td>51-55</td>
<td>Yes</td>
<td>Yes</td>
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<td>White – other</td>
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<td>46-50 (49)</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>42.</td>
<td>White English</td>
<td>M</td>
<td>56-60</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>43.</td>
<td>Indian</td>
<td>M</td>
<td>46-50</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>44.</td>
<td>White British</td>
<td>M</td>
<td>56-60</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>45.</td>
<td>White – other British</td>
<td>M</td>
<td>51-55 (54)</td>
<td>No</td>
<td>Yes</td>
</tr>
</tbody>
</table>

**Researchers**

| 46.    | Working-class Midlander with Irish Catholic background | M | 36-40 | Yes | No |
| 47.    | White British, white English, Scottish ancestry and from Kent | M | 51-55 | Yes | No |

**Medical Students**

<p>| 48.    | British, Caucasian                             | F      | Under 30 | Yes | In training |
| 49.    | White, Christian, but from a Jewish background | F      | Under 30 (23) | Yes | In training |
| 50.    | White, Church of England, South of England     | F      | Under 30 | Yes | In training |
| 51.    | Caucasian                                      | M      | Under 30 | Yes | In training |
| 52.    | European British, male or white depending on context | M | Under 30 | Yes | In training |
| 53.    | British person of Indo-African descent         | M      | Under 30 | Yes | In training |
| 54.    | Caucasian                                      | M      | 31-35 (31) | Yes | In training |</p>
<table>
<thead>
<tr>
<th>Number</th>
<th>Ethnicity as described verbatim by interviewees</th>
<th>Gender</th>
<th>Age</th>
<th>Medical school connection</th>
<th>In clinical practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Users/advocates</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>55.</td>
<td>Indian</td>
<td>M</td>
<td>41-45</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>56.</td>
<td>White</td>
<td>M</td>
<td>30-35</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>57.</td>
<td>Black British</td>
<td>F</td>
<td>41-45(42)</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>58.</td>
<td>Irish, Welsh, Celtic, English and working class</td>
<td>F</td>
<td>51-55 (53)</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>59.</td>
<td>White English</td>
<td>F</td>
<td>Over 60 (65)</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>60.</td>
<td>White Welsh</td>
<td>M</td>
<td>30-35</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>61.</td>
<td>British Muslim</td>
<td>M</td>
<td>Under 30 (26)</td>
<td>No</td>
<td>No</td>
</tr>
</tbody>
</table>
Table 12: Characteristics of those who responded but declined to participate

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

There were 11 individuals to whom I personally wrote and who did not respond. As enough participants had been recruited, only one of these received a reminder. 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 13: Characteristics of non-respondents

<table>
<thead>
<tr>
<th>Number</th>
<th>Role</th>
<th>Organisation</th>
<th>Clinician</th>
<th>Gender</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Teacher</td>
<td>Medical school</td>
<td>No</td>
<td>M</td>
</tr>
<tr>
<td>2.</td>
<td>Communications teacher</td>
<td>Medical School</td>
<td>No</td>
<td>F</td>
</tr>
<tr>
<td>3.</td>
<td>Researcher</td>
<td>Medical School</td>
<td>Yes</td>
<td>M</td>
</tr>
<tr>
<td>4.</td>
<td>Communications teacher</td>
<td>Medical school</td>
<td>Yes</td>
<td>F</td>
</tr>
<tr>
<td>5.</td>
<td>Researcher</td>
<td>University research group</td>
<td>No</td>
<td>F</td>
</tr>
<tr>
<td>6.</td>
<td>Policymaker</td>
<td>Royal College</td>
<td>Yes</td>
<td>M</td>
</tr>
<tr>
<td>7.</td>
<td>User rep</td>
<td>User organisation</td>
<td>No</td>
<td>F</td>
</tr>
<tr>
<td>8.</td>
<td>Student</td>
<td>N/A</td>
<td></td>
<td>F</td>
</tr>
<tr>
<td>9.</td>
<td>Policymaker</td>
<td>User organisation</td>
<td>Unsure</td>
<td>M</td>
</tr>
<tr>
<td>10.</td>
<td>Policymaker</td>
<td>User organisation</td>
<td>No</td>
<td>M</td>
</tr>
<tr>
<td>11.</td>
<td>Policymaker</td>
<td>User organisation</td>
<td>No</td>
<td>F</td>
</tr>
<tr>
<td>12.</td>
<td>Policymaker</td>
<td>User organisation</td>
<td>No</td>
<td>F</td>
</tr>
<tr>
<td>13.</td>
<td>Policymaker</td>
<td>Medical organisation</td>
<td>No</td>
<td>F</td>
</tr>
<tr>
<td>14.</td>
<td>Policymaker</td>
<td>User organisation</td>
<td>No</td>
<td>F</td>
</tr>
<tr>
<td>15.</td>
<td>Policymaker</td>
<td>User organisation</td>
<td>No</td>
<td>M</td>
</tr>
<tr>
<td>16.</td>
<td>Policymaker</td>
<td>Medical organisation</td>
<td>No</td>
<td>M</td>
</tr>
<tr>
<td>17.</td>
<td>Policymaker</td>
<td>Medical organisation</td>
<td>No</td>
<td>M</td>
</tr>
</tbody>
</table>
Appendix Seven: Table 14: Summary of content analysis undertaken on the information available from UK medical school websites as at June 2003

Bio means biomedical; beh means behavioural sciences

<table>
<thead>
<tr>
<th>Medical School</th>
<th>Course identified diversity as an issue</th>
<th>Diversity discussed as part of curriculum</th>
<th>Consistency between behavioural and biomedical sciences</th>
<th>Information re course available on website and whether 'cultural expertise' or 'cultural sensibility' approach</th>
</tr>
</thead>
<tbody>
<tr>
<td>University of Aberdeen</td>
<td>No</td>
<td>No</td>
<td>Bio&gt;beh</td>
<td>Not mentioned</td>
</tr>
<tr>
<td>Barts and the London School</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>Healthcare for minorities as SSSM</td>
</tr>
<tr>
<td>University of Birmingham</td>
<td>No</td>
<td>No</td>
<td>Bio=beh</td>
<td>Very brief, psychology and sociology of illness</td>
</tr>
<tr>
<td>University of Bristol</td>
<td>Yes</td>
<td>Yes</td>
<td>Bio=beh but not marked</td>
<td>Health and Society CE model</td>
</tr>
<tr>
<td>University of Cambridge</td>
<td>No</td>
<td>No</td>
<td>Bio&gt;beh</td>
<td>Not mentioned</td>
</tr>
<tr>
<td>University of Dundee</td>
<td>No</td>
<td>No</td>
<td>Bio&gt;beh but not marked</td>
<td>Not mentioned Integrated PBL</td>
</tr>
<tr>
<td>University of East Anglia</td>
<td>No</td>
<td>No</td>
<td>Nothing specific mentioned</td>
<td>Not mentioned Little course information Clinical presentation curriculum</td>
</tr>
<tr>
<td>University of Edinburgh</td>
<td>No</td>
<td>No</td>
<td>Bio=beh</td>
<td>Not mentioned Vertical integrated themes</td>
</tr>
<tr>
<td>University of Glasgow</td>
<td>No</td>
<td>No</td>
<td>Bio=beh</td>
<td>Not mentioned Very brief website; PBL</td>
</tr>
<tr>
<td>The Guy’s, King’s College and St Thomas’ Hospitals’ Medical</td>
<td>No</td>
<td>No</td>
<td>Bio=beh</td>
<td>11.7.1..1.1.1.1.1 Practice of Medicine SSSM cultural aspects of health of ethnic minorities Integrated curriculum</td>
</tr>
<tr>
<td>Imperial College</td>
<td>No</td>
<td>No</td>
<td>Bio&gt;&gt;beh</td>
<td>Not mentioned</td>
</tr>
<tr>
<td>University of Leeds</td>
<td>Yes</td>
<td>Yes</td>
<td>Bio=beh</td>
<td>Behavioural sciences Becoming a doctor Very explicit learning outcomes CE approach</td>
</tr>
<tr>
<td>Leicester Warwick University</td>
<td>Yes</td>
<td>Yes</td>
<td>Bio=beh</td>
<td>Human Diversity Module</td>
</tr>
</tbody>
</table>

306
<table>
<thead>
<tr>
<th>University of Liverpool</th>
<th>Yes</th>
<th>Yes</th>
<th>Bio=beh</th>
<th>Theme of Individuals and groups in society not expanded on: PBL</th>
</tr>
</thead>
<tbody>
<tr>
<td>University of Manchester</td>
<td>No</td>
<td>No</td>
<td>Bio&gt;beh</td>
<td>‘Other members of society’ mentioned suggests a CE approach</td>
</tr>
<tr>
<td>University of Newcastle</td>
<td>No</td>
<td>No</td>
<td>Bio=beh</td>
<td>PPD strand but not mentioned</td>
</tr>
<tr>
<td>University of Nottingham</td>
<td>No</td>
<td>No</td>
<td>Bio=beh</td>
<td>PPD strand</td>
</tr>
<tr>
<td>University of Oxford</td>
<td>No</td>
<td>No</td>
<td>Bio=beh</td>
<td>Lifestyle advice</td>
</tr>
<tr>
<td>Peninsula Medical School</td>
<td>Yes</td>
<td>Yes</td>
<td>Bio=beh</td>
<td>PBL People in different groups considered Suggests a CE approach</td>
</tr>
<tr>
<td>The Queen’s University of Belfast</td>
<td>Yes</td>
<td>Yes</td>
<td>Bio=beh</td>
<td>Science society medicine CE approach</td>
</tr>
<tr>
<td>Royal Free and University College</td>
<td>Yes</td>
<td>Yes</td>
<td>Bio=beh</td>
<td>Vertical strand</td>
</tr>
<tr>
<td>University of Sheffield</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>PBL Hard to identify from problem list</td>
</tr>
<tr>
<td>University of Southampton</td>
<td>No</td>
<td>No</td>
<td>Unclear</td>
<td>Brief with difficult to access website Integrated</td>
</tr>
<tr>
<td>University of St Andrews (Bute)</td>
<td>No</td>
<td>No</td>
<td>Bio=beh</td>
<td>Traditional broad beh sciences</td>
</tr>
<tr>
<td>St George’s Hospital Medical School</td>
<td>No</td>
<td>No</td>
<td>Bio&gt;beh but all brief</td>
<td>Patient/doctor relationship Community Professional development</td>
</tr>
<tr>
<td>University of Wales College of Medicine</td>
<td>Yes</td>
<td>Yes</td>
<td>Bio=beh</td>
<td>Health in Society Vertical strand CE approach</td>
</tr>
</tbody>
</table>
Appendix Eight: Questions from reading transcripts and keywords

Philosophy

1. To train doctors technical competence and social responsibility
2. Private versus public domain
3. Changing culture of medical students and medical schools
4. Levels of expertise and whose expertise counts
5. Layered/levels for definitions of cultural diversity
6. Assumptions of majority, assumptions of minorities
7. Culture means colour
8. Occupational, institutional and organisational cultures
9. Awareness of culture
10. At a time when medicine is already being questioned, do we want to question ourselves even more?
11. Medicine as a subculture
12. Work with limitations as may be only way to gets started.
13. Not all white male doctors are bad at dealing with patients; conversely not all minorities are intrinsically good at dealing with patients.
14. Acknowledging own prejudices
15. How am I going to reassure them (gay people) if it’s appropriate to reassure them?
   How is reassuring gay people different from reassuring other people
16. Who decided which value base we work from
17. Raising awareness in medical students that they are going to have to keep looking at people as individuals
18. Cultural diversity is now the norm in the community, still seen as new in the curriculum
19. Listening to people’s experiences and not categorising them
20. Negative views of whites, a bit like whites are ill informed and ignorant re cultural issues and others are not
21. Not just an ill considered add on
22. Does diversity teaching equal equality teaching
23. Teaching diversity as a foundation
Policies

24. How are the teaching and political agendas set? (x talks of “getting into the conscious”.
25. Much of the policy is decided by white men who hold the power
26. Divisions within disciplines e.g. sociology regarding what is important
27. Too inclusive a concept
28. Being driven to do it to show we are doing it rather than because it is perceived to be important
29. Seizing on what is fashionable and maximising opportunities
30. Knowing they are different – implies all difference is physically visible
31. Support from big shots
32. Putting policies into practice – does it actually mean anything

Curriculum design issues

33. Should not be separated out but concern that if this is not done, cultural diversity won’t be taught at all.
34. Disadvantages versus advantages of teaching it discreetly.
35. Concern re tick box approach
36. Different aspects being covered in different components of the course
37. Relationship of cultural diversity and other bits of the curriculum
38. Science versus humanities debate?
39. Response to GMC – lip service and knee jerk
40. Only interested in outcomes and yet process in this type of teaching may be equally important (links with evaluation)
41. Coordination across the curriculum
42. Treating cultural diversity as other parts of the curriculum
43. People not knowing how different parts of the curriculum fit together
44. Integrating different parts of the curriculum whilst retaining discipline integrity.
45. Some degree of consistency needed across medical schools
46. Assumption that there is as such a core curriculum for medicine

Contents

47. Matching the balance of theory with application for students
48. Impression that if have practical teaching and experience stereotypes, these will be
   challenged by the very nature of the experience itself (e.g. Y). Makes the
   assumption that people are prepared to accept that do see “others” stereotypically.
49. Setting the context
50. Being able to meet needs of diverse population not just about being nice
51. Long term or short term evaluations
52. How long does influence of teaching last (if it has any to start with)
53. Language for talking about diversity, the language for the dialogue
54. Different roles we have for ourselves
55. Teaching groups of white only and black only groups, advantages and
   disadvantages
56. Rooting diversity in a specific subject – advantages and disadvantages. How much
   is conceded to students who don’t value the teaching?
57. How much time – very few said how much more said what it should not be e.g. a
   single seminar (unclear whether this represented programmes or practices they
   have witnessed or participated in)?
58. Consistency with what programmes do and what people say they do, e.g. is there
   consistency with Positively Diverse (what was described by one interviewee as
   being said by the person involved was not what was on the website)
59. Balance between self-reflection and issues such as institutional racism
60. Trivialising the agenda and issue by getting teachers with unclear teaching
   agendas
61. No two people are the same but then for teaching about black issues needs a black
   person
62. Issue of language – instead of black people have less assumptive descriptions
63. Get students to face their prejudices and biases – meet those people, which they
   have negative and positive perspectives on.
64. Diversity teaching is just common sense
65. Balance knowledge with skill
66. Obvious differences commonly identified, more subtle differences may be ignored
67. How useful is knowledge without an ability to communicate
68. Encourage difference compared with minimise it or exaggerate it
69. International health and diversity are interchangeable or the same
70. Does teaching cultural diversity generate stereotypes
71. Range of humanities option so all students do at least one
72. The kinds of case scenarios used – do they really test what we want to test
73. Cultural diversity tests not needed – effective communication

Teacher issues

74. Isolation of teachers trying to change the identity and focus
75. Role of individuals in pushing forward curriculum as opposed to faculties
76. Faculty level support in course development
77. Skills of teachers
78. GMC policy as a backup to support arguments
79. Researching our teaching
80. Balance between what teachers think is necessary and demands made by students
81. Cultural bias of teachers
82. Teachers aware of their own experiences and gripes and when developing cdt how do they ensure that don’t influence it too heavily with their own perspectives
83. How much is conceded to students who don’t value the teaching?
84. How many teachers are happy with what they teach
85. Guidelines provide limits and goals for teachers.
86. Inconsistencies that often those who provide teaching (in and out of medical education context) have often not been through appropriate training themselves.
87. Teaching needs to ensure it is not attacking
88. Charisma of teachers – evangelical ones find it harder to engage with students.
89. If as a teacher you try and push diversity you come up against discrimination and are not taken seriously.
90. Need to be highly knowledgeable
91. The value of teaching in the NHS or the lack of it and to some extent universities

Student issues

92. Students struggling, difficulties, uncomfortable
93. Early induction to ways of learning
94. Concerns that if do too much on diversity, students will be disengaged.
95. Conflict of interest e.g. Islamic male students dismissing women
96. Challenging students about how the course has helped or not
117. Undergraduate and postgraduate continuity
118. Meaning or consequences for PRHO monitoring
119. Concepts of negotiation and shared care
120. Applicability of cultural diversity teaching to interdisciplinary teamwork
121. Readiness/preparedness to practise
122. Concept that if people are working in an area with diversity, automatically
must be dealing with issues of diversity (a bit like the idea that if Asian seeing
Asians must be meeting their needs)
123. Assumptions about what actually happens in practice – singular view as
though all practice re diversity and managing it is the same.
124. Problems in clinical care cut across all cultures.
125. Equality of care does it or does it not equal same care (implies needs are
the same)
126. Conflict of interest, patient versus family and confidentiality (raised by A)
– clinicians may recognise needs of Asian family’s wish to be involved but
dismiss the needs of white families based on stereotypes.
127. Important that students are trained to think about the people that they are
going to be looking after and the families that they are dealing with
128. System impacting on doctors to effectively be able to do their jobs
129. Needs of patients from similar background are met and we just need to
know about others
130. Balancing cultural and clinical need (e.g. circumcision)
131. Equitable outcomes of care – what does this mean
132. Negotiating with patients when their value base conflicts with yours.

Interview responses
133. Some respondents thought they had very good understanding of the issues
but then said some very inconsistent things in interviews (e.g. B, q13)
134. Does it need to be popular?
135. Does cdt really just mean racism – is it a nice way of saying let’s talk
about racism without being explicit.
97. Assumptions that older students are “more mature”, is that borne out in practice.
98. Interest in people and the humanities) selection procedures
99. Assumptions about what doctors can and cannot understand.
100. Are differences made by the skill or information that doctors have?
101. Students see a great deal of bad practice
102. Teaching versus learning
103. Student follow up in practice
104. How do we in a sense encourage students to explore people’s different
    ideas and beliefs and concerns without hanging it on a label of race or religion?
105. Students want security of knowledge
106. Need to encourage learners to explore their baggage – if the baggage
    comes out there is a chance for an honest discussion
107. Action against non credible students

Community involvement

108. Who to use in the community
109. Mutual learning opportunities for patients to learn about doctors too
110. Cultural diversity officers
111. Experts to teach students and increase student experience, e.g. Leeds
    curriculum has lots of different workshops taking place and very little actual focus
    on self-reflection.
112. What do minority groups “owe” majorities and vice versa.
113. Sometimes those interviewed did not see the bigger picture e.g. “Cultural
    diversity in training, it’s about making use of the community resources, tapping
    into the community…” or “Basically (cultural diversity is) about trying to
    encourage community involvement”.
114. Community liaison – is that cultural diversity?
115. Need to involve all parties, as increased participation reduces perceived
    threats
116. User perspectives – are they really user generated or generated by well
    meaning (or not) professionals with their own agendas.

Issues relating to clinical practice
136. Many don’t move beyond gut responses answer – C says something and then thinks about it and then recognises that is her bias so backtracks with different response

137. “Us and them” approach

138. Contradictions such as “it’s about using someone who is from a particular culture and asking what the expectations were….” “Every person perceives their own health in a different way”…
Key words

"These groups”  Actors  Application
Attitude  Balance  Black versus Asians
Blame culture  Certainty  Check
Clinical relevance  Coherent  Collaboration
Common sense  Communication Compartmentalised
Competing agendas  Complaints register  Complex issue
Conceptual  Core curriculum  Critical
Culturally neutral  Cultural problems  Cynical
Discrimination  Disparity  Embedded
Faculty and support  Fashionable/trendy  Ghettoised
Holistic/whole person  Humanities  Identity
Inconsistency  Integration  Inter-group issues
Investment  Irrelevant  Jobs
Judgement  Justification  Labels
Learning languages  Linking  Local
Marginalised  Mechanistic  Medical defence
Minority groups  Misconceptions  Mutual learning
Observation  Offence  Offensive/offending
Openness  Oppression  Over sensitiveness
Patient stories/experiences  Patronising  Peers
Policy  Political correctness  Positivist
Postgraduate courses  Private life  Problems
Process  Professionalism  Racism
Reflection/reflective practice  Research  Role models
Role-play  Second generation  Selection
Seriously  Shifting/fluid/dynamic  Simulated patients
Social responsibility  Spectrum  Student societies
Subcultures  Suitability to practice  Suing
Teamwork  Technical  Technical competence
Tick box  Tokenistic/tokenism  Toolkit
Truth  Uncertainty  Uncomfortable
User satisfaction  Valued  Values/attitudes/biases/prejudices
Videotapes  Western
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