

CULTURAL DIVERSITY EDUCATION: DOES THIS 'SOFT SCIENCE' DESERVE A PLACE IN MEDICAL CURRICULA?

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Introduction

Cultural diversity issues surround us in today's society and there continues to be much political and social debate about the myriad of topics that come under this heading. However this is yet to be mirrored in medical school curricula across the country. In the UK the need to train medical undergraduates and healthcare professionals to interact and work well with individuals from a diverse range of backgrounds has been emphasised by the General Medical Council (GMC) publication *Tomorrow's Doctors*, and the discussion papers that followed. It states that "[Graduates] must understand a range of social and cultural values, and differing views about healthcare and illness... They must 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" (GMC, 2007). As this is found in the Curricular Content section it would imply that Cultural Diversity Training should be integrated into the medical school programme.

It has been recognised by students, practitioners and policy makers alike that cultural, ethnic and social factors play a critical role in healthcare (Dogra, 2004b), however this acquiescence is the just the tip of the proverbial iceberg. Formal cultural diversity training is still in its infancy and its content, context, clinical relevance and value, practical application and evidence-based evaluation continue to be debated. To all intents and purposes it is accepted that training students to be competent and sensitive to cultural diversity whilst actively examining their own attitudes would fulfil the GMC curriculum content criteria.

However many questions still need to be answered before a cultural awareness course has a solid place in UK medical undergraduate institutions, starting with a concrete argument for why it should be integrated and what specifically would be taught under the heading of cultural awareness. Who would be responsible for the teaching and how would the teaching be carried out? At what point during the undergraduate programme would the teaching be applied and would assessment of these skills be a requisite? Themes arising from the debate include

ambivalence from students about the value of cultural diversity awareness (Dogra, 2006), fears that 'diversity awareness' may only encourage stereotyping and focus on 'difference', and uncertainty over the content and efficacy of existing pilot teaching projects (Dogra, 2005b).

Conflicting student opinion further highlights the uncertainty surrounding diversity training. In one qualitative study (Beagan, 2003) "Students indicated that they believed social factors had little or no effect on their experiences as medical students". Whereas in another survey-based publication (Dogra, 2001a) "Students accepted that doctors have a responsibility to be aware of the different cultures within their practice". These contradictory stances are to be expected considering the controversial and equivocal nature of the diversity training debate. The question that has to be asked is: will these changes benefit students, healthcare professionals and, perhaps most importantly, patients in the future?

'The People vs. Diversity Training': The Case for Cultural Awareness Education

Surely encouraging more cultural awareness in our rapidly diversifying society could only be perceived as a positive thing? However matters concerning the superficial and fundamental "differences" between us are rarely black and white. In medical practice people from all walks of life are thrown together through choice and necessity, so it is not only in the patient's best interests, but also in our own, to understand and respect any perceived diversity. Statutory bodies in the UK and US have taken on board this premise (Dogra, 2004a) and these ideas are beginning to filter down to medical school institutions. However a strong case still needs to be made for why cultural awareness training deserves an official place in the five-year medical course.

In today's society multiculturalism, ethnic diversity, racism and prejudice are constantly experienced and debated in the public arena. The medical world is no exception. Reports have exposed a lack of effective access to appropriate healthcare services for "ethnic minorities" (Smaje, 1994) and negative or racist attitudes of some healthcare workers delivering poor quality care to certain ethnic groups (Kai, 1999). At the root of why we need some level of culture awareness training is the doctor-patient relationship. Prejudice and misunderstanding of cultural norms have a clear negative effect on the patient experience and can actually lead to poorer health outcomes (Kai, 1999). The novel *The Spirit Catches You and You Fall Down* (Fadiman, 1998) echoes this sentiment. Fadiman describes the

miscommunication between a Hmong (an ethnic group in China and Southeast Asia) family and the healthcare workers treating their young daughter which lead to her unnecessary death from epilepsy. This extreme example should at the very least encourage debate about the need for cultural awareness and the detrimental effect of poor communication (Wear, 2001).

Moving from the old paternalistic style of consulting to a more patient-centred approach is also high on the training agenda. In essence, instead of the healthcare professional being the infallible authority figure, the patient becomes the focus. Patients should be encouraged to become more involved and invested in their care, including the decision-making process. The Picker Report (2006) argued that 'education is vital to the development of the attitudes, knowledge and skills that are essential if doctors are to involve patients more proactively in their healthcare'.

Also due to the highly mobile nature of a newly-qualified medic (Kai, 1999), cultural awareness training should in theory facilitate movement between cities, societies and cultural groups.

Cultural awareness training, combined with communication skill acquisition, would better prepare future practitioners to deal with patients and each other as equals. In one US study graduate participants felt 'disadvantaged by the lack of formal training and felt poorly equipped to deal with cross-cultural encounters'. Paradoxically, another study reported that pre-registration house officers [1st year post qualification - now 'foundation house officers'] felt that formal teaching on culture and ethnicity was not required, but acknowledged that their level of cultural awareness was low (Loudon, 2001). Crucially, however, it was noted in the same report that students who had experienced such teaching did find it clinically relevant and believed it would lead to improved care.

For straightforward validation of cultural diversity training we need only look at the data: 'Evidence shows that good communication skills diminish the risk of malpractice... Appreciation of cultural diversity should also increase patients' adherence to treatment regimens and improve outcomes, including patient satisfaction' (Dogra, 2005). Unfortunately, introducing what would have to be a complex and detailed cultural diversity section to an already packed medical curriculum is much easier said than done.

Content and context: What exactly is Cultural Awareness Training?

Kai et al. (2001) pointed out that 'although many medical curricula may include some reference to 'culture' few have significant, if any, multicultural components'. In the UK, cultural diversity teaching has tentatively evolved over the past decade but remains 'fragmented' with obvious uncertainty surrounding actual content (Dogra, 2005). This is partly symptomatic of the complexity of the subject matter itself. Whose responsibility should it be to sit down and write the rule book 'How and what to teach: Cultural diversity, the comprehensive guide'? This complicated task requires input from everyone involved (students, healthcare workers, policy makers and patients alike), a strong foundation in evidence-based study and the tried and tested formula of trial and error, whereby pilot attempts are evaluated, discussed and improved on (Dogra, 2005).

Current teaching appears to be limited according to various qualitative reports detailing student opinions. In one study based in a UK medical school 'teaching emphasized ethnic differences in disease prevalence, for example sickle-cell anaemia among African-Caribbeans, tuberculosis in South Asians...' (Kai, 2001). Essentially the majority of ethnic diversions in current curricula are a subset of disease aetiology. This teaching could fall into the pitfalls of stereotyping and 'tokenism', both concepts that formal cultural awareness training should avoid. Cultural awareness should promote the patient as an individual rather than an indistinct member of a homogenous group. A method of teaching in which ethnic diversity is characteristically 'bolted on' to the end of a topic (tokenism) works against this and perpetuates ethnic stereotypes (Kai, 1999).

Another common perception amongst students was that much of their multicultural awareness had been largely influenced by factors outside the medical curriculum, namely derived from cross-cultural clinical encounters or the "diversity" of the student body itself. However Shapiro et al. (2006) hypothesised that 'there tends to be more homogeneity than heterogeneity in terms of academic ability and socio-economic status in medical school' (Shapiro, 2006). Experiences in the "bubble" of medical school may not fully equip you to deal with every cross-cultural interaction as a newly qualified health professional. Some do believe that this sort of implicit learning is sufficient to teach multicultural values, but though this practical learning is irreplaceable, evidence has shown some sort of additional formal teaching is beneficial (Dogra, 2001b).

Various pilots have been initiated to teach cultural diversity in medical schools across the UK (Dogra, 2001b; Kai, 2001). In one such pilot, Dogra et al. (2001b) set out objectives enabling students to 'gain factual and practical information about other

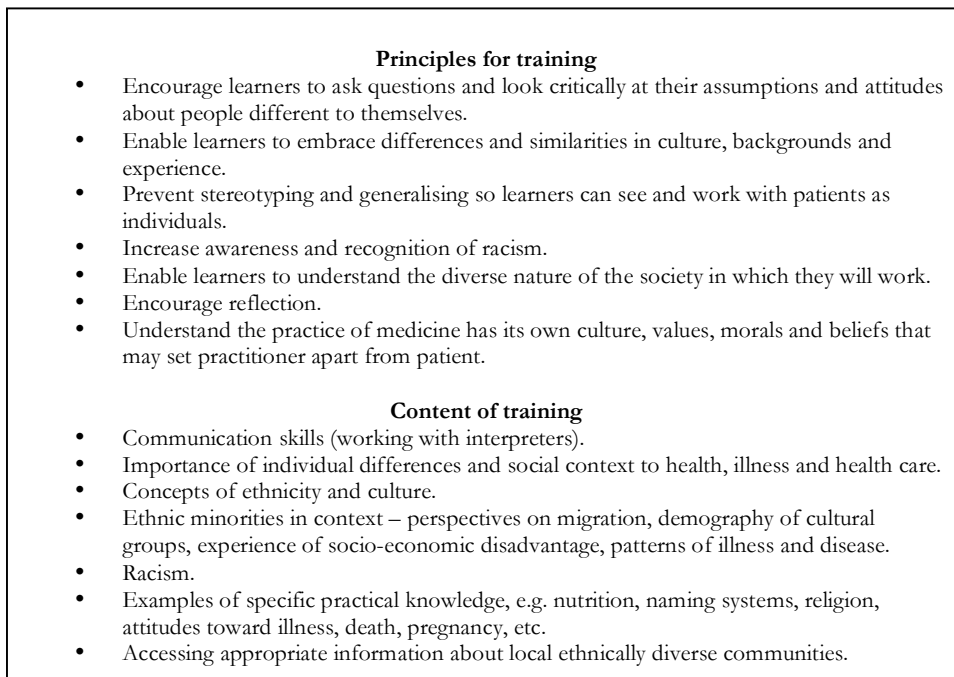


Figure 1: Learning to value ethnic diversity (Kai, 1999)

cultures and to examine their own attitudes'. This demonstrates the two sides to cultural awareness training; the facts, theory, knowledge and skills behind diversity education versus attitudinal change and self-reflection. For example, education about various ethnic origins, differing cultural beliefs and practices in relation to health and health care, cultural presentation of illness and cultural aspects of the doctor-patient relationship, would fall into the 'factual information' category (Dein, 2005). Recognising the limitations of your own knowledge and seeking advice, acknowledging and respecting the differences that exist between different groups of people, self-reflection and avoiding stereotyping and assumptions would be attitudinal adjustment

Though various studies reported that 'the main areas perceived as important centred upon factual knowledge and communication skills' (Kai, 2001), the attitudinal aspect of cultural awareness teaching is widely accepted as fundamental, yet is ironically only rarely applied in practice. Students should learn to honestly evaluate their own attitudes, biases and prejudices as part of cultural awareness education. Critical self-awareness and exploring one's own culture would lead to less focus on "difference" and perceiving "others" as a deviation from the norm. Beagan (2003) argued that it is all too easy to fall into the trap of subconsciously believing that 'Only immigrants and ethnic minorities have a culture, only those of Asian, African, or Indian heritage have a race, only women have a gender, only the gay and lesbian have a sexual orientation, only the working class and impoverished have a social class. Everyone else is neutral, normal' (Beagan, 2003). Self-

study exercises are set to be an integral part of cultural awareness training.

For cultural awareness training to be accepted and valued by undergraduates the subject matter must have clear clinical relevance (i.e. the content taught easily translates to the ward) and 'that factual knowledge should be relevant and grounded in healthcare issues, avoiding theoretical overkill' (Kai, 2001). The principle of self-reflection should be put across in such a way that it is not automatically perceived as "too touchy feely" (Beagan, 2003).

The terminology behind cultural awareness training is another grey area that should be focused on. There is a reported lack of consistency between the perceived definitions and use of the terms 'culture', 'multicultural', 'ethnicity' and 'race' (Dogra, 2004a). Before cultural awareness education can be standardised, the basic issue of language needs to be addressed, however the minefield of political correctness makes this task difficult.

Kai et al. (1999) put forward comprehensive principles for learning to value ethnic diversity, and these continue to form the backbone of cultural awareness training projects today (fig 1). The next step is *how* to facilitate diversity education.

Blackboard to brain: How should diversity training be taught and assessed?

In theory the integration of cultural awareness teaching should be simple once the content and context have been standardised. However another hurdle appears when considering how teaching should be delivered. Didactic teaching or small group work? Various methods of teaching cultural

awareness have been put forward by commentaries and studies. These include seminars, small group discussions, exercises, videos, clinical experience, community work, problem-based learning and peer tutoring, all with the help of thought-provoking and powerful media (Kai, 2001; Dein, 2005). Students in the UK were less likely to agree that cultural diversity could be taught via didactic teaching (Dogra, 2004). There is a need for an open forum of discussion about the best teaching methods comprising of evaluation and feedback.

This debate also introduces the million-dollar question: should cultural awareness be formally assessed? On the one hand, is it actually possible to conclusively assess student attitudes and would failing be a sacking offence? On the other hand, it is widely conjectured that, without assessment, students do not value content. One UK-based study (Dogra et al. 2006) gathered the opinions of policymakers, teachers of diversity, students, service users and carers. Ambivalence over the need to assess undergraduate medical students was a recurrent theme. Though the ‘no assessment, no value’ argument was put forward, some were concerned assessment may encourage false attitudes: “ ‘There is a problem about the gap between competence and performance. People may do well in the end of year OSCE [Objective Structured Clinical Exam; practical exam] on diversity but may have terrible attitudes whilst practising’ – diversity teacher’ (Dogra, 2006). Uncertainty also surrounded the best methodology for assessment. The OSCE arose as the most favoured, but deemed to be inadequate alone.

‘We used to have a communications OSCE station[practical exam]. Students would come in, they would sit down, they would have this intense eye contact, they may start to paw patients, empathise by holding their hand, because this was a niceness station, and no matter how crap your knowledge was, if you were nice to a patient you could pass... That’s not acceptable to me as a doctor’ – curriculum head (Dogra, 2006)

Other suggested methods included ‘multiple choice questions, short answer questions, clinical scenarios, written papers, portfolios, critical thinking and continuous assessment. Other publications have also championed the benefits of combining OSCE’s with another assessment format, perhaps a more long-term, peer-assessed option such as a reflective journal or portfolio.

There is also the educational model to consider, i.e. the style in which cultural awareness should be taught. Cultural competence and cultural sensibility are two distinct models. Dogra (2003) theorised that the cultural competence model ‘presents culture as a set of static facts that can be

learned... and reduces cultural diversity to a core set of beliefs and thoughts that are then extrapolated to a given minority group’. According to Dogra cultural competency disregards patient-centredness and respecting that each patient is an individual. The study goes on to propose the alternative of ‘cultural sensibility’. Cultural sensibility has communication and the patient at its core. Constant self-reflection and treating the patient as a unique, distinct entity are encouraged. ‘Students learn to view culture as constantly in flux and gain knowledge about culture through careful and thoughtful interactions with patients, colleagues and by exposure to various media’. On paper, the benefits to cultural sensibility are clear, but in practice a combination of both teaching models would perhaps work best in undergraduate curricula: the succinct, clear nature of cultural competence whilst learning cultural facts, teamed with the flexibility of cultural sensibility when reaching attitudinal objectives.

Securing a place for cultural awareness training in medical curricula is a daunting task, not least because of the imbalance of the biomedically relevant and the socially relevant (Prideaux, 1999). To completely permeate the medical school syllabus, cultural awareness teaching should be its own entity and not ‘tacked on’ to subjects that are perceived as more important. If the teachers and curriculum heads are lukewarm towards cultural awareness training, the medical students will reflect these sentiments (Kai, 1999). This brings us round to *who* should actually implement cultural awareness teaching and at what point during the undergraduate years should diversity education be integrated?

And finally... Who and When?

Both Prideaux, (1999) Kai and colleagues (1999) stipulate that staff development is crucial. To competently teach cultural awareness training they must fully understand and be confident in the material. It is also the responsibility of current practitioners to promote what has been learnt ‘in the classroom’ on the wards as their behaviour is highly influential (Beagan, 2003). The Picker Report noted that ‘much medical training appropriately takes place in the workplace. If trainee doctors are frequently presented with role models whose consulting styles and interactions with patients are stuck in a paternalistic or directive mode, there is a strong likelihood they will forget what they have been taught and instead adopt these observed behaviours.’ (Picker, 2006)

Prideaux (1999) also believed that ‘Medical schools should seek to attract members of cultural and ethnic groups... to their faculties. They should

become the designers, teachers, ongoing evaluators and innovators of the culturally and ethnically safe curriculum programs', a view not unlike the controversial US policy of affirmative action. Surely this fits well with the cultural sensibility model of constantly learning from colleagues and patients alike. Our ethnically diverse society should be mirrored in the student body and faculty.

For once, whilst considering *when* cultural diversity training should be implemented, there has been a general consensus. It has been suggested that teaching should be introduced pre-clinically (i.e. early lecture-based years during which students are rarely in hospital) and continue through to when the material had immediate and direct clinical application. Evidence suggested a vertical spine running throughout pre- and post-clinical years would be most beneficial. 'Our common findings across undergraduate year groups and with postgraduate learners suggest that training needs to be integrated across the different stages of the medical curriculum, and that locating training only in the early undergraduate years will be inadequate' (Kai, 2001). Though this is a nice idea in theory, any current cultural awareness training remains firmly in the backseat of pre-clinicals.

The Past, Present and Future of Cultural Awareness Training

Cultural awareness training is still taking its baby steps towards the standard medical curriculum. This perhaps is understandable considering the complex and controversial material it covers. Does what is perceived by many as a "soft science", i.e. "socially and culturally relevant" (Prideaux, 1999), have any place amongst the "biomedically relevant" aspects of the current medical curriculum? Will fully integrated diversity training be effective or well received? There are many sides to the discussion but notably these arguments were paralleled in the debate surrounding the introduction of communication skills training over 20 years ago (Kai, 1999), which has arguably received its own position in medical school teaching today.

The next step here is to start evaluating current pilot projects and open a public forum for debate. Simply participating in quantitative and qualitative studies has led to more cultural awareness and self-analysis on the part of the students. It is essential to keep this line of communication open so that change can be encouraged and monitored.

There are still many omissions, limitations and barriers around the development of cultural diversity training, not least because of the over-emphasis of political correctness. Beagan (2003) went

some way to breaking down these barriers by plainly stating:

A course intended to produce physicians able to work effectively across differences of race, culture, gender, sexual orientation, religion, and so on must explicitly address power relations. It must be about racism, not just cultural difference; it must be about homophobia and heterosexism, not just differences in sexuality; it must be about sexism and classism, not just gender differences and health issues faced by "the poor".

Cultural diversity is a topic that affects all of us, whether we acknowledge it or not; surely its integration into medical curricula is long overdue?

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