PERSPECTIVES

Teaching Cultural Diversity: Current Status in U.K., U.S., and Canadian Medical Schools

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In this paper we present the current state of cultural diversity education for undergraduate medical students in three English-speaking countries: the United Kingdom (U.K.), United States (U.S.) and Canada. We review key documents that have shaped cultural diversity education in each country and compare and contrast current issues. It is beyond the scope of this paper to discuss the varied terminology that is immediately evident. Suffice it to say that there are many terms (e.g. cultural awareness, competence, sensitivity, sensibility, diversity and critical cultural diversity) used in different contexts with different meanings. The major issues that all three countries face include a lack of conceptual clarity, and fragmented and variable programs to teach cultural diversity. Faculty and staff support and development, and ambivalence from both staff and students continue to be a challenge. We suggest that greater international collaboration may help provide some solutions.

KEY WORDS: cultural competency; diversity; education; medical; undergraduate.

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INTRODUCTION

As countries become more culturally diverse, efforts have been put into place to train future physicians to better serve their changing communities especially in the United Kingdom (U.K.) and North America. This paper presents the current state of cultural diversity education for undergraduate medical students in three English-speaking countries: the U.K., United States (U.S.) and Canada. For each country, we briefly review the drivers and current status before reviewing the issues and suggesting future directions. This paper focuses on key principles rather than specific details and highlights the commonalities that exist to enable educators to reflect on future directions of cultural diversity education in medicine. This paper is not intended to be a comprehensive inventory of reports or legislative documents but rather a review of key documents that have shaped cultural diversity education. The

purpose is to identify common problems and possible solutions through such a comparison.

The varied terminology is immediately evident. Suffice it to say, there are many terms (e.g., cultural awareness, competence, sensitivity, sensibility, diversity and critical cultural diversity)¹⁻³ used in different contexts with different meanings. There tend to be two specific approaches: those that involve acquiring a quantifiable knowledge, skills and attitudes that should enable physician to interact with patients of diverse cultural backgrounds; and those that assume that meanings of culture depend on situation and context, and aim to enable physician to reflect on the role these play in health care delivery^{2,3}.

UNITED KINGDOM

In the U.K., the population has become increasingly diverse⁴, and there have been corresponding changes in how medical students are educated⁵. In 1993, the General Medical Council (GMC), which governs medical education, produced a framework for curricula outcomes it expected U.K. medical schools to deliver. *Tomorrow's Doctors*² contained broad statements referring to the knowledge, skills and attitudes expected from students. The document included a statement about diversity but provided little in the way of explicit expectations in the area.

While most respondents participating in a study about cultural diversity education in the U.K. were familiar with *Tomorrow's Doctors*, there was little evidence to suggest that it has influenced the development of cultural diversity at U.K. medical schools⁶. In some schools, staff found themselves with the task of implementing policies without support or resources, and/or teachers experienced other constraints. 'Cultural diversity' may be so broad and inclusive a concept that it limits what can be taught or learnt. Gaps existed at three policy levels (GMC governance, faculty strategies, delivery and operations), which led to lack of coherence in development and delivery of U.K. cultural diversity teaching.

A recent initiative on medical leadership (NHS Institute of Innovation and Improvement)⁷ stated that competent doctors "recognise and articulate their own values and principles, appreciating how these may differ from those of other individuals and groups." Legislative changes (e.g. Race Relations Amendment Act 2000) may serve as added drivers and influence the agenda⁸.

In the early 21st century, more publications appeared about emerging programs^{9,10}. A 2003 study¹¹ found that while the

proportion of U.K. and Irish medical schools teaching 'cultural diversity' had increased to 70%, such education remained fragmented, unsystematic, and lacked clarity. The proportion of medical schools providing cultural diversity education was only slightly greater in 2008¹². These results showed a wide variation in teaching practices between healthcare professions and geographical regions.

Roberts et al.¹³ reported that "a sound theoretical approach and robust methods for learning about cultural awareness are lacking." Similar to earlier work^{14,15}, they concluded that students need more support in understanding their own personal values and uncertainties. This indicates that little has changed despite good evidence that change was required and that national guidelines are still needed to incorporate cultural competency training by all U.K. healthcare professional training bodies¹².

UNITED STATES

In the United States (U.S.), cultural competency education of health professionals has been identified as one approach to address long documented disparities in health status and health care access and utilization by race and ethnicity¹⁶⁻¹⁸. Established in response to the 1985 *Task Force Report on Black and Minority Health*, the HHS Office of Minority Health developed *National Standards on Culturally and Linguistically Appropriate Services* (CLAS)¹⁹. Although "primarily directed at health care organizations...individual providers are...encouraged to use the standards to make their practices more culturally and linguistically accessible". Four of the 14 standards are mandates for federal fund recipients and based on Title VI of the 1964 Civil Rights Act which prohibits discrimination on the basis of race or national origin.

In 2005, New Jersey became the first state to require cultural competency training of physicians as a condition of licensure²⁰. Legislation strongly recommending or requiring cultural competency education has since been signed into law in other states (see http://www.thinkculturalhealth.org/cc_egislation.asp, Accessed October 19, 2009).

At the same time that there were federal and state policy changes, accrediting bodies were also addressing health disparities. The accrediting body for U.S. and Canadian medical schools, the Liaison Committee on Medical Education (LCME)²¹, set standards in 2000 that "faculty and students must demonstrate an understanding of the manner in which people of diverse cultures and belief systems perceive health and illness and respond to various symptoms, diseases, and treatments." Furthermore, the LCME specified that "medical students must learn to recognize and appropriately address gender and cultural biases in themselves and others, and in the process of health care delivery."

Major domains for cultural competency training in undergraduate medical school were identified by the Association of American Medical Colleges' *Tool for Assessing Cultural Competence Training* (<http://www.aamc.org/meded/tacct/tacct.xls>, Accessed October 19, 2009) in 2003²². The Accreditation Council for Graduate Medical Education's proposed curriculum template also addresses elements of cultural competency through professionalism and interpersonal and communication skills²³. In addition to these new accreditation standards, many organizations (e.g., American Medical Association²⁴,

Society of General Internal Medicine Health Disparities Task Force²⁵) encouraged medical and graduate schools to provide training in culturally competent health care and health disparities.

Cultural competency curricula for medical students in the U.S. have been reviewed several times during the last three decades²⁶⁻²⁹. In a 1996-1998 review of 118 U.S. medical schools, only 8% had separate courses specifically addressing cultural issues²⁹. Such issues were usually addressed in one to three lectures as part of larger, mostly preclinical courses. Few U.S. schools taught about African-American (28%) and Latino (26%) issues (the two largest minority subgroups). Only 35% of U.S. schools addressed cultural issues of the largest minority groups in their particular states.

A review of 2001 curricular materials from 19 medical schools identified as leaders in integrating cross-cultural competence into medical school curricula showed considerable variation in cross-cultural education content and approaches³⁰. Few schools extensively addressed health care access and language issues. Most of the schools emphasized specific cultural information about the ethnic communities they served and general themes, such as the doctor-patient relationship, socioeconomic status, and racism³⁰. A more recent assessment of curriculum content at seven U.S. medical schools funded to develop cultural competency/health disparities curricula found that topics on health disparities, community partnerships, and bias/stereotyping topics were the least likely to be presented³¹.

U.S. medical schools generally include cultural competency education within required courses³². However, few medical schools have achieved longitudinal integration of issues of culture into 4-year curricula^{33,34} instead concentrating in the first or second years of medical school, often in a didactic or case-based format³⁵.

CANADA

Since 2002, LCME requires obligatory inclusion of cultural diversity education within curricula at all accredited Canadian medical schools²¹. In the same year, the Association of Faculties of Medicine of Canada developed the *Social Accountability Initiative* as a response to the call by the World Health Organization for all medical schools to address and advocate the changing needs of the communities they serve³⁶. These national directives give each school the freedom to determine the format and content of cultural diversity education.

Previous surveys documented that the inclusion of cultural diversity education and training in Canadian undergraduate medical curricula was inadequate with 67% (11 out of 16) Canadian medical schools incorporating some aspect of multicultural issues^{29, 37}. They recommended the development of increased educational opportunities to equip students with knowledge about cultural health beliefs and health problems of diverse cultural groups, and provide them with cross-cultural communication skills.

A recent review of Internet-based information and email correspondence with program directors, administrators and/or instructors from 12 of 14 English Canadian medical schools suggests that cultural diversity undergraduate education differs widely with respect to the concepts, structures and formats introduced, and the gap between schools is increas-

ing³⁸. Canadian medical schools vary in their understanding of cultural diversity and its place in the undergraduate curriculum, and their educational approaches to this topic are not uniform.

The majority of schools include cultural diversity education as “a curricular ‘add-on’” during the students’ pre-clinical years and to some extent in a few clinical courses³⁹, and focus mainly on the impact of diverse cultural beliefs, values and practices on health of minorities, working with interpreters, and practicing with simulated patients. The length of time these schools dedicate to cultural diversity education and training also differs significantly since some schools devote only a few hours to the teaching of these complex issues, while others provide students with continuous richer exposure through their field placements, community visits and clinical rotations.

Five medical schools followed a critical cultural approach to incorporate cultural diversity education throughout their entire undergraduate curricula³⁸. Students in these new medical programs are encouraged to learn about cultural diversity outside the traditional classroom setting and beyond the boundaries of race and ethnicity. They consider a wide range of social determinants of health and reflect critically on social injustice and structural oppression as main factors contributing to disparities in health and healthcare delivery within disadvantaged populations (e.g., Aborigines; immigrants and refugees; women; seniors; people with special needs, different sexual orientation, addictions; the impoverished; and the homeless).

We now discuss the challenges that are common to all three countries before presenting possible ways forward.

Conceptual Issues

In all three countries, there is lack of conceptual clarity about what cultural diversity means and how these concepts should be framed. While governing and licensing bodies require diversity to be addressed by medical schools, they do not offer sufficient guidance regarding how culture and diversity should be understood and embraced in school curricula or which educational approach is more effective. There is a great difference in how culture and diversity are understood by educators⁴⁰ as well as the philosophical stance that is taken². Medical schools in all three countries can determine their own pedagogical methods, formats and structure for cultural diversity education, making it difficult to compare curricula and effectively measure change or progress. Very rarely is the philosophy made explicit.

Curricular Issues

While the governing bodies require the inclusion of cultural diversity, they give sparse guidance regarding how to implement or assess the curriculum with varying degrees of prescription regarding medical school teaching. Without clarity about what cultural diversity means, the teaching can be hugely varied which is unlikely in subjects such as anatomy, physiology or biochemistry. While some schools understand that cultural diversity education is about developing students’ knowledge, skills and attitudes when working with patients from diverse backgrounds, others use a much broader definition of difference and diversity and prepare students to deal

with health and social inequalities. Licensing and governing bodies should clarify what should be taught in medical schools to ensure desired outcomes are met.

In all three countries there has been a tendency to emphasize teaching about different or “other” cultures rather than developing awareness of one’s own biases and prejudices which might influence adversely on care provided. The dominant discourse is still about students gaining “expertise” about other cultures and wanting certainty where it may not exist¹⁴.

Faculty Support and Development

Another common theme is the variability of faculty support and development of staff. There can be a tendency for the responsibility to be left with advocates with little formal support⁶. The level of expertise and experience of staff involved in cultural diversity education vary greatly in all three countries. Very few staff have formal education or training in the area when compared to staff involved in teaching core medical subjects. One of the authors (ND) has worked with diversity teachers in all three countries and conversations in the U.S. and Canada support findings from the U.K. that staff do not generally feel supported by faculty. Some of these issues may be addressed by developing a corporate environment which would integrate cultural diversity with strategic plans across academic programs, research, practice and policies⁴¹.

Student Issues

Perhaps not unsurprisingly there is commonality in that some students feel that because they live in “multicultural contexts,” or are members of minority ethnic groups themselves, they do not need to learn about cultural diversity. This demonstrates a lack of understanding about what diversity is and that within groups there is heterogeneity. For instance, in 2007 only 3.8% of 771 Canadian medical graduates disagreed that they were appropriately trained to care for individuals of diverse backgrounds⁴². Some Canadian medical graduates (6.2%) believed that instruction in cultural issues in healthcare was excessive. Cultural competency education may still be viewed as less important than the basic science courses or just “political correctness.”

Students are increasingly exposed to the effects of “hidden curriculum” in which they are responsible for their own self-learning; it is unclear what messages they are picking up from their interactions with other students, faculty and health professionals⁴³. A review of 142 U.S. and Canadian medical schools found virtual patient cases “did not as a whole exhibit racial or ethnic diversity⁴⁴.” Students are taught one thing but see another in practice.

Assessment Issues

Formal evaluation of cultural diversity education and program remains limited. In the U.K., there is some ambivalence that assessments are required in cultural diversity⁴⁵. There is also an understanding that assessments cannot be undertaken through a single method.

In North America, students’ subjective evaluation of cultural diversity education is captured with annual Graduate Questionnaires (on Medical School Program Evaluation and on Priorities in Medical Education) in which medical graduates

indicate whether they feel adequately trained⁴⁶, but the concepts may be outdated.

Future Directions

We believe that all three countries would benefit from effective leadership and clarity as to how terms of cultural diversity are defined and used in medical school curricula. Our review demonstrates that there is improved understanding that culture is more than just about somebody's skin colour, ethnicity or health beliefs.

Medical schools and education governing bodies need to better assess students' understanding of the impact of cultural diversity in health and healthcare. Better evaluation is needed of educational models to determine whether they influence changes in student attitudes and ultimately in health care outcomes. Some limited evidence exists that guidelines would be well received in the U.K.⁴⁷ and are now being suggested in light of the finding that diversity education continues to be varied and fragmented¹².

Given the common issues, international collaboration may be a productive way forward.

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