Preparing to care for a culturally and linguistically diverse UK patient population an ethnographic investigation of how medical students develop their cultural competence

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PREPARING TO CARE FOR A CULTURALLY AND LINGUISTICALLY DIVERSE UK PATIENT POPULATION: AN ETHNOGRAPHIC INVESTIGATION OF HOW MEDICAL STUDENTS DEVELOP THEIR CULTURAL COMPETENCE

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A thesis submitted in fulfilment of the requirements for the PhD Degree at King's College London

June 2020

Acknowledgement

I am grateful to my supervisors Dr. Shuangyu Li and Dr. Elaine Gill for their guidance and support throughout my PhD studies and in completing this thesis. Throughout the journey, they acted not only as my mentors but also as my dear friends. I also would like to give my thanks to Dr. Gabriel Reedy, Dr. Clyde Ancarno, Dr. Anna Jones, Dr. Thusari Welikala, and Professor Ben Rampton for their valuable feedback and suggestions as my PhD thesis progression committee members. My thanks go to Dr. Bernadette O'neil and Ms Shirley Marlin for their constant support as caring colleagues. I am grateful to the NHS R&D office for giving me constant guidance in completing my NHS R &D approval. I also thank the (Diversity in Medicine and Healthcare) DIMAH for granting me permission to use its collected documents for my research. I particularly want to give my gratitude to all the facilitators, simulated patients, patient educators, and most importantly, medical students, for getting involved in this research. This research would not have been possible without your contributions.

I would like to express a huge amount of gratitude towards my dear husband, Weikai Zhang, for his encouragement, patience and support throughout my academic journey. I am also grateful to my son, Muchen Lucas Zhang, who came to this world during the last year of my PhD study. His coming brought so much happiness and joy to lighten this difficult journey. I also thank my brother, Professor Bing Liu, for his constant inspirations as a mature academic. I thank my parents, Jufeng Liu, Baoju Wang, and parents-in-law, Zhancheng Zhang, and Xiuling Li for their selfless contributions in every possible means to support me to complete this journey.

Also, I want to thank my ex-colleague, Professor Haihua Wang for her constant encouragement to guide my professional growth. I thank my ex-colleagues and friends, Lin Xu (doctor to be), Weiwei Zhang (doctor to be), Daniel Sund, Yao Chong, and Shaila Hussain, for generously spending their time to proofread my chapters. I thank my PhD pal and critical friend, Mark Cabling (doctor to be), for his constant feedback to my research and generous support throughout this journey. I also thank my other PhD friends, Sha Zhou, Xianhui Peng and Jenjira Jaimunk for their company. They have not been peers of pressure during my PhD journey but peers of fun.

Lastly, I would like to thank myself, for my determination and perseverance throughout this challenging journey. Neither completing a PhD nor bearing and caring for a new-born is an easy task, but I have seen the opportunities and successes the hard work has brought to me. I have truly held on to George Washington Carver's famous words and seen how they shine—*there is no short cut to achievement. Life requires thorough preparation-veneer isn't worth anything*.

Abstract

The importance of cultural education has been largely recognised by medical schools globally, but training remains fragmented with a lack of consistency in structure, content, and process. Little is known about how students develop their cultural competence (CC) in educational and extracurricular settings. This study attempts to address the gaps of knowledge by aiming to a) provide an overview of cultural education in UK medical schools by systematically analysing their CC and diversity education curricula and b) provide a rich ethnographic description of the factors, both within and outside the educational settings, which may contribute to students' CC development. The following research questions were investigated: 1) How are CC and diversity taught in UK medical schools? 2) How do students develop their CC in campus-based formal classroom teaching? 3) How do students develop their CC in clinical placements? 4) How do students develop their CC through extracurricular activities?

Ethnography was adopted as my overarching approach in this study. This approach enabled me to bridge the distance between my interpretations and the meaning of students' life experiences via collecting data through deep immersion and first-hand involvement. It incorporated a range of research methods, including document review, participant observation, individual in-depth interviews, and focus groups. I started with a document review that presented an overview of cultural education in UK medical schools with an analysis of 24 posters and 9 websites. To produce both the etic and emic stances of investigation of students' views and experiences in developing CC, I conducted 109 hours of participant observation, 25 interviews, and 3 focus groups in a London inner-city medical school and its affiliated teaching hospitals. Different datasets were synthesised to answer the research questions. Ethical approval was approved by the University Research Committee (reference number: LRS-17/18-5013) and NHS R&D Office (IRAS reference: 234940).

The document review shows that successful CC delivery relies on both strong institutional development (e.g. through leadership, infrastructure/faculty development, culturally relevant institutional schemes) and systematic educational interventions. The ethnographic case study provides an in-depth exploration of students' views and their experiences in developing CC. The study shows that students develop their CC both consciously and unconsciously in classroom-based formal teaching, clinical placements, and through extracurricular activities. Their learning experiences in each setting are interrelated and constantly interacting with each other, which accumulatively contributes to students' CC development. Some aspects of the learning are more apparent and easier for students to internalise; other aspects may remain hidden even if they are absorbed. This requires medical educators to identify, and then integrate and balance, resources that

can contribute to students' CC development with a holistic view. Integrating the results and discussions allowed me to generate a theoretical model that conceptualises medical students' CC development. As a result of increased understanding in the context of medical education, the EDUCATIONIST guide, which consists of 12 educational tips, is proposed to inform pedagogical development. The key strength of this research is in its exploratory nature and its potential to shed light on understanding the development of CC among medical students in a global context. Universal themes can be contextualised culturally, which makes the study an important addition to the field.

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Abbreviations

BAME	Black, Asia and minority ethnic
CAP	Certified Authorisation Professional
CC	Cultural competence
DIMAH	Diversity in Medicine and Healthcare
EMDP	Extended Medical Degree Programme
EQ	Emotional intelligence
FGM	Female genital mutilation
GCSE	The General Certificate of Secondary Education
GMC	General Medical Council
GP	General practitioner
GPEP	Graduate/Professional Entry Programme
HV	Human values
IPE	Interprofessional education
ISCE	Integrated Structured Clinical Examination
LGBT	Lesbian, gay, bisexual, and transgender
LGBTQ	Lesbian, gay, bisexual, transgender and questioning (or queer)
MBBS	Bachelor of Medicine, Bachelor of Surgery
MCQ	Multiple-choice questions
NHS	National Health Service
OSCE	Objective Structured Clinical Examination
SSC	Self-selected component
STI	Sexually transmitted infection
UK	United Kingdom
US	United States
WHO	World Health Organisation

1. Introduction

1.1 The relationship between culture and health

The inextricable link between culture and health has been widely recognised over recent years (Betancourt, 2003, Betancourt, 2006, Srivastava, 2007, Napier et al., 2014, Dogra et al., 2015). Culture plays a significant role in shaping individuals' health-related views by determining people's perceptions of diseases, processes of consultation, as well as ways of reporting symptoms and seeking remedies (Srivastava, 2007). Failures to take cultural factors of individuals into account may lead to negative clinical consequences including miscommunication, stereotyping, and even biases or discriminatory treatment of patients based on race, ethnicity, language proficiency, social status, sexuality or other sociocultural domains (Donini-Lenhoff and Hedrick, 2000, Van Ryn and Burke, 2000).

The demand to understand health from a cultural perspective has become increasingly pertinent with the rise in globalisation and the movement of people worldwide (Brisset et al., 2013, Alizadeh and Chavan, 2016). This demand is noticeable in countries with relatively open immigration policies (e.g. United States, Canada, Australia, New Zealand) where culture clash exists between a Western-rooted healthcare system and individual patients' diverse health values and beliefs (Brach and Fraserirector, 2000, Srivastava, 2007). The identified problems have parallels in other developed countries and emerging economies that are experiencing greater phenomena of cultural diversity (Andrews and Boyle, 2002). In the United Kingdom (UK), there are continuous calls for health professionals and health services to become "culturally competent" in order to meet the needs of diverse patients (Emmerson et al., 2000). With international immigration as a fast-growing trend, Britain is becoming one of the most diverse countries in the world, and the challenges imposed by both linguistic and cultural discordances between patients and healthcare providers are obvious (Li et al., 2010). However, the growing health inequalities, disparities in the quality of care, lower rates of satisfaction, and a convincing perception of culturally insufficient healthcare provision for members of minority groups, reveal the vulnerability that the UK healthcare system is struggling to meet the growing challenges of its culturally diverse patient population (George et al., 2015).

In this context, understanding and providing culturally competent care is seen as a strategy to create a healthcare system and workforce that can deliver accessible and effective healthcare for the whole population (Brach and Fraserirector, 2000). The World Health Organisation (WHO) calls upon medical schools to "direct their education, research, and service activities towards addressing the priority health concerns of the community, religion, and/or nation they have a mandate to serve" (Boelen

and Heck, 1995, p.3). This requires medical students and other health students to develop cultural competence (CC) in order to prepare for an increasingly diverse patient population, both culturally and linguistically. The wider drivers for cultural education in medicine are important in the consideration of global healthcare, movement of people, and the demand for healthcare professionals to care sensitively and compassionately for patients regardless of beliefs, values, and language that may be different from their own. Indeed, culturally competent care is not an endpoint, but a process, which consists of continuous evaluation and reform of current evidence, practice and policies. The provision of healthcare is set in a context of social, cultural, educational, fiscal inequalities and differences wherever it is delivered. Challenges are increasingly raised to address the needs of mental and emotional health in individuals, ageing populations, dietary preferences, global mobility, and acknowledgment of gender and sexuality as cultural issues. How cultural competence is addressed in these areas by medical education remains subject to pedagogic debate.

1.2 Why this research

Due to an increased understanding of culture's impact on health (Betancourt, 2003, Betancourt, 2006, Srivastava, 2007, Napier et al., 2014, Dogra et al., 2015), the need to incorporate cultural curricula in medical education has been widely acknowledged. Regulatory and accreditation bodies in major western countries stipulate that medical graduates are required to provide culturally sensitive and appropriate care, such as the guidelines or graduate outcomes published by the Liaison Council on Medical Education[1] in the United States (US) and Canada, the General Medical Council[2] in the UK, and the Australian Medical Council[3]. In response, medical education at all levels has started to incorporate cultural education into their curriculum development. In the UK, the latest *Outcomes for Graduates 2018* by the British General Medical Council (GMC) sets the standards and requirements for newly qualified doctors from all UK medical schools. Cultural Competence is identifiable in eight sub-outcomes for UK undergraduate medical education under the three overarching outcomes: *professional values and behaviours*, *professional skills*, and *professional knowledge*[4].

[1] The Liaison Council on Medical Education https://lcme.org/
[2] The General Medical Council. https://www.gmc-uk.org/
[3] The Australian Medical Council. https://www.amc.org.au/
[4] Outcomes for Graduates 2018. https://www.gmc-uk.org/education/standards-guidance-and-curricula/standards-and-outcomes/outcomes-for-graduates

To clarify the key terms used in the thesis, *teaching* refers to the engagement, or a set of events, with learners to support their understanding and application of knowledge/concepts (Sequeira, 2012). Teaching includes getting learners involved in the active construction of knowledge (Sequeira, 2012). It includes curriculum design, content selection, delivery, assessment and reflection. As for *learning*, it is producing changes by developing new skills, acquiring knowledge, or changing existing attitudes, through studying, practicing, being taught or experiencing something (Sequeira, 2012). Learning may take place intentionally, for example within a classroom setting, or without planning, for example by experience (Sequeira, 2012). By *training*, in line with common practice, I refer to the process of learning with a goal of performing a specific skill or behaviour, often at an operational level. By *education,* I mean a systemic process of acquiring knowledge about facts, events, concepts, beliefs or principles around a topic, with the purpose to help learners develop a sense of reasoning, understanding, judgement and intellectual evaluation and judgement. In addition, the acronym *CC*, short for *cultural competence*, is used as an umbrella term in this thesis to refer to the associated terms and theoretical frameworks around cultural competence (see Page 48-49).

The current situation is that cultural education remains patchy across medical schools. Teaching is largely disjointed and fragmented with a lack of consistency in structure and process (Dolhun et al., 2003, Dogra et al., 2016). There is no consensus on what elements of CC and diversity should be taught, and less is known about what is currently being taught (Dolhun et al., 2003, Dogra et al., 2016). On that basis, medical educators do not benefit from an agreed-upon typology with a clear definition of key thematic areas, teaching methods, and skillsets.

Delivering effective cultural education requires educators to understand how medical students develop their CC. Students' CC development is a complex process that may be influenced by multifaceted elements such as the impact of formal education, their work environments and life experiences (Pérez and Luquis, 2013). However, although the importance ascribed to training and education in CC is high, limited information is available regarding the contents of learning methods, and there is no information on whether students from diverse sociocultural backgrounds have similar learning experiences (Bhui et al., 2007). Moreover, the importance of extended engagement with culturally diverse patient populations, such as training in hospital settings or local communities, has been raised, but practice and research in this field remain limited (Dogra et al., 2009). The dearth of information on understanding students' learning highlights the need to identify both the educational and extracurricular factors that may contribute to students' personal CC development. It also points out the need for continuing education in guiding CC teaching for practitioners in clinical education roles and providing pedagogical insights.

To summarise, the importance of cultural education in medicine and healthcare has been largely recognised throughout medical schools, but training remains inconsistent across structure, content and process. Little is known about how students develop their CC in different learning environments. Given the underdeveloped understanding of training and support to prepare medical students for culturally competent practice, it becomes clear that further study is required. On this basis, this project has the following objectives: a) to provide an overview of cultural education across UK medical schools by systematically analysing their undergraduate CC and diversity curricula, and b) to provide a rich ethnographic description of the factors, both within and outside the educational settings, which may contribute to students' CC development. The results of this ethnographic work provide insights into the personal experiences and multi-faceted factors around CC development among students who themselves come from culturally diverse backgrounds. As a result of increased understanding in the context of medical education, reasonable and evidence-based arguments are formed to inform curricula development.

1.3 Overview of chapters

Chapter 2 is a literature review. Starting by looking at educational theories that might be relevant to CC education, this chapter discusses the current situation of cultural education in medicine. It then reviews studies on discussing the theoretical frameworks around CC and its relevant terminology. It lastly identifies the gaps of knowledge in the literature, specifying that little is known about students' experiences in developing CC in both educational and extracurricular settings. The chapter ends with four research questions.

Chapter 3 outlines the methodological approach underpinning this project and explains the specific research methods I have utilised to conduct this research. This chapter starts with a description of the methodological justification for adopting an ethnographic approach to conduct a qualitative case study by using mixed methods, leading to an explanation of the research design. After discussing the document review, it then moves to address the ethnographic site selection and access, data collection, data analysis, and my reflectivity as a researcher. It concludes by addressing the issues of research trustworthiness, ethical consideration, and methodological limitations.

Chapter 4 presents a general overview of CC and diversity education across UK medical schools based on the results of a document review. The chapter starts by presenting the background of how the documents were produced and collected. It then presents the results of the document review and clarifies how the results of the review informed the rest of the study. The results also reassured my research plan to explore students' experience in three settings: campus-based formal classroom teaching, clinical placements in healthcare organisations, and students' extracurricular activities.

Chapter 5 to Chapter 7 are the results chapters that explored students' learning in the above-mentioned three settings. Fieldnotes generated from my ethnographic observation and quotations generated from the interviews and focus groups were synthesised to produce meaningful ethnographic accounts. Chapter 5 describes students' learning experiences that may contribute to their CC development in campus-based formal classroom learning. Chapter 6 describes students' learning in clinical placements. Chapter 7 identifies the relevant extracurricular activities and discusses how these activities may contribute to students' development of CC.

Chapter 8 reviews all the previous chapters and integrates the findings. Results are consolidated to answer the research questions as set out in Chapter 2. A theoretical model is proposed to glean meaning from the results to conceptualise the developmental process of students' CC. Twelve pedagogical tips are proposed to enhance cultural competence and diversity education for medical schools in general.

Chapter 9 discusses the findings of this research in light of existing theories. A conclusion is made to summarise this research at the end of this chapter.

2 Literature Review

The literature review was conducted to understand the current situation of cultural education in medicine, explore the term cultural competence (CC), and discuss how students can develop CC via different learning approaches. The chapter provides an overview of the teaching and learning theories that are relevant to medical education in general and reviews the terminology and theoretical frameworks around CC. It also discusses the current situation of cultural education across medical schools and identifies the gaps of knowledge in the literature.

2.1 Literature review strategy

The literature search strategy was informed by conversations with academics and clinicians who are involved in medical education research. The searched literature covered a wide range of sources, including academic databases, university library catalogues, and Google Scholar. The literature search encompassed two stages. The first stage was a general literature review that aimed to obtain an overview of the educational theories that are relevant to the teaching and development of CC. The second stage followed a systematic approach to literature search to review the definitions and theoretical frameworks around CC and CC education.

In stage One, a general literature review was conducted as a preliminary step to review the teaching and learning theories in adult education. This stage was a comprehensive and critical analysis of the current knowledge that is relevant to CC education and development in medicine. As one type of traditional or narrative literature review, a general literature review provides a review of the most important and critical aspects of the current knowledge of a topic (Onwuegbuzie and Frels, 2016). It is an ideal tool to map the available evidence, clarify essential concepts in the literature, and identify key characteristics for factors related to a concept (Onwuegbuzie and Frels, 2016). This stage also served as a precursor to the second stage of review, which followed a systematic approach to collect and review literature. In Stage One, I searched the keywords “medical education”, “cultural education” “cross-cultural education” “cultural competence education” “diversity education” “adult education”, and “adult learning” in my university library catalogues and Google Scholar. To identify key publications, I examined repeatedly cited publications in both search engines with a cited frequency higher than 200 and selected the ones that are relevant to medicine and healthcare. Reference citations in the key publications were carefully examined for additional pertinent sources. This stage generated three book chapters and 23 papers for review.

In Stage Two, I reviewed the definitions and theoretical models/frameworks around CC and CC education through a systematic literature search approach. This stage started with a sample keyword

search on six databases (Medline, Embase, CINAHL, PsycInfo, Proquest Social Sciences Premium Collection and Web of Science) to determine the relevance of each database. Three of the databases were shortlisted based on the relevance of search outcomes, with Web of Science focusing on the comprehensive cross-disciplinary citation search and Medline and CINAHL more pertinent to medicine. A systematic literature search was carried out in the three databases between 1st January 2017 and 30th June 2017. Search terms covered three topics: (a) cultural competence/diversity, (b) health/healthcare, and (c) theoretical frameworks (See Table 1). I searched both (a) and (b) in abstracts, and (c) in titles. This was because searching (c) in abstracts generated a large number of irrelevant studies. Search terms in each topic were combined with an *OR* operator. (a), (b) and (c) were then combined using an *AND* operator.

Table 1 Summary of key search terms

Concept A	Concept B	Concept C
cultural competen*	health	model
multi-cultural competen*	healthcare	models
intercultural competen*		framework
cross-cultural competen*		frameworks
trans-cultural competen*		toolkit
diversity		toolkits
cultural sensibility		principle
cultural sensitivity		principles
cultural awareness		theory
cultural skills		theories
culturally competent		
trans-cultural competen*		
cultural humility		
cultural safety		
structural competen*		

Note: competen* includes competence, competences, competency, competent, and competently.

The search results were further eliminated to include only peer-reviewed journal articles published in English after 1990, resulting in 1,151 references for screening. 461 publications were shortlisted after screening by titles and removing duplicates. 111 publications were then selected for screening

by abstracts. Two publications were excluded due to the lack of access. 49 were further eliminated after screening by full-text, leaving 60 publications, to review. Additional 9 hand-searched articles were added to the dataset through retrieving repeatedly cited references and identifying the publications of key authors in this field. The generated 69 publications for review.

Lastly, I combined the retrieved publications in Stage 1 (26) and Stage 2 (69) and reviewed a total number of 95 publications (see Figure 1 and Appendix 1).

Figure 1 Data filtering process

Specifically, I went through five stages to review the extracted literature: 1) repeated and iterative reading of the articles/book chapters to identify recurring concepts; 2) identification of initial arguments through a comparative and critical interpretation of texts; 3) forming arguments; 4) cross-evaluating the arguments with a potential PhD candidate; 5) reporting and discussing the arguments with my supervisors via a series of meetings. The reviewing process helped me identify the relevant educational theories concerning cultural education and develop an understanding of the current situation of clinical cultural education. It also helped me develop an evolving understanding of CC and its associated terms and identify the theoretical models, frameworks and concepts that are relevant. Themes generated from both stages were combined to produce a

comprehensive and critical review of the current knowledge on CC and cultural education in medicine. Sections 2.2 to 2.5 present the identified themes and arguments starting with an overview of the educational theories that are relevant to teaching and developing CC in medical education.

2.2 Understanding teaching and learning theories in medical education

2.2.1 The relevance of educational theories to CC development

The development of CC among healthcare professionals and students has been acknowledged as one solution to improve patient-centred care and reduce healthcare disparities in culturally diverse contexts (Calvillo et al., 2009). The literature search shows that abundant studies are available on defining CC and its domains in various health fields (Sue, 1991, Campinha-Bacote, 1999, Bhui et al., 2007, Shen, 2015, Alizadeh and Chavan, 2016), as well as the teaching strategies that may foster the development of these components and their effects on student learning (Kokko, 2011, Long, 2012, Garneau and Pepin, 2015, Dogra et al., 2016). However, limited studies are available on exploring the learning process involved in the development of CC among healthcare professionals and students (Garneau and Pepin, 2015). Particularly, there is a paucity of studies that have examined the progressive development of CC among medical students during their medical education. Therefore, this research aimed to address the knowledge gap by systematically exploring medical students' experiences in developing CC in different learning environments.

On this basis, reviewing the relevant educational theories was pivotal before I could delve into the exploration of how students develop their cultural competence throughout their medical training. Reviewing these theories enabled me to gain insight into adult learning that may help me conceptualise medical students' development of CC. For the purpose of this literature review, seven broad categories of educational theories are discussed in accordance with Kaufman and colleagues' (2000) groupings in Sections 2.2.1.1 to 2.2.1.7. These approaches have pertinence when I discuss students' development of CC based on the results of this research. I conclude in Section 2.2.2 with a consideration of the different learning environments that may exist in the medical education setting.

2.2.1.1 Adult learning principles

As adult learners, medical students demonstrate different learning features from child learners and tend to be more self-directed, internally motivated and ready to learn. Among a number of theoretical frameworks around adult learning, andragogy is the most widely acknowledged framework (Merriam, 1987). Andragogy, sometimes used synonymously with adult education, is based on the argument that the attainment of adulthood is marked by adults viewing themselves as

self-directed individuals (Kaufman et al., 2000). Malcolm Knowles (1980, 1984) defined andragogy as *the art and science of helping adults learn* and proposed six assumptions to understand the characteristics of adult learners (see Table 2). These assumptions underpin the belief that adults are motivated in aspects such as their self-concept, the role of their experiences, readiness to learn, orientation to learn, motivation to learn, and the need to know. Andragogy captures adult learners' general learning characteristics and offers guidelines for planning instruction with either independent or self-directed learners (Merriam, 1996). However, whether andragogy is a theory of how adults learn or mere prescriptions for practice remains debated (Kaufman et al., 2000). In understanding the relationship between andragogy and pedagogy, Knowles (1984) considered andragogy and pedagogy as a continuum and suggested that the use of both teaching methods is appropriate at different times in different situations, regardless of the learners' age. However, across the literature pedagogy is widely used as a synonym for teaching, or teacher-focused education, whilst andragogy defines an alternative to pedagogy and refers to learner-focused education. On this basis, I used andragogy to guide my exploration of students' learning and generated pedagogical tips based on the findings of the research.

Table 2 Knowles' six assumptions of adult learners (1980, 1984)

1	*Self-Concept*
	As a person matures his/her self-concept moves from one of being a dependent personality toward one of being a self-directed human being.
2	*Adult Learner Experience*
	As a person matures he/she accumulates a growing reservoir of experience that becomes an increasing resource for learning.
3	*Readiness to Learn*
	As a person matures his/her readiness to learn becomes oriented increasingly to the developmental tasks of his/her social roles.
4	*Orientation to Learn*
	As a person matures his/her time perspective changes from one of postponed application of knowledge to immediacy of application. As a result, his/her orientation toward learning shifts from one of subject-centeredness to one of problem centeredness.
5	*Motivation to Learn*
	As a person matures the motivation to learn is internal.
6	*Need to know*

	As a person matures he/she needs to know why they need to know how they will benefit from this new knowledge, for example, to solve a problem or apply immediately.

The implications for educational practice that can be derived from adult learning are identified in three areas: context, learner, and learning process (Merriam et al., 2007). As for *context*, in comparison to dependent child learners, adults assume responsibility for managing their lives. Also, different from child learners receiving generalised learning in the school setting, adults tend to learn and function in settings where situation-specific skills are required to resolve relevant problems. As for *learners*, adults conduct self-directed learning based on their large reservoir of experience. Their readiness to learn their social role and their desire for knowledge can be immediately applied to relevant problem-solving because of their internal motivation to learn. In the *learning process*, adults have different paces of learning through meeting deadlines. Adult learners need to know why they need to learn something. Sometimes other pressures in life may adversely affect their learning due to the competing demands. Adults sometimes perform poorly on learning tasks that are not meaningful or do not fall directly within their domain of interest. Taking into account the distinctive features of adult learning, whether and how medical students demonstrate these learning features in the development of their CC became one focus of this research.

2.2.1.2 Social cognitive theory

Social cognitive theory, also known as social learning theory, acknowledges the social/interactive aspect of learning (Bandura, 1986). Initially proposed by Bandura, this theory unites two approaches: the behaviourist approach that emphasises the influence of the environment on learners' actions, and the cognitive approach that emphasises the importance of cognition in mediating learning and functioning (Bandura and Walters, 1977). These two approaches are united in a basic tenet of social cognitive theory, which proposes that individual learners' actions, learning, and functioning are "the result of a continuous, dynamic, reciprocal interaction among three sets of determinants: personal, environmental (situational), and behavioural" (Kaufman et al., 2000, p.9). Personal factors include individual learners' attitudes, perceptions, values, goals, knowledge and all previous experience. Environmental factors encompass all the influence that may reward or hinder actions and the achievement of goals. According to Bandura (1977,1986), personal and environmental factors are dependent determinants and constantly interacting with each other. Individuals might create, alter, or destroy environments, and the changes they produce in environmental conditions will consequently affect their behaviours and the nature of future life. Bandura further argues that

behaviours are not detached by-products of persons and situations but also interacting determinants in the learning process.

Bandura (1986) listed five basic capabilities that underpin learning and functioning: symbolising capability, forethought capability, vicarious capability, self-regulatory capability, and self-reflective capability. Symbolising capability refers to the ability to use symbols to transform learners' experience into a form that can be internalised and guide future actions. Forethought capability means the ability to anticipate the likely outcomes of actions and plan goals and moves to maximise the likelihood of achievements. Vicarious capability means that much learning that can be acquired through direct experience can also be acquired or facilitated through observing other people's actions and the subsequent consequences. This applies to social development in situations where new behaviours can be conveyed effectively by modelling. Self-regulatory capability emphasises the capability of self-regulation. As explained by Bandura (1986), much of learning behaviours are regulated by individual learners' internal standards and evaluative actions; thus, self-evaluation serves as personal guidance for action. Self-reflective capability is the most distinctive capability which enables individual learners to analyse their learning experiences and think about the learning processes. This is also known as a metacognitive capability by some cognitive theorists. The five capabilities surround a central concept in social cognitive theory named self-efficacy, which refers to "the individual's judgement about his or her ability to carry out a specific task or activity" (Kaufman et al., 2000, p.10-11).

In the development of cultural competence, environmental and personal features (e.g. individual cognition) are vital factors (Lin, 2016). However, previous studies on CC are somewhat limited because few studies have included environmental influence or certain personal factors that can have an impact on individual behaviour and performance outcomes (Lin, 2016). On this basis, Lin (2016) suggests that a better understanding of issues relating to health professionals' cultural competence development needs to incorporate the perspectives of social cognitive learning.

2.2.1.3 Reflection and reflective practice

Reflection is a multifactorial approach that can bring a more systematic method of understanding situations and problems of practice in professional learning (Kaufman et al., 2000). The educational literature around adult learning identifies several definitions and approaches to reflection and reflective practice. Reflection, according to Moon (2013, p.45), is "a basic mental process with a purpose, an outcome, or both, applied in situations in which material is unstructured or uncertain and where there is no obvious solution". As perhaps the most influential academic in understanding reflective practice among professionals, Schon (1995, 2010) summarises that understanding

reflective practice needs to recognise three practices: knowing-in-action, on-the-spot experimentation (reflection-in-action) and action research (reflection-on-action). Knowing-in-action means professionals, with developed zones of mastery around areas of competence, practice within these areas almost automatically. Taking place during the process of an event, reflection-in-action involves three activities: "reframing and reworking the problem from different perspectives"; "establishing where the problem fits into learned schema"; and "understanding the elements and implications present in the problem, its solution, and consequences" (Kaufman et al., 2000, p.21). Reflection-on-action, which occurs after an event, is the "process of thinking back on what has happened in the situation to determine what may have contributed to the unexpected, and what has been learned from this situation may affect future practice" (Kaufman et al., 2000, p.21). Schon (1986, 2010) claimed that that reflection-in-action and reflection-on-action are iterative processes whereby insights and learning from one experience may be incorporated into future "knowing-in-action".

Reflection can be understood as the catalyst that moves surface learning into deep learning (Moon, 2013). Deep learning can be integrated with learners' current experience and knowledge, resulting in rich cognitive networks that individual learners can draw on in practice. However, one thought is that reflection has frequently been viewed as an individual professional activity (Kaufman et al., 2000). In some cases, reflecting inadequately or inaccurately on one's performance can result in "circular", "single-loop" learning, which may lead to confirmation of current behaviours, rather than to questioning or identifying areas for learning (Jennett et al., 1990). For this reason, reflection is suggested as a collective activity whereby individual learners can share individual insights and reflections and increase their collective and individual learning (Frankford et al., 2000, Lockyer et al., 2004).

Reflection has a central role in CC development because reflective skills are essential for developing an appreciation and understanding of each other's values, understanding, and unique behaviours. Existing scholarship suggests that CC learning should include the reflection on one's own culture and bias (Almutairi et al., 2015, Foronda et al., 2016, Olson et al., 2016). Facing an increasingly multicultural and multilingual patient population, healthcare practitioners need to continue to self-assess in order to know the patients better and to know oneself better. Schon's theory of reflective practice, which implores healthcare practitioners to engage with and reflect on the confusing daily problems in medicine and healthcare, is fundamental to develop one's cultural competence (Olson et al., 2016). However, current approaches to teaching CC are ad hoc, fragmented and inadequate, which approach ill-prepares students for self-reflection (Olson et al., 2016). Indeed, incorporating reflection into education is a challenging task as reflection may be a tacit process but teaching reflection requires making the implicit process explicit (Kaufman et al., 2000). Assessment is one

identified challenge in incorporating reflection in formal curriculum learning. Vivekananda-Schmidt and colleagues (2011) state that the assessment of reflection sometimes raises the tension between public and private reflection, which students may perceive as a challenge. Moreover, educators need to face challenges to select strategies that will facilitate the active development of reflective capacity and bear relevance to learning and practice (Kaufman et al., 2000). Further challenges in the professional context involve helping learners to appreciate the relevance of these activities to their development as culturally competent professionals.

2.2.1.4 Transformative learning

Largely developed by Mezirow, the concept of transformative learning is a comprehensive and complex theory in adult learning (Mezirow, 1990, Mezirow, 1991, Mezirow, 1994). Transformative learning is defined as "the social process of constructing and internalising a new or revised interpretation of the meaning of one's experiences as a guide to action" (Kaufman et al., 2000, p.15). Transformative learning enables learners to elaborate, create and transform their beliefs, feelings, interpretations, and decisions through reflection (Mezirow, 1990). Unlike conventional learning that simply elaborates learner's existing paradigm, transformative learning changes an individual learner's paradigm so radically that it becomes a new creation.

Mezirow (1991, 1994) claims that critical reflection and rational discourse are the primary processes in transformative learning. As a key concept in transformative learning theory, reflection is defined by Mezirow (1990) as the process of critically assessing the content, process or premises of individual learners' efforts to interpret and giving meaning to an experience. Mezirow (1990) also identifies three types of reflection: content reflection, process reflection, and premise reflection. Content reflection is the examination of the content or description of a problem. Process reflection refers to the examination of the problem-solving strategies being utilised. Premise reflection is questioning the problem itself, including its relevant social context, history and consequences, which may lead to a transformation of learners' belief systems. Mezirow (1990) states that the most significant learning involves the critical reflection around premises about oneself, as it may invoke self-examination and a critical assessment of assumptions. Through a process of exploring options for new roles, relationships and actions are established and new knowledge and skills are acquired. In addition to reflection, rational discourse is crucial in transformational learning. Rational discourse refers to a special kind of dialogue in which the focus is on content and attempting to justify beliefs by giving and defending reasons, and by examining the evidence for and against competing viewpoints. Rational discourse is central to transformative learning as participating fully and freely in critical discourse may lead to the empowerment of learners and ultimately form transformative changes.

Transformative learning theory continues to be a growing area of study of adult learning and carry important educational implications. One thought is that the theory has developed so rapidly that it seems to have replaced andragogy as the dominant educational philosophy of adult learning (Kaufman et al., 2000). To support transformative learning, educators need to follow a reformist perspective. This perspective is different from a subject-centred perspective in which the educator is considered the authoritative figure and designer of instruction (Brookfield, 2015). Nor it bears similarities with the consumer-oriented perspective in which the educator is a facilitator and resourceful person (Brookfield, 2015). From a reformist perspective, the educator is regarded as a co-learner and provocateur as they challenge, stimulate and provoke critical thinking (Cranton, 1994). Cranton (1994) lists the four stages of changes that are essential to transformative learning: initial learner development, learner critical self-reflection, transformative learning, and increased empowerment. Within the stages of changes, specific educational guidelines are proposed for educators such as developing group facilitation skills, encouraging decision-making by learners, encouraging self-reflection, considering individual differences among learners, and employing various teaching/learning strategies (Kaufman et al., 2000).

Earlier studies (Taylor, 1994, Bezard and Shaw, 2017) have discussed how transformative learning experiences can enable learners to develop their intercultural competence or multicultural self-awareness. These studies have pointed out that Mezirow's theory of perspective transformation can partially explain the learning process of intercultural competence. However, existing research on utilising transformative learning as a theoretical model to depict the development of cultural competence is primarily about the process of adaptation and adjustment in a foreign culture. Limited studies have discussed whether transformative learning can explain the CC development for healthcare professionals in the healthcare setting.

2.2.1.5 Self-directed learning

As an integral process of self-regulation, self-directed learning (SDL) is essential in the development and maintenance of professional competence. Kaufman (2000) summarises that the literature on SDL has developed along two overlapping pathways. First, self-direction has been framed as a goal towards individuals to strive, reflecting a humanistic orientation such as that described by Maslow (2013) and Brockett and Hiemstra (2018). The focus of these models is on self-actualisation, emphasising the acceptance of personal responsibility for learning, personal autonomy and individual choice. Second, SDL has been framed as a method of organising learning and instruction, with the tasks of learning left primarily in learners' control. Early linear models along this line include models depicting how learners moved through a series of steps to reach their learning goals, such as the work by Knowles (1975). Later scholars describe the SDL learning process as more interactive and

involving opportunities (Grow, 1991). A collaborative learning process is desired where the personal characteristics of learners, their cognitive processes, the context of learning and opportunities can validate and confirm self-directed learning.

Kaufman (2000) argues that self-direction is a natural human process that can occur both within and/or outside formal educational settings. In other words, SDL does not exclude formal activities such as lectures or courses, but it is the learner's choice of activities to meet and manage a particular learning goal that denotes self-direction. Kauffman (2000) also lists several factors that may affect individual learners' ability to self-direction, including learners' self-perceived competence, their previous mastery of knowledge, the demands of the learning situation, available assistance when needed, and learners' understanding and experience of a broad range of discipline-relevant contexts. In addition, the ability to self-assess is critical to effective self-directed learning. To properly direct one's ongoing learning, and to assess where and what learning is required, SDL requires individual learners to be able to assess their current practice with reasonable accuracy.

With the advent of e-learning and open schools, adult learners are expected to participate in their own preparation for gaining knowledge and skills. Kirkpatrick and colleagues (2015) conducted a study on utilising self-directed learning to enhance nursing students' intercultural competence concerning lesbian, gay, bisexual, transgender, and queer (LGBTQ) health. This study concludes that self-directed learning, along with self-awareness and teamwork, needs to be in line with technological advances to create learning opportunities for healthcare practitioners, in order to improve equity and inclusiveness and ultimately have an impact on health care disparities. The key to support SDL is the creation of a supportive learning environment where learners feel safe to ask questions and to admit not understanding. Learners need opportunities to develop and practise skills that can directly enhance effective SDL, which may include asking questions, seeking relevant information and a critical appraisal of new information. For ongoing SDL, deep learning skills (Entwistle and Ramsden, 2015), which involves understanding principles and concepts, and elaborating the relationship among them, are of key importance. Making use of learners' existing knowledge structures and assisting them to enrich those structures can deepen understanding, encourage individual learners to understand their knowledge base and identify gaps. Ultimately, the fundamental skill in self-direction is a critical reflection on one's own learning and experience.

2.2.1.6 Experiential learning

Experiential learning describes the process of learning from experience and explores the distinctions between how individuals react to perceptions of experience and learn in unique ways. It emphasises the central role that experience plays in individuals' learning process. The term "experience" is

described by Weil and McGill as “the process whereby people individually and in association with others, engage in a direct encounter and then purposefully reflect upon, validate, transform, give personal meaning to and seek to integrate their different ways of knowing” (1989, p.248). Advocates of experiential learning draw heavily on Kolb’s (1984) work, which conceptualises individual learning as a process of “individual transformation” and views knowledge as bound to the person from whom knowledge is constructed.

Kolb (1984) built his theory of experiential learning on the previous works of Dewey, Lewin, and Piaget, which works highlighted the relationship between the processes of actual experience and education. These scholars argued that active engagement and interaction with external experiences can assist learners in establishing applied versus abstract knowledge. On this basis, Kolb (1984) developed the four-stage model of experiential learning, moving through concrete experience, reflective observation, abstract conceptualisation and active experimentation. Kolb envisaged active learners taking responsibility for their own learning, which is holistic, focuses on process and experience, creates knowledge, addresses conflicting viewpoints, and involves “people-environment” transactions. Among the different stages, reflection is pivotal for experiential learning (Eraut, 1987, Maudsley and Strivens, 2000). This means educational materials need to be presented in a way that allows learners to relate information to their personal experiences. Consistent with Kolb’s work, Bound and colleagues (1993) describe experiential learning as a socially and culturally constructed holistic process influenced by the socioemotional context. Experiential learning needs to posit experience as its foundation and also stimuli and involves learners actively through constructing experience.

Critiques of experiential learning claim that these themes are limited in the acknowledgement of the social context, with a higher emphasis placed on individual knowledge. In the *Ambiguities of Experience*, James March attributes the problems and pitfalls of experiential learning to the incomprehensive nature of experience and claimed that experience is “rooted in a complicated casual system that can be described adequately by a description that is too complex for the human mind” (2010, p.47). However, in health education settings experiential theories are ideal for practising skills in a specific context or focusing on developing certain competences. Learners along the medical education continuum use various experiential learning methods, such as “apprenticeship, internship or practicum, mentoring, clinical supervision, on-the-job training, clinics and case study research” (Kaufman et al., 2000, p.19).

The value of experiential learning for health professionals and students to develop their cultural competence has been widely recognised (Lockhart and Resick, 1997, Sharma, Lalinde & Brosco, 2006, Kratzke and Bertolo, 2013, Cahn and Smoller, 2019). One study reported that medical students

demonstrate enhanced respect, positive attitudes toward patients, and an understanding of challenges faced by disabled children and families after home visits (Sharma, Lalinde, & Brosco, 2006). The personal experiences could not be obtained from classroom lectures. Another study on understanding students' experience in short-term experiences in global health programmes reported that through experiential learning in a global health programme, students' understanding of culture included an acknowledgement of structural conditions that affect the availability of resources and the need to avoid making cultural assumptions about patients (Cahn and Smoller, 2019). Students also reported an improvement in culturally appropriate communication through immersion in a new cultural context and constant interaction with patients. These findings suggest the importance of cultural competence education and experiential learning to explore students' perceptions of their biases and attitudinal changes.

2.2.1.7 Situated learning

With a sociocultural basis, situated learning views learning and development as occurring through participation in the learning experience. Situated learning is in line with community-based learning, which is a pedagogical approach that is based on the premise that the most profound learning comes from contextually based community experiences. Learning takes place through participation and collaboration with other learners and more senior community members in carrying out activities that are relevant to the community (Lave and Wenger, 2001). As learners' participation increases, they take more responsibility and start to understand and acquire knowledge that distinguishes that community from others.

One central tenet of situated learning is that learning occurs through social interaction (Borg, 2003). Individual learners acquire knowledge from all aspects of their participation, particularly through the interaction with and bonds between members of the community. Borg (2003) identifies that a powerful source of learning is the "discourse" or "talk" of the community. Discourse is defined here as the way people "talk about" their work and other aspects of the world and frame the way we view it. Participation in discourse enables learners to participate in the community, which offers a wide range of relationships and exemplars from whom to learn. Through interaction, individuals learn how more senior members of the community work, talk and conduct their lives, observe what other learners are doing and what is needed to become part of the community.

Situated learning echoes with the social cognitive learning theory (Bandura, 1986) by viewing that learning occurs in a dynamic interaction between the learner and the environment. Situated learning suggests that learning is not separate from cultural and contextual influences; therefore, the context in which learning occurs is critical. This view supports the belief that some task-related knowledge is

only present in the context or location of the task. According to Lave and Wenger (2001), situated learning extends beyond the acquisition of concepts and structures by individual learners and includes multidimensional learning in the learning environment. It views the community and learning opportunities as a way of structuring learning resources, with pedagogical activities as only one source among many.

Building on the advantages of situated learning can help educators rethink students' experiences and consider ways to enhance their learning. The notion of situated learning was originally a means for studying the learning that occurs through apprenticeship, which remains a pervasive teaching and learning method in medical education (Kaufman et al., 2000). As for situated learning in clinical placements, Kaufman and colleagues argue (2000) that participation in the work of the clinical site or community is a key to this understanding of learning. When learners are involved in a clinical setting, participation in the actual daily round of activities is important in enhancing the effectiveness of learning. Despite that different fields of medicine have distinct knowledge and skills base, there are aspects that are common to all, including clinical communication, ethical approaches and grounding of actions, sound clinical skills, and developing cultural competence.

2.2.2 Learning beyond the formal curriculum

A comprehensive understanding of adult learning encompasses the recognition that learners learn not only in the formal classroom setting but also outside the classroom. In medical education, this means not all of what is taught during medical training is captured in course materials (Hafferty, 1994). Instead, a great deal of what is taught, and most of what students learnt, takes place not only within formal course offerings but also within medicine's "informal" or "hidden curriculum" (Hafferty, 1994). Moreover, students may learn in direct contradiction to the intentions of educators and what the formal curriculum purports to teach (Wear and Skillicorn, 2009). Therefore, recognising the latent and implicit side of medical education is essential for educators to develop a comprehensive understanding of how students learn.

The concept of different types of curricula was brought to medicine by Hafferty and Franks (1994) in their landmark article named "The hidden curriculum, ethics, teaching, and the structure of medical education". In this article, Hafferty and Franks describe that the medical school is a "multi-dimensional" learning environment and argue that comprehensive medical training needs to acknowledge the broader cultural milieu within which that curriculum must function. Apart from the formal curriculum, the hidden curriculum has a significant role in teaching value-based medical subjects. This is because medical training at root is a process of "moral enculturation", and that in transmitting normative rules regarding behaviours and emotions to its trainees, medical schools

function as a moral community (Hafferty, 1994, p.861). Most of the critical determinants of physician's identities lie not within the formal curriculum but in a subtly hidden curriculum. A hidden curriculum need not depend upon social actors to convey its messages. This is because medical education does not take place in a "cultural vacuum", within "a value-neutral environment" or in a place in which medical morality simply replicates lay values (Hafferty, 1994, p.865). Instead, appreciable information about the "nature of things", including messages about rightness and wrongness, is embedded in the very structure of medical work and the learning environment. These messages are often unintentionally imparted through actions, discussions, and relationships among members of the community (Hafferty, 1998).

In a later publication named "Hidden in plain sight: the formal, informal and hidden curricula of a psychiatry clerkship", Wear and Skillicorn (2009) proposes the categorisation of three levels of curricula: formal, informal and hidden. In the thesis, I follow Wear and Skillicorn (2009, p.452) and use the formal curriculum to narrowly represent the "actual course of study, the planned content, teaching, evaluation methods, syllabi and other materials in any education setting from lecture halls to labs to seminar rooms". I use the term informal curriculum to denote students' learning in clinical settings, mainly the "opportunistic, idiosyncratic, pop-up, and often unplanned instruction" that takes place between clinicians and students (Wear and Skillicorn, 2009, p. 452). Informal learning also takes place within the institutional environment such as faculty offices, hallway interactions, or the countless interactions students have with academics or clinicians. The informal curriculum reflects educators' belief in what students should acquire in terms of attitudes, awareness, knowledge and skills. As for the hidden curriculum, it refers to the "ideological" and "subliminal" messages of both the formal and informal curricula, which can be transmitted from both human behaviours and practices of institutions. The hidden curriculum is reflected in the physical workforce and organisational infrastructure in the academic setting that influences students' learning process and the socialisation to professional norms and rituals (Hafferty, 1998). It teaches students values and moral judgements that may be found especially in the institutional policies, language, assessment strategies and allocation of resources of an institution (Hafferty, 1998). Parts of the informal curriculum may also be the hidden curriculum. Outside the educational setting, potential learning opportunities are conceptualised as "extracurricular learning".

2.3 Cultural education in medicine

After discussing the educational theories around medical education and how they can inform practice, this section reviews the foundation of cultural education in medicine and summarises the educational philosophy and conceptual approaches around it.

2.3.1 The foundation of cultural education

A noticeable trend is that contemporary medical education is transferring from a traditional biomedical approach to a more humanistic approach, with a renewed focus on patient-centeredness (Swanwick, 2011). Scholars (Monrouxe and Rees, 2009, p.198) believe that medical education has benefited from its association with hard medical science by encouraging the engagement of clinicians in research activities, however, this benefit may be "offset by a particular loss represented by the failure to understand that medical education is about people, and the way we think, act and interact in the world." This means contemporary medical education needs to include cultural transmission, affective development and cognitive development, with an emphasis on reason around social, cultural and moral issues (Self, 1993, Brody, 2011).

Given that sociocultural factors are widely acknowledged as critical to medical encounters, "cultural education", or "cross-cultural curricula" (Carrillo et al., 1999, Green et al., 2002, Betancourt, 2003) have been incorporated into medical education aiming to train medical students with the capability to deal with cultural challenges in clinical practice. The ultimate goal of cultural/cross-cultural education in medicine and healthcare is to train students to "communicate effectively and care for patients from diverse social and cultural backgrounds, and to recognise and appropriately address racial, cultural, gender and other sociocultural relevant biases in healthcare delivery" (Betancourt, 2003, p.561).

The emergence of cultural education in medicine can be attributed to three factors (Betancourt, 2003). First, cultural education has been deemed pertinent in preparing health providers to meet the health needs of the growing, diverse patient population (Betancourt, 2003, 2006). Second, whilst the issue of health disparity and inequality may put groups of people who are already socially disadvantaged at a further disadvantage (Braveman and Gruskin, 2003), cultural education has been proposed as a valid approach to enhance provider-patient communication and contribute to eliminating the pervasive disparities (Williams and Rucker, 2000). The Lancet paper on *Culture and Health* (Napier et al., 2014) argues that health is inseparable from cultural perceptions of wellbeing, and cultural competence needs to be considered as a domain of medical and health training. Two reports, *Crossing the Quality Chasm* and *Unequal Treatment,* also highlights the importance of providing cultural competence education as an approach to improving the quality of healthcare and eliminating health disparities (Betancourt, 2006). Third, regulatory and accreditation bodies for medical training across major western countries have established standards that require cross-cultural curricula as part of undergraduate medical education. These include stipulations such as the

Tomorrow's Doctors published by the General Medical Council in the UK[5], the *Standards for Assessment and Accreditation of Primary Medical Programs* by the Australian Medical Council[6], and the *Functions and Structures of a Medical School* by the Liaison Committee on Medical Education in the United States and Canada[7]. These stipulations or guidelines have given added impetus and emphasis to medical schools to either introduce or identify CC training in their medical curriculum.

Dogra and colleagues (2016) argue that the underpinning values of cultural education are a) patient-centred care, b) professionalism, and c) the elimination of health disparities. First, cultural education is underpinned by models of patient-centred care and shared decision-making, with the emphasis on patients being actively involved in decisions about their care. According to the UK *Consensus Statement on the Role of Doctors*[8], providing patient-centred care requires healthcare professionals to demonstrate a set of generic attributes to merit the trust of patients that underpins the therapeutic relationship, including good communication, teamwork, non-judgmental behaviours, empathy and integrity. It also requires health professionals to be able to assess patients' healthcare needs taking into their personal and social circumstances. Second, the aim of cultural education in healthcare is to improve attitudes, knowledge, and skills, which are essential attributes for developing professionalism (Chisholm, 2004). Medical students need to develop a critical consciousness of questioning and curiosity, which are essential in developing competences to deal with issues around culture and diversity (Dogra and Karnik, 2003). Lastly, by providing a practical framework to guide inquiry with individual patients, cultural education has been acknowledged as essential to improve the quality of healthcare for all and address the health disparities and inequalities that are prevalent in minority and marginalised patient populations (Betancourt, 2003, Dogra, 2016).

2.3.2 Educational philosophy and conceptual approaches to cultural education

Dogra and colleagues (2016) point out that there are two main approaches to cultural education: the positivist approach and the social constructivist approach. Whilst the positivist approaches are concerned with gaining knowledge in an objective world by using scientific methods of inquiry, the social constructivists examine the development of jointly constructed understandings of the world by individual participants that form the basis for shared assumptions about reality (Palincsar, 1998).

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[5] https://www.educacionmedica.net/pdf/documentos/modelos/tomorrowdoc.pdf
[6] https://www.amc.org.au/wp-content/uploads/2019/10/Standards-for-Assessment-and-Accreditation-of-Primary-Medical-Programs-by-the-Australian-Medical-Council-2012.pdf
[7] https://lcme.org/publications/
[8] https://www.medschools.ac.uk/media/1922/role-of-the-doctor-consensus-statement.pdf

Many models for cultural education take a positivist approach that grounds education on the belief that there are absolute truths or facts about cultural groups that can be learned. In this sense, culture is reduced to specific traits and simplified into a list of items that can be observed and learned by the outsiders (McGarry et al., 2000). This philosophy is compatible with the "biomedical model" (Sheridan and Radmacher, 1992), in the view that the core competence can be learned in the same way as medical disorders. On the contrary, social constructivist approaches are rooted in a wider social context and hold the view that there is no one absolute truth as the context is relevant. Social constructivists avoid reducing culture to a list of characteristics and do not search for signs and assumptions, which can potentially lead to generalisation of an ethnic group or other social categories (Dogra, 2016). Instead, they acknowledge that culture and diversity are individual-based rather than group-based; therefore, one should refrain from passing judgements, and that all cultural norms are valid with none being superior to another.

The major difference between the two approaches is in the view of culture. Positivist supporters tend to view culture as essentially static, so the concept of culture and race and ethnicity are sometimes used interchangeably (Sue, 1991). This is exemplified by a few early cultural immersion programmes which suggest that learning about one ethnic family in-depth somehow provides knowledge that can be generalised to encounters with others from the same ethnic group (Loudon et al., 1999, Godkin and Weinreb, 2001). Scholars (Sears, 2012, Dogra et al., 2016) claim that whilst this approach is generally rewarding in introducing students to culturally diverse perspectives, it may lead to stereotyping and oversimplified cultural assumptions. On the contrary, social constructivist approaches describe culture as "an internal ongoing dialogue that an individual has with other individuals with whom there may be both similarities and differences" (Dogra et al., 2016, p.325). Culture in their mind is a multidimensional construct and ethnicity is one component among many that make up an individual's sense of self. To address the multidimensions of culture, Sears (2012) discussed the importance to use an intersectional framework to capture the contribution of studying individual culture from the perspective of identities, which include gender, race, social class, ethnicity, nationality, sexuality, religion, mental health and physical health as well as other forms of identity.

Betancourt (2003, 2006) claims that although the positivist approaches can be conducive to learning about the health beliefs of a specific community, when more broadly applied, they can lead to assumptions about culture and oversimplify the fluidity of culture and the diversity within cultures. Betancourt further argues that there is no manual on how to care for patients from diverse cultural groups, instead, the implementation of contextualised practical frameworks to guide inquiry with individual patients can be effective. Betancourt (2003) further categorises cultural education in medicine into three conceptual approaches: the awareness/sensitivity approach, the multicultural/categorical approach, and the cross-cultural approach. The three approaches focus

respectively on the teaching of cultural attitudes, knowledge and skills. Although the three approaches have different goals and focus, any single approach is unable to achieve comprehensive teaching when not fully supported by the other two, and ultimately the union of three can be combined to strengthen the learners' capability to care for patients from diverse backgrounds. Table 3 outlines the focus, content, and potential limitations of each approach.

Table 3 Three conceptual approaches to cultural education in medicine (Betancourt, 2003, p.561)

Three Conceptual Approaches to Cultural Education in Medicine
Approach A: Awareness/Sensitivity approach ● The primary focus is on provider *attitudes*. ☐ The goal is to increase provider awareness of the impact of sociocultural factors on individual patients' health values, beliefs, and behaviours, and ultimately on the quality of care and outcomes. ☐ Students explore and reflect on culture, racism, classism, and sexism. ☐ The importance of curiosity, empathy, and respect in the medical encounter are highlighted. ■ This approach is primarily taught early in the first and second years of medical school.
Approach B: Multicultural/Categorical approach ● The primary focus is on increasing provider *knowledge* of cultural/cross-cultural issues. ☐ The limits of focus on teaching unifying cultural characteristics of cultural groups are identified. ☐ New focus is to teach methods of community assessment and evidence-based factors. ☐ These include disease incidence/prevalence among groups, ethnopharmacology, and historical factors that might shape health behaviours. ■ This approach is taught throughout undergraduate medical education.
Approach C: Cross-cultural approach ● The primary focus is on developing *tools* and *skills* for providers. ☐ Process-oriented instruction is used to meld medical interviewing and communication skills with sociocultural and ethnographic tools of medical anthropology. ☐ These include approaches to elicit patients' explanatory model (patients' conceptualisation of illness), methods to assess patients' social context, and strategies for provider-patient negotiation and facilitation of participatory decision making. ☐ A foundation to care for diverse populations is laid through the development of interviewing frameworks. ■ This is a practical approach for clinical years.

Among the divergent academic perspectives around what is the "correct" approach to understanding and addressing issues related to culture and diversity in healthcare, Bowen (2004) broadly categorises the perspectives into four groups: cultural literacy/cultural relativism, relational/intercultural approaches, anti-racism/anti-oppression approaches, and an emerging integrative social realistic approach (Table 4). This categorisation presents the evolution of academic thinking on what is required of cultural competence. The traditional approach of culture literacy allows health professionals to recognise that there are different worldviews and ways of being that

are critical to patients' health experience (Baker, 1997). This approach focuses on health professionals becoming knowledgeable about the patients' cultural values, and the underlying assumption is that the values of healthcare providers may be different from that of patients. The limitation of this approach is that it minimises the differences that may be present among members of a particular group.

The relational/intercultural approach holds the belief that culture is individually and socially constructed, thus understanding the structure and content of the clinical encounter between the healthcare providers and patients is key (Dreher and MacNaughton, 2002). This approach has an explicit requirement for developing communication and interpersonal skills. However, it downplays the values of acquiring cultural knowledge, by suggesting that healthcare providers should consider themselves as cultural strangers but only negotiate mutual understanding on-site. While this approach highlights the value of communication and interaction, it puts pressure on patients having to be able to articulate their own culture and practices.

The anti-racism/anti-oppression approach helps identify the need to explore power relationships and the inherent barriers within the healthcare system. This approach focuses less on the person but more on the dynamics of differences across populations (Yee and Dumbrill, 2003). The limitation of this approach is that healthcare providers have found it difficult to apply the theory into clinical practice, as it has provided little guidance for translating such awareness into practice.

The most recent perspective calls for models of integration to include the social context of illness for all patients (Anderson et al., 2003). It advances the way to examine how the social backgrounds of patients and healthcare providers affect care. This approach also allows healthcare professionals to understand the individual problem contextualised in broader issues such as racism, oppression, inequity, discrimination and exclusion.

Table 4 Approaches to culture and diversity (Bowen, 2004, p.260)

APPROACH	FOCUS OF APPROACH	LEARNING STRATEGY	FOCUS OF INTERVNETION	GOAL(S)
Cultural literacy	Individual level	• Develop cultural sensitivity and awareness • Become informed about cultural traditions, customs, and values in order to serve as an effective cultural broker	• Clients (individual or group)	• Address cultural barriers by developing interventions that reflect/incorporate client cultural values (culturally congruent care)
Relational/ intercultural	Individual level	• Develop self-awareness (be cautious of own ethnocentrism and response to difference) • Approach clients from a position of not knowing and of learning from the other	• Relationship between the client and the healthcare provider	• Avoid cultural imposition • Learn from clients about their needs and wishes and include those in the care provided
Anti-racism/ anti-oppression	Organisational or systemic level	• Understand and challenge power and hierarchy inherent in all systems • Acknowledge gender, race, and class as important categories of culture • Challenge personal and institutional racists attitudes	• Organisational systems and structures (policies and practices) • Identify the various systemic factors that may be impacting on the client's expression and response to illness	• Equity and access • Social justice
Social realist/ integrative	Individual level and systemic level	• Emphasize partnership and a sophisticated awareness of race and culture	• System and client	• Reduction of health disparities

2.4 Understanding cultural competence

This section reviews the theoretical frameworks underpinning CC. It discusses the definition and fundamental components of CC and then reviews the relevant terminology around this term as well as the various models and frameworks.

2.4.1 Cultural competence definitions

The notion of "cultural competence" (Cross, 1989, Leininger, 1991, Campinha-Bacote, 1995, Burchum, 2002) consists of two components, with "cultural" being the adjective of the term, and "competence" referring to the performance aspect. Culture itself has multiple definitions. It is commonly compared to an iceberg with a visible above-water section representing explicit behaviours and lifeways, and a hidden below-water section representing implicit values and beliefs (Hanley, 1999). According to Leininger, culture is "the learned, shared, and transmitted knowledge of values, beliefs, norms, and lifeways of a particular group of people that guides an individual or group in their thinking, decisions, and actions in patterned ways" (1995, p.60). Culture is both individual and shared, stable over a period but dynamic over time (Leininger, 1991, Srivastava, 2007). In other words, while individuals may share characteristics, values, and beliefs with others, the

degree to which the characteristics are shared can vary greatly. Moreover, although the shared patterns of learned behaviours and values are relatively stable over a period of time, the fluid nature of culture means that changes may take place in subtle and tangible ways.

Just as there are many ways to understand *culture*, there are many ways to define *cultural competence* (Shen, 2015). Cultural competence was first used by Cross (1989, p.7) who defines it as "a set of congruent behaviours, attitudes, and policies that come together in a system, agency or among professionals and enables that system, agency or those professionals to work effectively in cross-cultural situations". As CC consists of two sub-concepts, culture and competence, its definitions may vary depending on which component is in focus (Shen, 2015). With *competence* in focus, the characteristics of competence may be manifested explicitly as sensitivity, knowledge, and skill. With *culture* in focus, the domains of culture mainly include cultural values, religion, and health beliefs (Shen, 2015). Scholars (Campinha-Bacote, 1995, Papadopoulos et al., 2004, Doorenbos et al., 2005, Jeffreys, 2010) have attempted to define this term from different perspectives, each emphasising certain elements of culturally competent care, however, generally lacking in providing a coherent and systematic understanding.

Despite the difficulty in reaching a unified definition, the key attributes of CC are also disputed (Srivastava, 2007). For example, Burchum (2002) identified a total of six attributes of CC that are described in the literature most consistently, namely *cultural awareness*, *cultural knowledge*, *cultural skill*, *cultural sensitivity*, *cultural interaction*, and *cultural understanding*. Balcazar (2009) listed four attributes of CC: *cultural desire*, *cultural awareness/knowledge*, *cultural skill*, and *cultural support*. Campinha-Bacote (2002) points out five CC constructs: *cultural awareness*, *cultural knowledge*, *cultural skills*, *cultural encounters* and *cultural desire*. The identified components can be generally categorised into three interdependent domains—affective, cognitive and behavioural domains (Shen, 2015, Liu et al., 2020). The affective domain of CC refers to the self-motivated willingness to explore new ideas and treat cultural differences positively and without judgement (Liu et al., 2020). The cognitive domain of CC involves the consciousness of self-assessing one's views such as ethnocentric, biased and prejudiced beliefs towards other cultures, as well as the accumulated information about other cultures and its implications on health provision and health behaviours (Liu et al., 2020). The behavioural domain of CC refers to the communication and behavioural capabilities/skills to carry out effective communication and provide culturally appropriate healthcare with people from diverse cultural backgrounds (Liu et al., 2020).

A comprehensive understanding of cultural competence needs to address CC development at four levels: individual, team, organisation, and system level (Srivastava, 2007, Liu et al., 2020). Most literature on CC focuses on the individual healthcare provider operating within the broader context

of professional practice. The underlying theme is that healthcare providers need to understand culture-relevant issues and health beliefs and capable of providing tools and strategies to elicit, negotiate, and manage cultural issues aroused from clinical encounters (Srivastava, 2007). The organisational CC emphasises the need for organisational change by zeroing in on organisational structure, governance, policy, and programs, including techniques such as interpreter services, recruitment and retention policies, and immersion into another culture (Brach and Fraserirector, 2000). When it moves to the system-level, it addresses issues beyond the healthcare organisations, and reflects a focus on the interaction between researchers, practitioners, and policymakers, and potentially offer insights in turning research knowledge into information that can be used to develop programs and policies (Bowen, 2004). Recently, a notion of team-level CC proposes creating an environment to promote healthy dialogues on differences and link the organization's espoused values to day-to-day care practice (Srivastava, 2007).

Besides deconstructing CC into different levels, a systematic understanding of this term also requires the awareness that CC development should be viewed as a process rather than an endpoint (Pérez and Luquis, 2013). The below table (Table 5) summarises four continuum models proposes by scholars. Cross (1989) describes CC as a continuum that ranges from cultural destructiveness, cultural incapacity, gradually to cultural blindness, cultural pre-competence, and finally to cultural competence and cultural proficiency. Theories in intercultural sensitivity and communication can be also applied to shed light on the developing process of CC in medicine. Bennet (1986) proposes a six-stage model of intercultural sensitivity that begins with denial and evolves through the stages of defence, minimisation, acceptance, adaptation and integration. Howell describes a communication continuum of five levels that learners undergo when developing empathetic communication skills, ranging from unconscious incompetence, conscious incompetence, to the middle layer of conscious competence, and finally to unconscious competence and unconscious super-competence (Crandall et al., 2003).

Table 5 Cultural competence continuum models

Authors	**Developmental model**	**Process/Stages of cultural competence**
Cross et al., 1989	Cultural Competence Continuum	cultural destructiveness cultural incapacity cultural blindness cultural pre-competence cultural competence cultural proficiency
Tripp-Reimer et al., 2001	Continuum of Culturally Responsive Interventions	culturally neutral culturally sensitive culturally innovative culturally transformative
Bennet, 1986	Model of Intercultural Sensitivity	denial defence minimisation acceptance adaptation integration
Howell (Crandall et al., 2003)	Levels of Communication Competence	unconsciousness incompetence conscious incompetence conscious competence unconscious competence unconscious super-competence

2.4.2 Cultural competence-many names, one goal

A challenge in understanding CC is a lack of consensus on its associated terminology. Srivastava (2007) discusses terminology and identifies basic principles that can help reduce confusion and pedantic polarisation. Despite the most prevalent term in most of the literature, CC is sometimes used interchangeably with terms such as “cultural competency”, “cultural awareness” “cultural sensitivity”, “intercultural competence”, “cross-cultural competence”, and “multi-cultural competence”. While these terms emphasise on different perspectives, they share some fundamental principles (Srivastava, 2007). To begin with, CC is a developed theoretical framework that captures the essentials of “intercultural competence” “cross-cultural competence” and “multi-cultural

competence" (Srivastava, 2007). It evolves from older terms such as cultural sensitivity and cultural awareness but expands these terms to a broader sense. While sensitivity and awareness refer to "requirements on the part of the healthcare professionals and imply a need for specific knowledge and skills", CC takes the concept further by referring to "the ability of healthcare providers to apply knowledge and skills appropriately in interactions with clients" (Srivastava, 2007, p.9).

The terms "competence" and "competency" also generate a semantic debate, but in education, preoccupation with the definition of the two terms seems to miss the focus. Whilst a competence is a specific, measurable entity (knowledge, skill, behaviour) that the learner should display by the end of the programme, the term "competency" tends to suggest the "underlying propensity" to turn competence into performance (Swanwick, 2011, p.41). Grant (2010) explains that a curriculum that bases itself on the specification of competences is only recognising the first step on a path that leads to the comprehensive development of the ultimate complex professional performance. However, in semantic terms, the words "competence" and "competency" are alternative words both meaning "the ability to do something successfully or efficiently /to perform a given task", and both terms share the same goal in medical education (Swanwick, 2011). On this basis, Grant argues that medical educators need to switch their attention from debating these two terms, as spending too long on debating the two terms is no more than "sublimating energies and closing eyes to more difficult questions" (2010, p.41).

Moreover, CC and its associated terminology have evolved. The terminology evolution is a journey from static and linear behavioural-focused competence development towards a more holistic and dynamic approach (Liu et al., 2020). Since its emergence in the United States in the late 1980s, the term CC aims to address the vast disparities in health outcomes between the white and other ethnic minorities in North America. CC education at an early stage was mainly concerned with healthcare disparity among different racial or ethnic groups, with a focus on learners' acquisition of cultural knowledge pertaining to certain cultural communities (Liu et al., 2020). The competence-based framework draws criticism due to the inadequacy of its behaviourist view. The behavioural objectives, or competences, cannot describe complex human behaviours because the sum of what professionals do is far greater than any of the parts that can be described in competence terms (Grant, J., 1999). It may also lead to the tendency to oversimplify the complexity of individual culture, leading to over-generalisation and stereotyping of people sharing similar racial traits. Other marginalised cultural groups (e.g. people with disabilities, LGBT+ population) were not mentioned at that time.

The recent three decades have witnessed a range of models and frameworks around CC. The understanding of culture as beyond race and ethnicity is depicted in various cultural models. The Sunrise Model (Leininger, 1991) and the Purnell Model (2002), for example, defined culture as a

multifaceted entity, shaped by people's diverse sociocultural determinants, including language, gender, sexuality, religion, education, and socioeconomic status (see Figure 2 and Figure 3). Moreover, a growing number of scholars began to question the limitations of conventional behavioural-based CC training. They argue that comprehensive training was needed to encourage more sophisticated cognitive development to allow true behavioural change. Reflection, intuition, critical reasoning, and critical consciousness are needed to be incorporated to achieve meaningful cultural education (Facione, 1993, Kumagai and Lypson, 2009). Scholars sharing this view proposed alternative conceptual models, such as *cultural humility* (Tervalon and Murray-Garcia, 1998, Foronda et al., 2016), *cross-cultural efficacy* (Nunez, 2000), *cultural sensibility* (Dogra, 2003), *cultural safety* (Walker et al., 2009) and *critical cultural competence* (Almutairi et al., 2015). These models dispute the use of "competence" because it suggests a detached mastery of a finite body of knowledge, which might not be appropriate for cultural education in medicine. Cultural humility is one of the alternatives. This model demands that learners have a lifelong commitment to self-evaluation and self-critique, which could lead to internally motivated continuous development (Tervalon and Murray-Garcia, 1998, Foronda et al., 2016). It aims to break the power imbalance between healthcare professionals and patients, demanding for a mutually beneficial and advocative partnership between them. Cross-cultural efficacy is another alternative which emphasises the effectiveness of the caregiver, emphasising that every encounter is a cross-cultural event with the co-existing tri-cultures; that is, the culture of the patient, the culture of the physician, and the medical culture surrounding them (Nunez, 2000). Cultural sensibility promotes an attitudes-and-awareness-oriented approach to encourage higher-level development through respectful questioning, and constant reflection of one's unconscious bias (Dogra, 2003). Cultural safety aims to advocate a collaborative partnership between healthcare professionals and patients in order to create a safe, healing environment and system so as to minimise risks (Walker et al., 2009). Critical cultural competence is a model that requires a critical application of cultural knowledge and skills through developing sophisticated reflexive skills (Almutairi et al., 2015), to allow clinicians to be strategic and adaptable when dealing with cross-cultural situations.

Figure 2 Leininger's Sunrise model (Leininger, 1991)

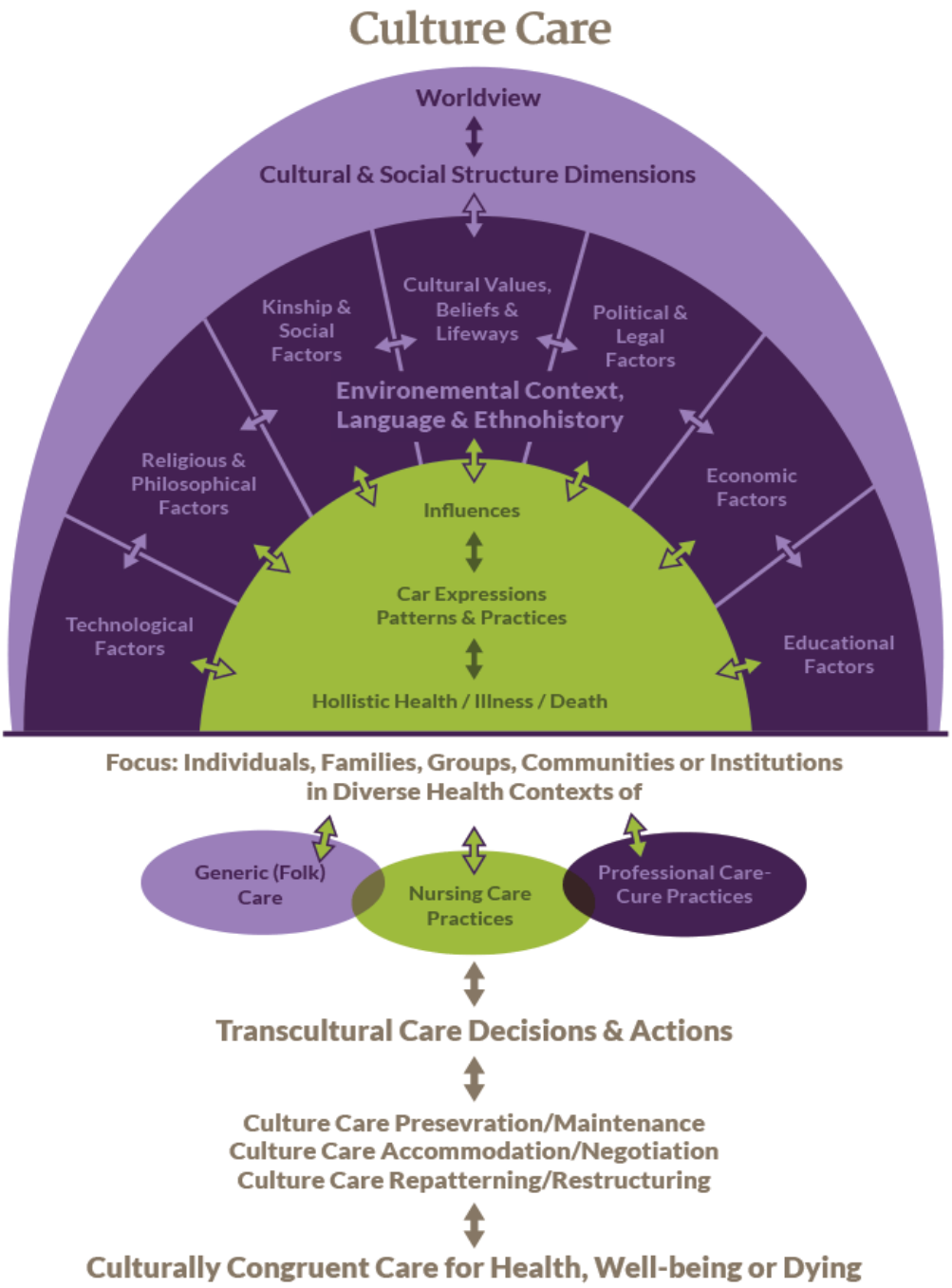
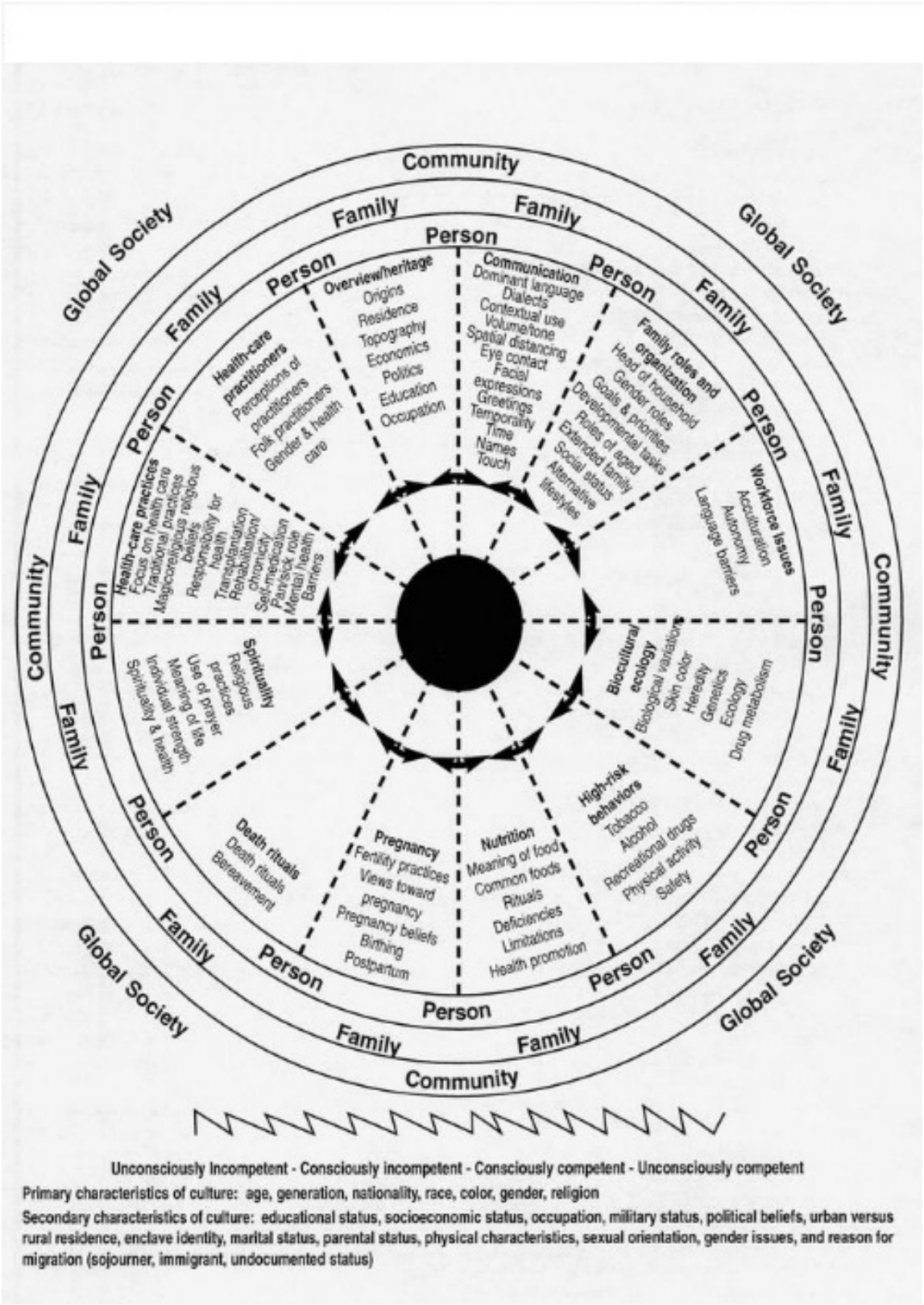


Figure 3 The Purnell model for cultural competence (Purnell, 2002)



Primary characteristics of culture: age, generation, nationality, race, color, gender, religion

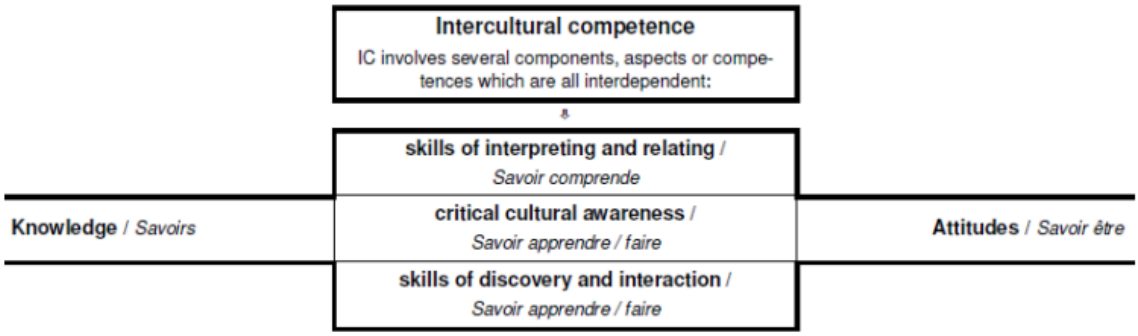
Secondary characteristics of culture: educational status, socioeconomic status, occupation, military status, political beliefs, urban versus rural residence, enclave identity, marital status, parental status, physical characteristics, sexual orientation, gender issues, and reason for migration (sojourner, immigrant, undocumented status)

In recent years, the term *structural competence* was proposed to advocate that CC development should go beyond the individual level and attend to the social structures that shape and enable varied healthcare outcomes (Metzl and Hansen, 2014). This term resonates with the multi-level development of CC as discussed in Section 2.4.1. There is also an emerging school of thought in *critical health humanities* and *critical consciousness* in medical education (Kumagai and Lypson, 2009, Wear et al., 2012). This academic school proposes that cultural education needs to go beyond the traditional notions of CC but incorporate the fostering of critical awareness, or consciousness, of the self, others, and the world. Learners also need to demonstrate a commitment to addressing issues of societal relevance in healthcare.

Most of the terms and models are originated in North America except the term *diversity,* which was proposed to replace the term CC in the UK. Diversity supporters use the term to depict the multidimensional sociocultural differences that are ubiquitous at an individual level. They also propose the use of *diversity education* to highlight the educational focus by following a "principle-based approach" (Dogra et al., 2007). Such principles require healthcare professionals to engage in continuous professional development, demonstrate a patient and person-centred approach to interactions, and flexible, non-judgemental practices as well as respect for colleagues, peers, and patients. Diversity education is also clarified to be not political correctness, tokenism, or only about ethnicity. It is not a tick-box or endpoint exercise with teaching on stereotypes or simple categorisation of populations.

Beyond the field of medicine and healthcare, models of intercultural communicative competence in the field of sociolinguistics and general education also inform the understanding and development of cultural competence. An example is the Savoirs framework (see Figure 4) proposed by Educationalist Byram and Risager (Byram, 1997). The Savoirs framework consists of five separate but interdependent components: attitudes, knowledge, skills of interpreting and relating, and skills of discovery and interaction, which together lead to critical cultural awareness (Lu and Corbett, 2012). Byram's model highlights that intercultural competence has an affective domain (attitudes), a cognitive domain (knowledge) and a behavioural (skills) domain. Additionally, Byram combines intercultural competence with communicative competence and highlights intercultural communicative competence as the interplay of linguistic competence, sociolinguistic competence, discourse competence, and intercultural competence.

Figure 4 Byram's intercultural competence model (Byram, 1997)



Taking into account the above discussions, a comprehensive understanding of CC requires a thorough understanding of all the related terms but also bearing in mind that the definition and components of CC are not static or finite (Liu et al., 2020). CC is considered as a two-dimensional concept putting equivalent weight to both *culture* and *competence.* This means a dynamic definition of CC needs to address the manifestations of the culture and competence components by characteristics in affective, cognitive and behavioural domains. *Cultural* is the adjective to depict the context where clinical competences are relevant, and *competence* emphasises the demands for the ability to provide care for patients. In other words, CC engages more than accepting cultural diversity between and within different cultural groups, it also advocates a sense of professionalism by highlighting the "to do" for healthcare providers and implies having the capacity to adjust and function effectively as an individual or an organisation. For this reason, I will use "cultural competence/CC" in this thesis as an umbrella term to refer to all the cultural frameworks and models that were discussed in this thesis (see Figure 5). Moreover, considering the growing popularity of "diversity education" as a term to delineate the educational focus, a coined term "CC and diversity education " is used to encompass cultural/cross-cultural and diversity education in the field of medicine and healthcare.

Figure 5 Using CC as an umbrella term

cultural competence/CC	cultural competence
	cultural competency
	transcultural competence/competency
	cross-cultural competence/competency
	intercultural competence/competency
	multicultural competence/competency
	diversity
	cultural sensitivity
	cultural sensibility
	cultural humility
	cultural safety
	cultural care
	structural competence/competency
	critical cultural competence/competency

2.5 Cultural competence and diversity education in medicine

Following the above discussion of the terminology and theoretical frameworks around CC, this section reviews CC and diversity education in the medical curriculum, such as curriculum content, delivery, teaching formats and assessment.

2.5.1 Content

The current situation is that CC and diversity education remains inconsistent across medical schools with a lack of clarity on teaching domains, teaching methods and skillsets (Dogra et al., 2016). There is no consensus on what elements of cultural competence should be taught, and less is known on what is currently been taught. There is also a paucity of studies that have comprehensively looked at the current teaching around CC and diversity across medical schools. A few existing studies (Dolhun et al., 2003, Betancourt et al., 2005) in the US conclude that CC curriculum of most medical schools aim to teach the general themes of culture, the doctor-patient relationship, clinical communication, equality and racism, and specific cultural information/knowledge pertaining to the ethnic communities they serve. Dolhun (2003) analysed the curricular materials of 19 medical schools and identified eight content areas with component items that are unique subjects taught within a commonly accepted rubric of curricula in US medical schools (Table 6). The study shows that

most American medical schools perform generally well in teaching “conceptual cultural themes”, “racism”, “doctor-patient interaction”, “specific cultural content”, “socioeconomic status”, and “gender roles/sexuality”. However, few schools have extensively addressed issues around “language” and “access”.

Table 6 Key CC and diversity education teaching areas in US medical schools (Dolhun et al., 2003)

Content Areas
General concepts of culture (culture, individual culture, group culture)
Racism (racism and stereotyping)
Doctor-patient interactions (trust and relationship)
Language (the meaning of words, non-verbal communication, use of interpreters, coping with language barriers
Specific cultural content (epidemiology, patient expectations and preferences, traditions and beliefs, family role, spirituality and religion)
Access issues (transportation, insurance status, immigration/migration)
Socioeconomic status (SES)
Gender roles and sexuality

In the UK, an Association for Medical Education in Europe (AMEE) guide, published by members of the Diversity in Medicine and Healthcare (DIMAH) organisation, points out the key areas that need to be included in the curriculum when teaching diversity to medical undergraduates (Dogra et al., 2016). These areas include teaching the key concepts in the diversity of human experiences, such as culture. They also include informing students of the relevant policies around equality, equity and discrimination, as well as the requirements of CC and diversity education stipulated by the national medical/regulating bodies. The AMEE guide suggests that teaching should cover population-level characteristics which may lead to health inequality, such as disability, social deprivation, gender, sexuality, ethnicity, age, homelessness and refugee health. Evidence-based practices that can contribute to the provision of culturally appropriate care should also be actively discussed. Moreover, the guide also highlights the need to make the clarification that people can “belong to multiple groups” (Dogra et al., 2016, p.329)”.

However, while regulatory and accreditation bodies require the inclusion of CC and diversity, sparse guidance is available for educators to design or implement the curriculum. A study titled *Teaching cultural diversity: current status in U.K., U.S., and Canadian medical schools* concludes that both

British and North American medical schools are encountering a lack of conceptual clarity over the meanings of CC and diversity and how these concepts can be framed in teaching (Dogra et al., 2010). The conceptual ambiguity may consequently result in a gap in faculty training, leading medical schools to devise their own pedagogical methods, formats and structure in addressing CC and diversity. By broadly reviewing the curriculum development in UK, US and Canadian medical schools, Dogra and colleagues (2010) conclude that the core topics around culture and diversity are covered by most medical schools, but the range of topics included in the curricula can be influenced by factors, such as the local community in which the medical school is based and the personal and professional interests of individual staff who deliver the teaching. Therefore, there is a wide variation across the teaching areas, indicating that some medical schools focused extensively on certain areas, whereas others neglected them.

It is also necessary to acknowledge that CC and diversity education has a cross-disciplinary root so not all contributed teaching is clearly labelled (Dogra et al., 2016). Among the associated medical subjects, clinical communication training makes an important component of CC and diversity education as it covers a wide range of cultural issues, such as ethnicity, disability and sexuality. In the UK, the GMC (2018) requires that medical students need to demonstrate effective communication with diverse patients and encourages medical schools to deliver teaching on British Sign Language, deaf blind communication, and the use of interpreters with patients who could not speak English. According to McEvoy and colleagues (2009), teaching on the use of interpreters through workshops and communication sessions has been found to increase perceived efficacy in communicating with patients who speak limited English, and to equip medical professionals with skills in working with interpreters. Hargie and colleagues (2010) conducted a survey of current trends in clinical communication training in UK medical schools and concluded that diversity issues were most effectively covered in dealing with patients with culturally diverse backgrounds and those with disabilities. However, although it is recognised that the teaching of clinical communication and the teaching of CC and diversity are connected and supplementary to each other, there is limited literature regarding diversity and clinical communication teaching and “much of it is descriptive” (Dogra et al., 2016, p. 331). Moreover, Nazar et al. (2015, p.386) point out the challenge that some clinical communication teaching may lead students to perceive certain patients as “creating problems”. Therefore, it demands the need for clinical educators to reflect on their own views on cultural diversity and acknowledge that their views are likely to be imparted to students through their teaching as potential role models.

In addition to clinical communication, CC and diversity curricula are realised in a wide range of clinical and academic disciplines, such as primary care, psychiatry, palliative care, public health and social sciences (Dogra et al., 2016). The value of having multi-disciplinary input is that the teaching is more

likely to be comprehensive and balanced, as each discipline offers a different perspective for understanding culture and culturally appropriate care. Moreover, the teaching of associated subjects may contribute to students' comprehensive and critical understanding of issues around the provision of culturally competent care that will, in turn, help develop attitudes and skills. For instance, the social sciences subjects, such as epidemiology, sociology, language studies and political science, may contribute to students' knowledge on cultural issues through the exploration of artefacts, concepts, research and policies (Dogra et al., 2016). However, whether the cross-disciplinary input may create challenges of educators and students to integrate the teaching resources remains under-discussed in the existing literature.

2.5.2 Delivery

According to Dogra and colleagues (2016), the essential first step to successful CC and diversity education delivery is to discuss with students the importance of CC. The second step is to engage with students by having an open debate about why CC matters and how it relates to improving their clinical practice (Dogra et al., 2016). Educators need to be aware that students are not a homogenous group with identical experiences so they may demonstrate varying levels of motivation to engage with cultural learning (Abu-Arab and Parry, 2015, Dogra et al., 2016). As for who should be involved in CC and diversity education, a range of stakeholders (e.g. patients, clinicians, academics) may be included but an agreed key point is that students and clinicians expect the teaching to be clinically relevant. This means that delivery may be incorporated as an element in many different parts of the curriculum involving a range of stakeholders, but there needs to be "clarity about the purpose of their involvement and those delivering it need to be comfortable about the potential sensitivities the subject may raise and how to manage these" (Dogra et al., 2016, p.330).

Given the complexity of CC and diversity education, a variety of teaching methods can be used so that students can explore their attitudes, increase their knowledge, and develop relevant skills (Dogra et al., 2016). Dolhun's (2003) study shows most American medical schools are consistent in adopting common pedagogic techniques by offering a didactic component and encouraging active student participation through case studies and group-based discussions. However, although common pedagogic techniques such as small-group discussion and case studies are widely used, there are considerable variations across medical schools (Brown and Manogue, 2001, Dolhun et al., 2003). Similarly, in the UK, the current situation is that teaching formats for CC and diversity education can be multilevel and multifaceted, and these may be influenced by the interest of staff and resources available (Dogra et al., 2016). Courses may be on a weekly or monthly basis, organised in teams or groups, and at the school-based or community-based levels. Popular teaching methods include lectures, seminars, workshops, simulation, community-based training or site visits, E-learning,

student-centred learning, peer learning, as well as hidden and informal learning (Dolhun et al., 2003, Dogra et al., 2016).

Previous literature has concluded that lectures are effective at presenting information and providing explanations but are limited in changing attitudes (Brown and Manogue, 2001, Thistlethwaite and Ewart, 2003). In delivering CC and diversity education, Dogra and colleagues (2016) suggest that lectures can be used to introduce the subject and provide a framework for opening discussions about diversity. In a lecture setting, the relevance of CC can be highlighted by reviewing current policies and debates in medicine so as to engage reluctant or ambivalent students. However, because of its didactic nature, one challenge is that lecturers need to be creative and enhance interaction by providing students with the opportunity to review their own perspectives and engaging with an exploration of the issues (Brown and Manogue, 2001). On this basis, Thistlethwaite and Ewart (2003) argue that it is necessary to combine lectures with small group work led by experienced facilitators so that students can voice opinions and discuss issues following lectures.

Compared with lectures, seminars and workshops are more effective to achieve attitude change in medical education (Dogra et al., 2016). Dogra (2001) evaluated a seminar programme whose learning objectives were to respect cultural differences and concluded that the teaching format helped students to achieve these learning aims. Dogra et al. (2016) further argue that small group work contextualised in a clinical situation is probably the most effective format in achieving students' deep learning. However, the affective development resulted from students' participation may be "transient and not long-lasting without further reinforcement" (Dogra et al., 2016, p. 331). This requires educators to integrate CC and diversity education throughout the curriculum in a spiralling manner so as to effectively refresh students' understanding and encourage deep learning.

Simulation-based learning is a technique to replace and amplify real experiences by bridging the gap between classroom learning and real-life clinical experiences (Lateef, 2010). Although simulated learning is widely used in medical education, how it applies in CC and diversity education is largely unknown (Paroz et al., 2016). Paroz and colleagues (2016) tested the feasibility of cultural competence training with simulated patients and concluded that the use of patient-centred simulated clinical practice as a teaching approach can contribute to providers' self-reflection about CC and enhance their cultural sensitivity. Participants gave positive feedback as they expressed that the approach enhanced the impact of the session in real-world practice. However, using simulated patient scenarios as a teaching format in CC and diversity education may lead to cultural stereotypes if the teaching cases are reinforced or outdated. Therefore, educators may consider adding discussions about the potential generalisation of population groups when using teaching cases (Paroz et al., 2016).

Community-based training, or site visits, can benefit students' development of CC as students are exposed to diversity issues with a closer link to patients' lives and local contexts (Dogra et al., 2016). Experiential learning (Kolb, 1984) and situated learning (Lave and Wenger, 2001) may surface as this type of training often involves fieldwork and practice within communities and medical settings. Community-based learning not only includes students conducting local placements but also includes immersion programmes or electives that take place in an international setting. The effects of community-based learning are in line with cultural immersion, a frequently adopted teaching method in cultural and language education. Previous studies (Crampton et al.,2003, Neander and Markle, 2005, Canfield et al., 2009, Larson et al., 2010) have concluded that immersion in culture and language is an effective means to learning about oneself and about another culture. In the healthcare context, cultural immersion provides opportunities for students to expand cultural awareness, enhance cultural knowledge, and learn some of the principles associated with CC development in medicine. However, despite the vast learning opportunities, using immersion to develop students' CC can potentially result in limited influence. Students may form cultural stereotypes due to limited exposure as the effects of immersion can be restricted if the immersion does not involve a detailed observation of the "daily reality" of other cultural groups over an extended period of time. As for many study-abroad programs, participation depends on students' personal interests, which may lead to a group of "self-selected" students (Canfield et al., 2009, p.320). Moreover, if CC has not been highlighted as a distinctive learning outcome, the effects of CC and diversity education may be compromised if immersion activities are combined with other healthcare-oriented educational tasks (Crampton et al., 2003).

E-learning tools are a useful addition to traditional teaching methods and are generally well-received by students (Chumley-Jones et al., 2002). A variety of online resources may be incorporated in the diversity curricula, such as short courses, blogs, discussion groups, reading materials, online lectures, webinars and videos (Dogra et al., 2016). Hawthorne and colleagues (2009) have conducted an evaluation of an online diversity training programme and concluded that online learning is the way forward for CC and diversity education given that it is easily accessible and affordable. According to Dogra and colleagues (2016), online tools can be used for CC and diversity education such as introducing faculties and students to CC-related regulations and graduate outcomes and presenting culturally relevant knowledge components/issues that they may be unfamiliar with. However, online modules may also lead to tick-box exercises on cultural topics and indicate to students that there is finite knowledge that can be assimilated (Dogra et al., 2016). Therefore, Dogra and colleagues further pointed out that online materials may "discourage engagement with the material and limit reflection" and suggested that the most effective module should link online teaching with "face-to-face work, reflective practice or online discussion" (2016, p.332).

Student-centred learning and peer learning also constitute a format of CC and diversity education. Student-centred learning includes students engaging in student self-selected components or electives (Dogra et al., 2016). During the process, self-directed learning (Knowles, 1975) takes place when students with particular interests in culture and diversity issues undertake small projects to develop their interest. Peer learning is increasingly gaining popularity in CC and diversity education (Dogra et al., 2016). Dogra (2001) described a peer-to-peer interview task through which students have challenged their cultural assumptions and reflected on their potential bias by interviewing and been interviewed by their peers. Students gave positive feedback after participating in the peer-to-peer interview as they felt it offered them chances to practice asking potentially sensitive or difficult questions in different ways. However, the challenge of peer learning lies in the difficulty to create an equal and reciprocal learning environment by ensuring that students are sufficiently challenging of each other (Dogra, 2001).

In addition to formal teaching, students also learn issues around CC and diversity in an informal or hidden manner (see Section 2.2.2). The reality is that much CC and diversity learning may take place without the awareness of students, exerting both positive and negative influence upon students' development of CC (Dogra et al., 2016). Whereas students' positive experience in the hidden and informal learning is a useful addition to students' overall learning, students may receive inconsistent messages in the informal and hidden teaching compared with what they have learned in the formal teaching. Turbes et al. (2002) argue that medical curricula need to explore aspects of CC and diversity across the curriculum to address the potential undermining of CC and diversity education. For example, they discovered that unintentional repetition of similar case profiles (e.g. gay men with multiple sex partners) in different clinical subjects may reinforce stereotypes through the epidemiology of cases. Table 7 summarises the existing teaching formats that may be used to deliver CC and diversity education by drawing on their respective advantages and limitations.

Table 7 Pros and cons of diverse teaching methods

Teaching methods	Merits	Limitations
Lectures/ didactic	• Useful to highlight the relevance of CC and engage reluctant or ambivalent students (Dogra et al., 2016) • Effective in presenting information and providing an explanation (Brown and Manogue, 2001)	• Limited influence in changing attitudes (Brown and Manogue, 2001) • Less creative and interactive (Thistlethwaite and Ewart, 2003)
Seminars/ workshops	• Effective in attitudes change or achieving deep learning (Dogra et al., 2016)	• Potentially transient attitudes shift without further reinforcement (Dogra et al., 2016)
Simulation	• A safe learning environment with face to face feedback (Paroz et al., 2016))	• Potential reinforcement of cultural stereotypes when using outdated teaching cases (Paroz et al., 2016)
Community-based training/site visits	• A closer link to patients' lives and local contexts (Dogra et al., 2016) • Valuable cultural immersion programmes (Dolhun et al., 2013)	• The difficulty of standardisation (Dogra et al., 2016) • Potential development of cultural stereotypes (Dogra et al., 2016) • Self-selected participation for overseas programmes (Canfield et al., 2009)
E-learning	• Useful additions to teaching methods (Chumley-Jones et al., 2002) • Accessible and affordable in terms of resources (Hawthorne et al., 2009)	• Potential development of tick-box exercises (Dogra et al., 2016) • A possible limit of students' reflection (Dogra et al., 2016)
Student-centred learning and peer learning	• Beneficial to students' cross-cultural skills through cultural engagement (Dolhun et al., 2013)	• Limited influence in guaranteeing an equal and reciprocal learning environment (Dogra et al., 2016)
Hidden and informal learning	• Supplementary to formal teaching without the requirement of time and space arrangement (Dogra et al., 2016)	• Potential reinforcement of stereotypes • Inconsistent messages with formal teaching (Turbes et al., 2002)

2.5.3 Assessment

This section reviews existing CC and diversity education assessment methods. In the UK, the GMC (2018) requires all medical schools to have an overarching, strategic and systematic approach to assessment and stresses the necessity for each medical school to develop fair, cost-effective and feasible assessment methods. The assessment guidance by the GMC (2011, p.18) states that "equality and diversity training will be a core component of any assessor/examiner training

programme". Given the innate complexity of CC and diversity education, it is unlikely that any single assessment method is suitable to achieve all learning outcomes (Dogra and Wass 2006). Instead, the development of a range of tools to effectively assess the various components of CC and diversity education is demanded (Dogra et al., 2009). Below I outline the two main types of assessment methods that are relevant: Observed Structured Clinical Examinations (OSCEs) and written assessment.

As a widespread tool in assessing clinical competence, the OSCE is one approach to assess clinical and communication practices by setting up a series of scenarios to assess a range of skills, by using real or simulated patients to create a clinically simulated situation (Boursicot, 2013). Dogra and Wass (2006) suggest that the OSCE can be one of the most effective tools to assess whether students know how to appropriately address cultural and diversity issues. Moreover, OSCEs stations with culturally relevant themes, particularly formative OSCEs, can be used to help students to address the impact of their cultural values and prejudices through practice and feedback (Altshuler and Kachur, 2001). Teachers can help students' development of CC by giving more extensive feedback. The GMC (2018) reinforces this view by suggesting that all UK medical schools should consider incorporating stations where cultural or linguistics difference is a focus so that students will be prepared to face the cultural and linguistic challenges brought by diverse patient communities. However, one limitation is that the scenarios may be too complex or unrealistic and would require a level of rapport that would be too difficult to achieve in 10-15 minutes typically given to each OSCE station (Hamilton, 2009). It is also warned that there is a possibility of cultural simplification or stereotyping if any cultural topics are too typical or constantly reinforced (Betancourt, 2003).

In addition to the OSCEs, other existing assessment methods for CC and diversity education include written assessments such as multiple-choice questions, short answer questions, essays, reports, reflective portfolios and questionnaires (Dogra et al., 2016). Multiple choice answers and short answer questions can help with the embedding of CC and diversity into a wider range of clinical subjects, however, they are limited in assessing cultural issues because using these as assessment tools may reinforce the view that CC and diversity education is merely about acquiring a body of relevant knowledge (Dogra et al., 2016). Written assessments also include designing questionnaires to enable students' self-assessment, particularly after students attended training sessions on CC and diversity. Nevertheless, even though questionnaires can be a self-assessment tool to encourage students to reflect on issues related to CC and diversity, questionnaires need to be carefully designed and validated so as not to reinforce pigeonholing or stereotyping (Dogra et al., 2016).

Another frequently adopted form of written assessments is through the production of essays and reflective portfolios. Essays and reflective portfolios can take many forms, such as collections of

checklists of observation or experiences, signed debrief of case presentations or learning experiences, or short reflective pieces based on culturally relevant questions/topics. In addition to assessing students' level of CC, the written assessments may also potentially contribute to students' development of CC as deep learning may be achieved through the process of self-reflection. Particularly, reflective writing can benefit the development of CC for more critically conscious students when they reflect on their own practice and relate to the relevant literature (Moon, 2004).

2.6 Gaps of knowledge

As cultural competence has been widely acknowledged as an essential approach to providing quality and equity in healthcare, medical schools have over the last three decades attempted to incorporate CC and diversity into their medical training. Consequently, CC and diversity education has evolved from a supplementary component in the medical curriculum to an essential subject, as a strategy to improve healthcare quality and address disparities. However, one prevalent criticism is that when CC and diversity education is included in the curriculum, it is often piecemeal and fragmented with a lack of consistency in structure and process across medical schools (Dogra et al., 2016). There is no consensus on what elements of CC and diversity should be taught, and less is known about what is currently being taught. As a result, medical educators do not benefit from an agreed-upon typology that defines key thematic areas, teaching methods, and skillsets regarding CC training. Scholars also argue that much CC and diversity teaching to date has generally taken a "categorical" approach to acquire cultural knowledge of certain cultural groups (Garneau and Pepin, 2015). Many previous efforts have aimed to teach the health-related attitudes, values, beliefs, and behaviours of certain cultural groups, such as the important "do's and don'ts" for caring for a patient from a racial/ethnic group (Betancourt, 2006). This means training has a narrow focus at the expense of promoting a balance with self-reflection upon attitudes and developing generic skills (Kai et al., 2001, Dogra et al., 2016). Instead, a dynamic understanding of *culture* and *cultural competence* is called for to acknowledge the multifaceted forms of cultural diversity in society, such as age, gender, sexual orientation or socioeconomic status (Garneau and Pepin, 2015, Liu et al., 2020). An evolutionary understanding of cultural competence includes systematic and holistic learning that allows more sophisticated affective and cognitive development. CC development is a life-long learning process and demands for a constant focus on developing reflection, intuition, and critical reasoning (Liu et al., 2020).

Although many researchers recognise that the development of CC is a continuous, evolutionary, dynamic and developmental process (Campinha-Bacote, 2002, Dogra, 2003, Srivastava, 2007, Almutairi, 2015, Shen, 2015), existing models on CC fail to present the developmental levels of this competence (Garneau and Pepin, 2015). The majority of CC models focus on discussing the various

attributes of CC, such as cultural sensitivity, awareness, knowledge and skills (Shen, 2014). Nevertheless, the learning processes involved in the concurrent evolution of these domains remain underresearched (Garneau and Pepin, 2015). A few CC models have presented the different developmental stages of cultural competence (Bennet, 1986, Cross et al., 1989, Tripp-Reimer et al., 2001), but the models remain descriptive without a clear depiction of the progression of this competence that could inform education (Garneau and Pepin, 2015). Moreover, although some authors have highlighted that the importance of CC development at the organisational and systemic level (Srivastava, 2007), the majority of CC models focus on individual actions without providing clarity on how to achieve integration to form "a united theoretical proposition" (Garneau and Pepin, 2015, p.1064).

The literature review also identifies that there are limited published studies that have systematically explored the processes involved in the development of CC among medical students in different learning environments from a constructive point of view. Despite the identification of the main teaching areas in formal-classroom teaching, what competences and how students can acquire these competences through formal classroom learning remains unknown. The cross-disciplinary nature of CC and diversity education means it is necessary to explore what subjects in the undergraduate medical curriculum, and how these subjects, may contribute to students' development of CC. Several studies have presented teaching strategies that can foster the development of CC and their effects on student learning (Kokko, 2011, Long, 2012). However, amongst the different teaching and learning methods, there is little evidence to indicate which methods are the most effective to deliver training as few programmes have been formally evaluated (Dogra et al., 2016). Moreover, although it is known that students may receive cultural exposure in clinical placements, how and to what extent the exposure influences students' development of CC in an informal and hidden way requires systematic investigation. That way that students' learning in the campus-based formal classroom teaching can impact students' engagement in the clinical placement also remains underresearched. Furthermore, beyond the educational setting, there is no published research that examines medical students' learning that may benefit their development of CC in extracurricular settings. What extracurricular activities are available and how these activities may contribute to students' development of CC need to be identified and discussed.

Educators also need to be aware that students are not a homogenous group with identical experiences so they may demonstrate varying levels of motivation to engage with cultural learning (Abu-Arab and Parry, 2015, Dogra et al., 2016). However, a paucity of studies has examined the associated factors (e.g. personal, institutional and systemic) that may lead to students' diverse learning experience, thus creating further challenges for CC and diversity education.

To summarise, what is already known from the literature is that CC and diversity education is an essential component of medical education and should be systematically integrated into the overall medical curriculum. As a subject, it has been broadly carried out in medical schools across major developed countries, but delivery is patchy and lacks standardisation and guidance. There is no conceptual clarity of how CC and diversity are taught by medical schools. Moreover, few empirical students have explored students' views in learning CC and diversity as a subject during their medical training. No studies have looked at students' experiences in developing CC in different learning environments ranging from classroom-based formal teaching to clinical placements and extracurricular activities. The multi-level factors in influencing medical students' development of CC remain largely unknown.

2.7 Research questions

In order to address the knowledge gaps, this study aims to systematically explore medical students' experiences in developing cultural competence in different learning environments through a constructivist lens. The purpose of this study is to a) provide an overview of CC and diversity education in UK medical schools by systematically analysing their CC and diversity education curricula and b) provide a rich ethnographic description of the factors, both within and outside the educational settings, which may contribute to students' CC development. Four research questions are proposed with the next chapter outlining the methodological design to address the proposed questions:

1. How are CC and diversity taught within UK medical schools?
2. How do medical students develop their CC in campus-based formal classroom teaching?
3. How do medical students develop their CC in clinical placements?
4. How do medical students develop their CC through extracurricular activities?

3 Methodology

The focus of this chapter is to justify the methodological approach underpinning this research and explain the research methods that were utilised. In this chapter, I argue my philosophical stance from a constructivist point of view and explain how my worldview has guided me to design and conduct this research. The epistemological postulate of constructivism is that realities in the world are subjective and multiple, and knowledge is actively created by social relationships and interactions. This worldview has guided me to choose ethnography to answer my research questions. After justifying my methodological stance for adopting an ethnographic approach, I then explain my research design by outlining the two research stages and multiple methods that were utilised, address the details regarding the site selection, access, data collection, data analysis, and my reflectivity as an ethnographer. This chapter concludes by discussing the issues of research trustworthiness, ethical consideration, and methodological limitations.

3.1 Methodological justification

3.1.1 A constructivist approach to understanding ethnography

Worldviews, or paradigms, contain an essential set of assumptions or beliefs that guide research inquiries and describe how researchers view the world and conduct research (Creswell and Clark, 2011). Worldviews embody different sets of beliefs and agreements shared between scientists about how phenomena and problems may be understood or addressed. Creswell and Clark (2011) identify four commonly shared worldviews that can inform research that incorporates multiple or mixed research methods. These worldviews (postpositivist, constructivist, participatory and pragmatist) provide a general philosophical orientation to conduct research and can be used either individually or in combination (see Table 8).

Postpositivism generally retains the idea of objective truth. It follows a deterministic thinking pattern in which causes determine effects or outcomes. It is also reductionist in that the intent of conducting research is to reduce the ideas into a discrete set of ideas to test, such as the variables that comprise hypothesis and research questions. Postpositivists normally begin with a theory, collect data that either support or refute the theory, and then make necessary revisions before additional tests are made.

Constructivism is typically associated with qualitative approaches and works from a different perspective by claiming that the understanding or meaning of phenomena is formed through participants and their subjective opinions. Constructivists hold the belief that social interaction with

others and experiences from personal histories contribute to the process of sense-making. Inquiries are often shaped "from bottom up" from individual perspectives to broad patterns so as to form general understanding (Creswell and Clark, 2011, p. 40).

Participatory worldviews support a close working relationship between researchers and participants. Heavily influenced by "political concerns", these views tend to address issues such as "empowerment, marginalisation, hegemony, patriarchy" and potential factors impacting marginalised or disadvantaged groups (Creswell and Clark, 2011, p. 40). The fundamental goal for participatory researchers is to empower the disadvantaged groups and change the social world.

As for pragmatism, it advocates the use of multiple methods of data collection to shed light on the problems under study by emphasising the research questions and consequences of research. Pragmatism is pluralistic and often focuses on "what works" and practice (Creswell and Clark, 2011, p.40).

Table 8 Basic characteristics of four worldviews used in research (Creswell and Clark, 2011, p.40).

Postpositivist Worldview	**Constructivist Worldview**	**Participatory Worldview**	**Pragmatist Worldview**
Determination	Understanding	Political	Consequences of action
Reductionism	Multiple participant meanings	Empowerment and issue-oriented	Problem centred
Empirical observation and measurement	Social and historical construction	Collaborative	Pluralistic
Theory verification	Theory generation	Change oriented	Real-world practice-oriented

A constructivist worldview can provide philosophical guidance for this study that aims at exploring medical students' experiences in developing CC in both educational and extracurricular settings. Constructivism believes in multiple realities, manifested through participants' diverse perspectives and experiences. It resides within the philosophical tradition of "interpretivism" and is related to the ways through which people construct their lived worlds (Williamson, 2006). Interpretivism, a broad term that encompasses many paradigms, is concerned with the meanings of experiences of human beings. It advocates "naturalism inquiry" by adopting an inductive style of reasoning through the use of qualitative data (Williamson, 2006). As such, researchers embracing constructivism tend to resort

to qualitative approaches that allow them to understand meanings that participants assign to a phenomenon inductively.

Taking the worldview of constructivism, I have taken ethnography as the methodology as it best suits my research aims. Ethnography refers to "the study of people in naturally occurring settings or field by methods of data collection which capture their social meanings and ordinary activities, involving the researcher participating directly in the setting, if not also the activities, in order to collect data in a systematic manner" (Brewer, 2000, p.6). It is an approach that enables researchers to investigate and explore the societies and cultures which compose an essential part of human interaction by collecting data and gaining insight through first-hand involvement (Murchison, 2010). Early ethnographic works had an anthropological focus on studies of unknown cultural groups. Many classical ethnographers in the nineteenth century travelled worldwide to observe diverse pre-industrial cultures (Silverman, 2015). Names like Malinowski and Evans-Pritchard, along with their ethnographic works, such as studying the indigenous culture of Trobriand Islanders, the people, religion, marriage and kinship among the Nuer, have become great milestones throughout the ethnographic history (Murchison, 2010, Silverman, 2015). Different from the traditional anthropological research, contemporary ethnography has expanded into various disciplines (e.g. anthropology, education and sociology), and is used as a practical research technique in researching public policy and management (Murchison, 2010). The adoption of ethnography in various disciplines highlights that a comprehensive and in-depth understanding of social and cultural dynamics within cultural groups is in demand (Murchison, 2010). In this research, medical students are considered as a distinctive cultural group whose learning experience in CC development is under-researched.

Ethnography was adopted so as to explore medical students' views and experiences in developing CC and glean added meaning from the data unearthed. The gist of ethnography lies in studying human behaviours and actions in social contexts by focusing on social interaction and the ways in which these environmental contexts impose restraints on interaction (Murchison, 2010). Ethnography allows researchers to observe and experience events, behaviours, and interactions of a defined group in action, and meanwhile investigate whether there exists a discrepancy between participants' actions and their self-reported meaning on particular matters. For this research, an ethnographic approach was able to bridge the distance between my interpretation and the meaning of students' life experiences that may contribute to their CC development. Moreover, the investigation of CC development among medical students required a close and comprehensive examination of their views and experiences, both within and outside the educational settings, which cannot be achieved by purely a short-period single research method. Instead, ethnography offered a unique way for exploration via deep immersion and first-hand data collection.

I will further explain my ontological, epistemological and axiological assumptions as an ethnographer. To start with, ontology refers to the understanding of "the nature of reality" and reflects individuals' understanding of what constitutes facts or knowledge (Creswell and Clark, 2011). Ethnographers hold the belief that multiple realities exist, and it is the co-construction between researchers and participants that constitute the realities. That is to say, ethnographers contend that "realities are jointly constructed at given points in time by the ethnographer in conjunction with the people being studied" (Whitehead, 2004, p.21). The research findings are based not only on the observations of ethnographers but also on the input of the research participants (Whitehead, 2004). The way ethnographers work involves generating "thick descriptions", which means that they need to understand the relevant cultures, experience cultures in situated contexts and interpret them by studying interactions through social activities or events (Cunliffe, 2009).

Epistemology is the study of knowledge and the ways that people can gain knowledge (Creswell and Clark, 2011). Epistemologically, ethnographers advocate closeness between researchers and participants and believe that data collection can only take place when researchers visit participants at their sites. The underlying assumption of ethnography is that certain information is only accessible through immersion and first-hand research. For ethnographers, the complexity of human lives and social interaction does not simply equate to a rigid laboratory experiment with strict control of variables; instead, the most appropriate way to study social and cultural phenomenon is to study it in action (Murchison, 2010). On this basis, ethnography is not a quick dip into the research sites by using surveys or interviews, but an extended period in which ethnographers immerse themselves into the community they are studying. To obtain first-hand data, ethnographers become participant-observers through involvement with the researched community, and this positioning makes them primary research instruments through which information is collected and recorded (Murchison, 2010). The term participant-observation distinguishes ethnography from other methodologies in which researchers employ more detached research approaches (Silverman, 2015). As I carried out more in-depth critique across a range of qualitative approaches, ethnography became an important focus. Participant observation was embraced and the relational position between the researcher and participants was one of the engagements to enhance shared understanding, something I was keen to explore in this research.

Axiology refers to the role values play in research (Creswell and Clark, 2007). Ethnographers acknowledge that all researchers bring values to a study and attach importance to reflexivity through which biases and interpretations are actively discussed (Whitehead, 2004). Ethnographic reflexivity is not only an ongoing process of what is being observed or studied, but also a continuing examination and re-examination of the research process, the basis for one's interpretations, and the potential biases in representation (Whitehead, 2004). Reflexivity requires the awareness of an

ethnographer's contribution to the construction of meanings throughout the research process, and an acknowledgement of the impossibility of remaining entirely detached from the study (Murchison, 2010). Following a constructive point of view, I believe that all research findings are subjective interpretations made by researchers according to what they have observed in the research setting. Therefore, I undertook an active approach in understanding the data collection, representation or interpretation bias in ethnographic research. Both my philosophical and methodological stances, as well as the research dynamics between me and the participants, were taken into consideration throughout the research process. This reflexive approach is consistent with the values advocated by the term "interpretive validity" (Altheide and Johnson, 1994), which emphasises the role of reflexivity in enhancing research validity. It also contributed to generating quality materials in contextualised settings over a prolonged period of time to ensure research trustworthiness.

3.1.2 Ethnography as a multi-method approach

As a "toolbox of methods", ethnography involves understanding how to best combine different methods or complement one method with additional ones (Murchison, 2010). Ethnography fully utilises the collection of unstructured qualitative data by incorporating "the collection of observational data, in-depth interviews, life histories or documents" (Reeves et al., 2013, p. 1367). It also utilises the "triangulation" of these qualitative methods, which term refers to the use of multiple methods or data sources to develop a comprehensive understanding of the phenomenon (Flick, 2004). The combination of multiple research methods in ethnography contributes to gathering rich and contextually detailed data. On this basis, ethnography is a demanding methodology because it is not only labour-and-resource intensive but also a challenge due to the potential difficulties of recording the multifaceted nature of social action (Reeves et al., 2013). The below sections review the four research methods that were adopted in this study. The procedures in operationalising these methods are further discussed in Section 3.2.

3.1.2.1 Documents

Early ethnographic work has traditionally focused on the investigation of oral cultures by drawing data from face-to-face interviews and observation but can potentially overlook or neglect written documents other than those produced by the fieldworkers themselves (Hammersley and Atkinson, 2007). However, constructivists use written accounts as valid contributions to data gathering (Silverman, 2015). This is because written documents can be used as a resource for social scientists to gain contextualised knowledge and obtain a more comprehensive understanding of how a social institution operates (Murchison, 2010). As the term "documentary constructions of reality" depicts, documentary sources, together with other written accounts, construct facts, records, decisions,

diagnosis and rules that are involved in social activities and together make the context for research (Hammersley and Atkinson, 2007).

The types of documents can be categorised in terms of their formality, ranging from the "informal" to the "formal" or "official" (Hammersley and Atkinson, 2007, p.123). At the end of the informal spectrum are documents and accounts of everyday life that researchers can draw on for certain research purposes. Informal documents include "diaries, fictional literature, autobiographies, letters, and mass media products" (Hammersley and Atkinson, 2007, p.123). These documents, normally produced by the research informants, are of pertinence for ethnographers to understand the routines, troubles, reactions, and basically everyday life of the group being studied (Hammersley and Atkinson, 2007). On the contrary, formal written accounts, including official publications, statistics, and organisational documents, provide ethnographers with a rich vein of analytic topics, as well as valuable sources of data and information (Silverman, 2015).

For this review, I undertook a social constructivist standpoint by viewing documents as social products generated within specific contexts. One critique raised by sociologists is about the validity of documents, particularly about official documents. The critique is that documents may be subject to bias or distortion, or that bureaucracies' practical concerns may mean that data are not formulated in accordance with researchers' interest (Hammersley and Atkinson, 2007, p.130). This concern does not deny the significance of documents in providing insight into the organisation of social action in certain settings; instead, it emphasises the importance of viewing documents from a social constructivist point of view (Silverman, 2015). A constructivist perspective argues that official documents and enumerations should not be relied on uncritically as a research resource but should be treated as social products. To be specific, qualitative researchers should not merely stop at working out what really happened, but how such documents are assembled and evaluated (Silverman, 2015). This requires a systematic examination of documents by not only concentrating on the content of the documents but also the background of these documents. Hammersley and Atkinson have brought up some questions that ethnographers need to address when undergoing a systematic examination of documents, such as "How are documents written? How are they read? Who writes them? Who reads them? For what purpose? On what occasions? With what outcomes? What is recorded, and how? What is omitted? What does the writer seem to take for granted about the readers? What do readers need to know in order to make sense of them (2007, p.132-133)"? These questions guided me to conduct a systematic examination of my collated documents. On this basis, I took into account the sociocultural context of the documents to explore from whom and for what purposes my collated documents were generated and circulated. The background of the documents collated for this research and its implications are further explained in Chapter 4.

3.1.2.2 Participant observation

Participant observation is an essential component of ethnography (Reeves et al., 2013). According to Denzin, participant observation is "a field strategy that simultaneously combines document analysis, interviewing of residents and informants, direct participation and observation, and introspection" (1989, p.157-158). Participant observation normally occurs when a researcher becomes a part of the group under study over an extended period of time in order to collect data and understand a social phenomenon or problem. Successful participant observation requires a balance between the seemingly paradoxical subject positions of participation and relatively objective observation (Reeves et al., 2013, Murchison, 2010). Through participation, the ethnographer begins to gain a deep understanding of and familiarity with a studied group along with their values, beliefs and ways of life, and starts to behave as an "insider" through personal involvement with the participants to gain further access (Reeves et al., 2013). This is consistent with the "emic" view, which refers to understanding the intrinsic cultural distinctions that are meaningful to the members of a cultural group from a participant's perspective. Conversely, participant observation also requires the ethnographer to aim to be an objective observer and have the intention to separate oneself from the group being studied as an "outsider" (Reeves et al., 2013). This is in line with the "etic" view, which is the scientist-focused perspective denoting the description of a behaviour or belief by a culturally neutral observer.

The tension between the "practising insider" and "analytical outsider", or the "emic" and "etic" stances, lies in the difficulty of trying to understand the perspective of participants from the inside and viewing them with distance (Dwyer and Buckle, 2009, Bergman and Lindgren, 2018). This is because true objectivity is only an ideal given the way that knowledge is constructed and shaped by our previous experiences and through constant interaction with others. Therefore, tension may arise when an ethnographer attempts to navigate between acting as an insider and taking the position of an outsider. As such, self-reflexivity is key to ethnography as it allows ethnographers to recognise the way they might influence the field of research and the data collected. Reflexivity enables ethnographers to juxtapose different types of information and further explore the complexity of human lives and social action from multiple lenses (Murchison, 2010, p.88). In this research, my insider's perspectives are rooted in my role as a participatory PhD student from the same department. The shared identity between me and the medical students helped me get in touch with research participants (see Section 3.2.2.1) and recruiting participants for data collection (see Section 3.2.2.2). My other identity as an "outside" researcher helped me maintain a reasonable distance with the participants and constantly reminded me to keep a relatively objective mind throughout the research process, such as during the processes of data analysis and self-reflection (see Section 3.2.2.4 and Section 3.3). This positioning, though sometimes paradoxical, provided me with an opportunity

to be neither an absolute observer nor an inclusive participant, but an "observant participant" with a pair of critical eyes (Murchison, 2010). It allowed me to explore the ways that medical students can potentially develop their CC, and by immersing myself in the new social setting and participating in their daily activities, I developed ongoing relationships with students and gained an in-depth understanding of their experiences and views on CC development.

As an active and rigorous enterprise, conducting ethnographic work involves two distinct activities: first-hand participation in some initially unfamiliar social setting and the production of written fieldnotes of that setting by drawing upon such participation (Emerson et al., 2011). On the one hand, ethnographers must make their ways to gain access to the new worlds and immerse themselves in the new social setting. By participating in the daily routines, ethnographers develop ongoing relationships with the people being studied and meanwhile observe what is going on. On the other hand, ethnographers record what they observe in regular and systematic ways what they have seen and experienced as fieldworkers (Atkinson and Pugsley, 2005). Through participation and observation, ethnographers ultimately produce field notes of what they have seen, heard and experienced. These may include memos, maps, tables, charts and relevant statistical data. The importance of writing field notes while carrying out ethnographic practice at the same time has been iterated by others (Atkinson and Coffey, 2004, Emerson et al., 2011, Reeves et al., 2013). This is because, without immediate recording, researchers are likely to lose sight of information and neglect important details presented throughout participant observation. Fieldnotes also serve as evidence for researchers to produce meaning and generate an understanding of the culture, social situation, and phenomenon being studied at a later stage.

3.1.2.3 Interviews

Interviews serve a complementary role to participant observation in ethnographic research. This is because whilst the latter provides insight into everyday life, the former provides insight into the articulation and interpretation of the various events in social life (Reeves et al., 2013). In general, ethnographers are expected to design and carry out ethnographic research that combines and balances participant-observation and interviewing despite that there is no strict line between the two (Murchison, 2010). Sometimes, chances to have further conversations through interviews emerge when conducting participant-observation; similarly, ethnographers may wish to widen their focus to the larger surroundings in the context of interviewing. To make the most of the possibilities, ethnographers are expected to act as "sharp observers" and "engaged conversationalists" at all times until they are clear of what is happening around and what the participants really mean (Murchison, 2010).

It is necessary to clarify the differences between the ethnographic conversations and the individual in-depth interviews. On the one hand, ethnographic conversations, sometimes named ethnographic interviews, refer to unstructured interviews, which do not involve fixed questions but aim to engage the interviewees in conversation "to elicit their understandings and interpretations" along with participant observation (Liamputtong and Ezzy, 2005, p.332). Unstructured ethnographic conversations tend to be informal and natural-flowing. They usually take place in situ when the ethnographer asks probing or follow-up questions to explore a respondent's circumstance (Bauer and Gaskell, 2000). On the other hand, the individual in-depth interviews in an ethnographic project usually refer to the semi-structured or structured interviews taking place at a later stage to supplement or cross-check the findings of participant observation. Beginning ethnographic fieldwork with informal purposeful conversations may give ethnographers a good position to decide when and what kind of formal interviews they intend to pursue (Murchison, 2010). Conducting formal interviews at a later stage after a better understanding of the research may boost the effectiveness of these formal interviews (Silverman, 2015). In this research, the ethnographic conversations that were relevant to the research were documented in the observation fieldnotes. The individual in-depth interviews were conducted based on a semi-structured question guide separately (see Section 3.2.2.3).

3.1.2.4 Focus groups

As a research method, focus groups were firstly conducted to assess the impact of American wartime radio propaganda in the 1940s (Silverman, 2015). Early focus groups followed a positivist fashion with participants simply offering dichotomous answers such as "approval" or "disapproval" (Bloor, 2011, p.1-2). It then gained rapid popularity in the 1990s and spread across a variety of disciplines, such as marketing, communication, sociology, social psychology, feminist research and education (Wilkinson, 2011). Currently, focus groups, sometimes used interchangeably with group interviews, are a commonly used method in qualitative research in which a group of participants is facilitated to talk about their perceptions, beliefs, or understandings of certain products or social phenomenon (Silverman, 2015). A focus group refers to a small size, usually six to eight, of demographically diverse participants being studied in either guided or open discussions to inform researchers of the expected reactions of a larger audience (Silverman, 2015). Normally, the sampling of a focus group largely depends on the stratifications (e.g. age, sex, nationality, socioeconomic status) of a population which the researchers consider significant to the research topic.

Unlike one-to-one individual interviews, focus groups allow researchers opportunities to study people and their interaction in a more natural conversation pattern (Silverman, 2015). Conducting a focus group normally requires the presence of a "moderator". Moderators are not expected to ask

questions in turn but, instead, facilitate group discussion by actively encouraging the interaction of participants (Wilkinson, 2011). The involvement of moderators varies among focus groups depending on the group dynamics and the extent of the designed structural protocol. Focus groups are not a "stand-alone" method but are frequently incorporated in a mixed-method study by either a) extending, clarifying or qualifying findings produced by other research methods, b) communicating research findings to participants, or c) identifying research "foci or develop research questions prior to the conduct of the main study" (Silverman, 2015, p.208). For example, focus groups may be used in combination with participant observation to facilitate understanding groups and their patterns of interaction. Researchers conducting a focus group need to record and note down key points made by participants, including both verbal and non-verbal data.

Focus groups entail certain advantages. First, researchers can obtain the results relatively quickly by conducting focus groups and easily increase the sample size by talking with several participants at the same time. The analysis follows conventional qualitative techniques, mainly content or thematic analysis (Wilkinson, 2011). Second, focus groups hold ground to investigate the complex behaviours, obtain detailed information about personal and group perceptions, and discover how different groups think of a topic while seeking clarification. Third, focus groups are an empowering data-collection method since participants are provided with opportunities to raise their viewpoints. The group communication can be understood as a group occasion for participants with similar backgrounds to learn from and communicate with each other through discussion and interaction (Silverman, 2015).

3.2 Research design

This is a two-stage study following an exploratory sequential design (see Table 9). Stage One presented a general overview, or synopsis, of CC and diversity education in UK medical schools by using a document review. The results of the document review informed the design and implementation of Stage Two as they outlined that CC development can take place in various settings in the medical education environment. The document review also informed the directions of my subsequent participant observation and the design of the interview questions as they pointed out the potential elements and educational activities that may have influences on students' CC development.

Stage Two was an ethnographic case study that provided an in-depth exploration of students' views and experiences in developing CC in both educational and extracurricular settings. As a method used to investigate the characteristics of an individual unit such as a person, a group or a community, in order to analyse various phenomena in relation to that unit of study, case studies produce valuable

reports of experience and offer evidence to explore a social or cultural problem in great depth (Stake, 2005, Zainal, 2007). Through the ethnographic case study, I obtained an in-depth understanding of students' experiences in CC development in a chosen medical school. The case study approach included the exploration of students' experiences that may be representative of students beyond one medical school. Therefore, the synthesised results shed light on understanding medical students' learning experiences in general.

Stage Two incorporated three research activities: participant observation, individual interviews and focus groups. To explore students' experience through first-hand immersion, participant observation occurred both on campus and in hospitals, students' living residences and also public areas. General participant observation was conducted in campus-based formal classroom teaching sessions (e.g. lectures, workshops and tutorials). Shadowing was adopted to explore students' learning in clinical placements because students have individual-based rotation rather than standard group teaching in formal classrooms. Shadowing was also adopted to explore students' extracurricular life as students have individually diverse extracurricular choices. Moreover, 25 semi-structured individual in-depth interviews were conducted simultaneously along with the participant observation to elicit students' views and experience in-depth. In addition, three focus groups (6-8 students each) were conducted at three designated points throughout Stage Two. The first focus group was conducted before my participant observation in order to inform my direction of observation. The latter two focus groups were conducted after the preliminary findings on my participant observation were consolidated. They had a member-checking role with the results validating and supplementing the preliminary results generated from the participant observation and interviews.

Table 9 Synopsis of research design

Stage One	
Purpose	▪ A preparatory stage using document review to gather a general overview of how CC and diversity is taught in UK medical schools
Data	▪ DIMAH (Diversity in Medicine and Healthcare) official posters and medical school website information
Data source	▪ DIMAH website and official school websites
Data analysis	▪ Thematic analysis employing NVivo 11
Output	▪ A synopsis of CC and diversity curricula in UK medical schools ▪ Informing the design and implementation of Stage Two

Stage Two	
Purpose	▪ An ethnographic description of students' views and experiences in CC development in campus-based formal classroom teaching, clinical placement and extracurricular activities
Data	▪ Fieldnotes from my journals ▪ Recordings of interviews ▪ Recordings of focus groups
Data source	▪ Ethnographic fieldnotes capturing my daily participant observation and shadowing, conversations with participants and relevant learning materials (e.g. curriculum learning outcomes) ▪ Individual interviews with 25 participants ▪ Three focus groups (6-8 students for each group)
Data analysis	▪ An interpretative approach to analyse the ethnographic data, which involved iteratively, inductively, interactively and reflexively reviewing data employing NVivo 11 to generate thick descriptions
Output	▪ Identifying what cultural competences that medical students can develop and how they can develop these cultural competences ▪ Informing pedagogical development

The design of this research addressed the four proposed research questions (Table 10). First, the results of the Stage One document review addressed the first research question by providing a synopsis of CC and diversity education across UK medical schools. The results were further enriched by the detailed information generated from the observational results in the campus-based formal classroom setting in a chosen medical school. Second, the results of participant observation in

campus-based formal classroom teaching, supplemented by the results of individual interviews and focus groups, addressed the second research question. Third, the results of my participant observation in clinical placements addressed the third research question when supplemented with the results of interviews and focus groups. Lastly, the results obtained by shadowing students' extracurricular activities addressed the last research question when combined with that of interviews and focus groups.

Table 10 Research questions and related research activities

	Research questions	**Activities to answer the research question**
1	How is cultural competence taught in UK medical schools?	• Document review • Participant observation in campus-based formal classroom teaching
2	How do students develop their cultural competence in campus-based formal classroom teaching?	• Participant observation in campus-based formal classroom teaching Participant observation in • Individual interviews • Focus groups
3	How do students develop their cultural competence in clinical placements?	• Participant observation (shadowing) in clinical placements • Individual interviews • Focus groups
4	How do students develop their cultural competence through extracurricular activities?	• Participant observation (shadowing) in students' extracurricular activities • Individual interviews • Focus groups

3.2.1 Document review

In Stage One, official posters mapping out the CC and diversity curricula of each medical school were collected from the UK DIMAH (Diversity in Medicine and Healthcare) website[9]. DIMAH is a UK-wide academic group made up of academics and healthcare professionals from medical schools and medical regulatory bodies (e.g. the General Medical Council) whose aim is to support cultural and diversity education across UK health schools. These posters were submitted to DIMAH and presented in the DIMAH Conference organised by DIMAH and the UK Medical Schools Council[10] on 6 May 2016. Out of the 33 medical schools in the UK, 24 medical schools submitted posters. The posters were

[9] https://www.dimah.co.uk/

[10] https://www.medschools.ac.uk/

mostly developed by representative medical educators or relevant course/academic leads from UK medical schools. The 24 posters are now available on the DIAMH website, and I have access to these materials considering I am a member (see Appendix 2). With permission from the DIMAH committee, these posters were downloaded for the purpose of this research. As for those medical schools that have not submitted a poster, official school websites were reviewed to explore its curriculum design on CC and diversity. Contents were combined and converted into word/pdf documents and imported into NVivo 11 for analysis.

Thematic analysis was employed to identify a set of patterns or themes within the collated documents. The purpose was to understand the status quo of CC and diversity education by exploring "what is taught" and "how is it taught". By using NVivo 11, a set of themes were generated to provide a synopsis of how CC and diversity are taught in UK medical schools. Informed by Braun and Clarke (2006), a six-stage thematic analysis approach was adopted by following the process of 1) familiarising myself with the documents through repeated active reading, 2) generating initial codes, 3) searching for themes, 4) reviewing the emerging themes, 5) defining and naming themes, and 6) producing the report. The names of medical schools are anonymised in reporting. The results of the document review provided a general overview of cultural competence and diversity education in UK medical schools, which informed the design of Stage Two ethnographic case study. The results also confirmed the participant observation settings to include campus-based formal classroom teaching, clinical placements and students' extracurricular activities.

3.2.2 Ethnographic fieldwork

This section presents a detailed account of Stage Two ethnographic fieldwork. Three research activities (i.e. participant observation, interviews and focus groups) were conducted in one medical school and three different settings—on campus, in hospitals and in students' social events. In this section, I elaborate on the rationale for my site selection for the ethnographic case study, the process of gaining access, the criteria of participant recruitment and the procedures of data collection and analysis.

3.2.2.1 Site selection and gaining access

This research was chosen to be conducted in a medical school based in central London. The setting is ideal for this research because it has three distinctive characteristics: 1) the medical school is located in an area with a socially, culturally and linguistically diverse population; 2) the medical school has a diverse student body; 3) the medical school has strong institutional development on CC and diversity education.

First, the medical school's proximity to a culturally and linguistically diverse patient population allowed me to better capture the innate complexity of culture and cultural competence. Second, the backgrounds of medical students were considered relevant as previous literature showed that students from culturally and linguistically diverse backgrounds demonstrate different learning features (Abu-Arab and Parry, 2015). Third, the strong institutional development of CC and diversity education can potentially facilitate my participation in both campus-based and clinical settings to capture students' learning experiences. The strong institutional support in the medical school was demonstrated by the presence of a nominated academic lead on cultural competence and the ready access to relevant curriculum information on its official website.

Accessing campus-based formal classroom teaching was facilitated through communicating with relevant academic staff after gaining the Gatekeeper Approval from within the chosen medical school. The Gatekeeper Approval was granted by the director of Educational Research and Innovation at the medical school so that I was allowed to participate and observe relevant campus-based teaching activities (e.g. lectures, seminars, workshops and project-based tutorials). Purposeful conversations with the academic lead provided me with the background information regarding the institutional development on CC and diversity education at the medical school and the specific teaching sessions that may be relevant to my research (e.g. cultural competence lecture and diversity workshop). Before conducting my formal participant observation, I thematically analysed the learning outcomes of the medical curriculum in order to identify the teaching sessions that have distinctive learning outcomes that can contribute to students' development of CC (see Section 5.1.2). Access to the teaching sessions was obtained by contacting the corresponding module leads and instructors to introduce my research purpose either in person or by email. All instructors (e.g. lecturers, facilitators, patient educators and guest speakers) allowed me to observe their teaching sessions as a participant-observer. Some instructors in small-group teaching sessions (e.g. workshops and seminars) introduced me to the students and briefly introduced the reason for my observation at the beginning of my teaching session.

Access to the students' learning in the clinical setting was achieved through my communication with relevant clinical staff. The access was also facilitated by my identity as an enrolled student in the medical school. Gaining access to the observation of students' learning in the hospital setting is a challenging task as safeguarding patients is the primary goal in healthcare and any intervention in the normal daily running of services is under scrutiny. This includes education and service delivery studies. In this research, communication with clinical staff paved the way for me to identify a relevant clinical block for participant observation and establish contacts with the administrative staff that was involved. With the help of my supervisors and other clinical staff, I was able to gain approval from the then block lead of the Human Development rotation block, who was in charge of overseeing the

management and delivery of students' clinical placements in the block. The Human Development Block was a seven-week rotation block during which Year-2 medical students from the chosen medical school were arranged to rotate one day each week in a designated central London hospital. In addition, my role as a PhD student enrolled at the medical school eased my access to the hospital site. As an ethnographer, I was mindful of my position as a fellow student and how it may be helpful to identify similar experiences and concerns to build rapport with my participants. It proved to be a positive approach and a flat platform through which to encourage open communication. The established rapport also helped me gain access to the observation of students' extracurricular life.

To access students' extracurricular activities, I employed a participatory approach by involving six medical students as my key informants (Table 11). In participatory research, participants have an influence over the research agenda, the process and actions (Whyte et al., 1991). The six students were reached based on my personal connections and the networks of my supervisors and colleagues. They played a vital role for me to gain access to students' extracurricular activities by introducing me to the varieties of student activities (e.g. student societies, home parties, sports clubs and cultural events). Moreover, the six students were closely involved throughout the research process from participant recruitment to data collection (see Section 3.2.2.2 and Section 3.2.2.3). They not only helped me to gain access to students' extracurricular activities but also contributed to the process of participant recruitment and data collection. All of them invited other medical students to participate in this research project. Three of them assisted with the delivery of two focus groups by taking up jobs such as recording and note-taking. Two of them assisted with transcribing the focus groups.

Table 11 Demographic information of six key informants

	Nationality	Ethnicity	Age	Gender	Language (Native)	Language (other)	Sexuality	Year of Study when recruited
1	British	Caucasian	29	male	English	English, French	heterosexual	2
2	British	Indian	21	female	Gujarati	Hindu, English	heterosexual	1
3	British	Korean	22	female	South Korean	English	heterosexual	2
4	Italian	Chinese	19	male	Italian	English, Mandarin, Spanish	heterosexual	2
5	British	Chinese	19	male	English	Cantonese	heterosexual	1
6	Singaporean	Malay	25	female	English	Portuguese	homosexual	2

3.2.2.2 Participant selection and recruitment

Participants for this study are Years 1-5 medical students (above 18 years old) undertaking an undergraduate degree in medicine (e.g. MBBS programme) from the chosen medical school. Among

the research activities conducted in Stage Two ethnographic fieldwork, one activity (campus-based teaching observation) consisted of my participant observation without formal participant recruitment but the other activities required formal participant recruitment (i.e. shadowing in hospital, shadowing in extracurricular activities, interviews and focus groups).

First, participant observation in the campus-based formal classroom did not require formal participant recruitment as I conducted general participant observation instead of shadowing any individual students. To collect data, I observed the teaching sessions after gaining oral or email permission from the corresponding teaching instructors. Ethnographic conversations were conducted with students during the break or after the teaching sessions for further information or clarification when necessary. Oral consent was obtained from these students, but they were not formally recruited.

Second, purposive sampling was used to recruit participants for shadowing in clinical placements. The five participants that were shadowed in clinical placements were all Year-2 medical students undertaking the Human Development Rotation Block. As my observation was conducted in the Human Development Block, to recruit participants, I introduced my research and procedures for participation to all the students undertaking this block during their briefing sessions on 08 April 2018. All potential participants received an information sheet further explaining the research process and how to volunteer to participate. Those who were willing to participate were recruited by signing and returning the consent forms at the end of the briefing session. Five students were recruited.

Third, purposive sampling was adopted to recruit participants for shadowing in the extracurricular setting from within the key informant team. The three participants were selected as the relatively close relationship between us enabled me to shadow them in a non-academic environment with the usual presence of their friends and family members. These shadowing activities were only possible after I have developed relatively established relationships with them, as sensitive or personal issues may arise during students' extracurricular life. With the participants' permission, I joint them in their extracurricular activities such as sports events, society events, volunteering and home parties with their friends. This also re-confirmed my decision of employing a participatory approach to gain access to participants' extracurricular life.

Fourth, to recruit interview participants, I advertised the research through the standard university research newsletter. I also put up research posters in designated areas on campus (e.g. notice boards outside the library and the dining hall) for participant recruitment (see Appendix 3). A snowballing strategy was employed to expand the number of interview participants. Potential participants were

also reached out with the assistance of my colleagues and the key informants. In addition, the eight participants who were shadowed all agreed to be interviewed.

Lastly, three focus groups recruited a total of 20 participants. The first focus group, which was conducted at the beginning of my observation, included four key informants and four other participants that were recruited via a snowballing strategy. This focus group had a pilot nature and its results informed the directions of my subsequent observation. The latter two focus groups aimed at communicating the preliminary findings to the participants so that they could evaluate and supplement the research findings. On this basis, I invited the participants who were involved in earlier research activities to take part. Six out of the 12 participants in the latter two focus groups took part in other research activities conducted for the purpose of this research (e.g. interviews/shadowing). A snowballing strategy was further adopted to expand the number of participants to make the two focus groups a valid and manageable size. The below table summarises the sampling criteria and recruitment strategies used for the four research activities that were applied in this research.

Table 12 Participant recruitment strategies

Research Activity	Sampling Criteria	Recruitment Strategies
Campus-based teaching observation	Year 1-Year 5 medical undergraduates (above 18 years old) in the chosen medical school	N/A (Note: teaching sessions highlighting CC as part of their learning outcomes were chosen for observation; Permission to observe was sought from instructors before observation.)
Clinical placements Shadowing	Purposive sampling among Year-2 medical students undertaking the Human Development Rotation Block	Face-to-face recruitment in the block briefing session
Extracurricular shadowing	Purposive sampling among key research informants	Email recruitment within the key research participant team
Individual interviews	Year 1-Year 5 medical undergraduates (above 18 years old) in the chosen medical school	Public advertisement; a snowballing strategy; and the invitation of the shadowing participants
Focus groups	Year 1-Year 5 medical undergraduates (above 18 years old) in the chosen medical school	The invitation of all involved participants; a snowballing strategy

During the process of participant recruitment, information sheets for each of the above-mentioned research activities were provided (see Appendices 4-7). Consent forms were signed (see Appendix 8). Moreover, to inform my participant recruitment, all participants were required to fill in a Participant Demographic Questionnaire (see Appendix 9). The design of this form reflected my understanding of culture as a combination of collective and individual features as described in the literature review chapter (see Section 2.4.1). Therefore, guided by students' region of domicile I

explored participants' cultural backgrounds from various aspects including their ethnicity, nationality, language background, gender, age, religion, sexuality, health status, length of stay and socioeconomic status. The personal information of participants helped my data analysis when any participants mentioned that their CC development is related to their individual cultural backgrounds. It also helped me with my data interpretation by enabling me to link students' understanding and levels of CC with their cultural backgrounds. To summarise, a total of 53 participants were recruited for the four research activities. Eight students were shadowed for observation: five in clinical placements and three during extracurricular activities. 25 students were interviewed. 20 students participated in the focus groups. The demographic information of the participants recruited for the four research activities is presented in Tables 13-16. All the participants listed below are identified by pseudonyms.

Table 13 Demographic information of shadowed participants in extracurricular activities

No.	Pseudonyms	Gender	Age	Year of Study	Sexual Orientation	Length in the UK	Native Language	Other languages	Ethnicity	Religion	Self-reported social class
1	Dante	Male	18-24	2	heterosexual	1-3 years	Italian	English, Spanish, Mandarin	Chinese	None	middle class
2	Kyle	Male	18-24	1	heterosexual	since born	English	Cantonese	Chinese	None	middle class
3	Paige	Female	18-24	1	heterosexual	5-10 years	Gujarati	Hindu, English	Indian	Jain	middle class

Note: BSc stands for Bachelor of Science. MSc stands for Master of Science.

Table 14 Demographic information of shadowed participants in clinical placements

No.	Pseudonyms	Gender	Age	Year of Study	Sexual Orientation	Length in the UK	Native Language	Other languages	Ethnicity	Religion	Self-reported social class
1	Usher	Male	18-24	2	homosexual	since born	English	French, Spanish, Welsh	White British	None	upper-middle class
2	Potter	Male	18-24	2	heterosexual	since born	English	French, German, Mandarin	White British	None	middle class
3	Simon	Male	18-24	2	heterosexual	1-3 years	Italian	English, Spanish, Mandarin	Chinese	None	middle class
4	Andy	Male	18-24	2	heterosexual	1-3 years	English	Mandarin	Chinese	Catholic	---
5	Mandy	Female	18-24	2	heterosexual	5-10 years	English	Cantonese	Chinese	None	middle class

Table 15 Demographic information of interviewed participants

No.	Pseudonyms	Gender	Age	Year of Study	Sexual Orientation	Length in the UK	Native Language	Other languages	Ethnicity	Religion	Self-reported social class
1	Damian	male	18-24	1	heterosexual	since born	English	None	White	None	middle class
2	Abbie	female	18-24	2	heterosexual	1-3 years	English	Hindu and Malay	Indian	Christianity	working class
3	Amelia	female	18-24	1	heterosexual	1-3 years	English	Tamil, Telugu	Indian	Hindu	middle class
4	Samantha	female	18-24	1	heterosexual	5-10 years	English	---	Nigerian	None	middle class
5	Karen	female	18-24	2	---	1-3 years	English	Cantonese	Chinese	None	---
6	Timothy	male	18-24	2	bisexual	since born	English	French, Spanish, Portuguese	Black African-Nigerian	None	middle class
7	Jim	male	18-24	5	---	since born	English	Cantonese, French, Spanish, Welsh	Chinese	None	working class
8	Wei	male	25-34	5	heterosexual	5-10 years	Mandarin	Cantonese, English	Chinese	Christianity	middle class
9	Mikul	male	18-24	3	heterosexual	since born	English	Gujarati, French	Indian	Hindu	middle class
10	Rachel	female	18-24	Intercalating	bisexual	since born	English	None	White British	Agnosticism	working class
11	Ross	male	25-34	5	homosexual	3-5 years	English	Spanish, Irish, German	White	None	working class
12	Penny	female	18-24	5	heterosexual	5-10 years	English	Cantonese	Chinese	None	---
13	Rebecca	female	18-24	1	heterosexual	5-10 years	English	French, Chadian, Arabic	White British	Christian	middle class
14	Lilys	female	18-24	2	I'd rather not say	since born	English	---	Mixed	Rather not say	middle class
15	Raymond	male	18-24	2	bisexual	Since born	English	---	Asian-Sri Lankan	Catholic	middle class
16	Nina	female	25-34	2	heterosexual	5-10	English, Arabic	---	Iraq	Islam	middle class

17	Arka	female	25-34	5	homosexual	since born	English	Turkish, French	Turkish	None	middle class
18	Usher	male	18-24	2	homosexual	since born	English	French, Spanish, Welsh	White British	None	upper middle
19	Andy	male	18-24	2	heterosexual	1-3 years	English	Mandarin	Chinese	Catholic	---
20	Mandy	female	18-24	2	heterosexual	5-10 years	English	Cantonese	Chinese	None	middle class
21	Potter	male	18-24	2	heterosexual	since born	English	French, German, Mandarin	White British	None	middle class
22	Simon	male	18-24	2	heterosexual	1-3 years	Italian	English, Spanish, Mandarin	Chinese	None	middle class
23	Dante	male	18-24	2	heterosexual	1-3 years	Italian	English, Spanish, Mandarin	Chinese	None	middle class
24	Kyle	male	18-24	1	heterosexual	since born	English	Cantonese	Chinese	None	middle class
25	Paige	female	18-24	1	heterosexual	5-10 years	Gujarati	Hindu, English	Indian	Jain	middle class

Note: BSc stands for Bachelor of Science. MSc stands for Master of Science.

Table 16 Demographic information of focus group participants

No.	Pseudonyms	Gender	Age	Year of Study	Sexual Orientation	Length in the UK	Native Language	Other languages	Ethnicity	Religion	Self-reported social class
1	Walter	male	18-24	2	heterosexual	since born	Urdu/English	None	Pakistan	Muslim	lower class
2	Maya	female	18-24	2	heterosexual	Over 10 years	South Korean	English	South Korean	Christianity	working class
3	Brian	male	18-24	4	homosexual	since born	English	German	White British	None	middle class
4	Taran	male	18-24	2	heterosexual	1-3 years	French	English, German	White European	Atheist	class
5	Damian	male	25-30	1	heterosexual	since born	English	None	White	None	middle class
6	Dante	male	18-24	2	heterosexual	1-3 years	Italian	English, Spanish, Mandarin	Chinese	None	middle class
7	Kyle	male	18-24	1	heterosexual	since born	English	Cantonese	Chinese	None	middle class
8	Paige	female	18-24	1	heterosexual	5-10 years	Gujarati	Hindu, English	Indian	Jain	middle class
9	Adam	male	18-24	1	heterosexual	3-5 years	Tamil	English	Indian	None	---

10	Rajesh	male	18-24	1	heterosexual	since born	Tamil	English	Tamil	Hindu	middle class
11	Abbie	female	18-24	2	heterosexual	1-3 years	English	Hindu and Malay	Indian	Christianity	working class
12	Emily	female	18-24	1	heterosexual	Less than one year	Finnish	English, Swedish	White	None	middle class
13	Wei	male	25-34	5	heterosexual	5-10 years	Mandarin	Cantonese, English	Chinese	Christianity	middle class
14	Wade	male	18-24	2	heterosexual	Since born	Urdu/English	None	Pakistan	Muslim	middle class
15	Amelia	female	18-24	1	heterosexual	1-3 years	English	Tamil, Telugu	Indian	Hindu	middle class
16	Lilys	female	18-24	2	I'd rather not say	since born	English	N/A	Mixed	Rather not say	middle class
17	Aisha	female	18-24	1	heterosexual	5-10 years	Gujarati	Hindu, English	Indian	Jain	middle class
18	Jun	male	18-24	1	heterosexual	since born	English	Hong Kong	Chinese	None	upper middle class
19	Potter	male	18-24	2	heterosexual	since born	English	French, German, Mandarin	White British	None	middle class
20	Karen	female	18-24	2	---	1-3 years	English	Chinese	Chinese	None	---

Note: BSc stands for Bachelor of Science. MSc stands for Master of Science. iBSc stands for the International Bachelor of Science.

3.2.2.3 Data collection

Data collection in Stage Two ethnographic fieldwork included data collected from my participant observation (general participant observation and shadowing), individual interviews and focus groups. Participant observation occurred both on campus and in hospitals, students' living residences and also public areas. To prepare for my data collection, I spent 12 months (October 2016-October 2017) immersing myself in intensive fieldwork observation. This took the form of activities such as classroom observation and participation in students' events held by the University Student Union. My preliminary fieldnotes became an important part of the inductive process in my research journey. Formal data collection started with my participant observation in formal classroom teaching on campus. First, six-month participant observation of relevant teaching activities was conducted, including lectures, workshops, project-based seminars with both direct and indirect links to teaching cultural competence. A total amount of 60 hours' observation was collected, and fieldnotes were produced by recording my observation in light of relevant learning materials (e.g. official learning outcomes, students' assignments and online learning resources). Second, five medical students undertaking the Human Development Block in Year 2 were shadowed each for a clinical day to gain insight into medical students' experiences of CC development in clinical placements. 25 hours' observation was conducted and fieldnotes were produced. Third, to capture students' experiences in extracurricular activities (e.g. activities organised by the Student Union or networking events), three participants were shadowed each for an entire day. The shadowing collated 24 hours' observational data. The three activities amounted to a total of 109 hours' observation.

To record my observation and experiences in regular and systematic ways, I developed two observational templates based on Spradley's (1979) nine observational dimensions in ethnography (see Table 17). First, to observe students' learning through the teaching activities in campus-based formal classroom teaching, Observational Template One (see Appendix 10) was formulated to record my observation from the aspects of module background, teaching topic, space, time, participants, learning outcomes, teaching format, teaching activities, CC-related teaching content, pedagogy, students' feedback and my refection as an ethnographer. Second, to shadow students in clinical placements and extracurricular settings, a more fluid Observational Template Two (see Appendix 11) was created to capture the environmental diversity and students' experiences from the perspectives of environment, activities, interaction, cultural elements and my personal feelings as an ethnographer.

Table 17 Nine observational dimensions in ethnography (Spradley, 1979)

Nine Observational dimensions	
Dimension	**Descriptor**
Space	Physical layout of the spaces
Actor	Range of people involved
Activity	A set of related activities that occur
Object	The physical things that are present
Act	Single actions people undertake
Event	Activities that people carry out
Time	The sequencing of events that occur
Goal	Things that people are trying to accomplish
Feeling	Emotions felt and expressed

Furthermore, 25 semi-structured individual in-depth interviews (each lasted around 25-35 minutes) were conducted simultaneously along with my observation. The interviews were audio-recorded by an encrypted audio recorder and were transcribed either by me or a professional transcriber. The interviews helped me elicit life stories of participants and explore their views and experiences of CC development in great depth. The question guide (see Appendix 12) of the interviews was informed by the results of the Stage One document review. It covered themes generated from the document review such as the institutional development of CC, CC curriculum design and delivery, subject-specific CC sessions, students' experiences in clinical placements and extracurricular activities. Based on a framework of pre-determined questions and themes, the semi-structured interviews allowed flexibility for new ideas to emerge. It covered four areas: 1) students' general understanding of CC and CC development; 2) students' experiences in developing CC in campus-based formal classroom teaching; 3) students' experiences in developing CC in clinical placements; 4) students' experiences in developing CC in extracurricular activities.

In addition, three 1.5 hours-2 hours focus groups (6-8 participants for each group) were conducted. The first focus group was conducted in December 2017 and its question guide was informed by my preparatory observation before my formal data collection (October 2016-October 2017). The second

focus group was conducted in May 2018 and its question guide was based on the preliminary findings of my participant observation in campus-based formal classroom teaching and students' extracurricular activities. The last focus group was conducted in June 2018. Its question guide was informed by my preliminary findings based on my participant observation in clinical placements (see Appendix 13 for question guides for the three focus groups). The three focus groups were both video-recorded and audio-recorded. One focus group was transcribed by me. Two focus groups were transcribed by two key student participants who took part in the focus groups and volunteered to do the transcription to gain more research experiences. Confidentiality Agreements (see Appendix 14) were signed before they started the transcription. Table 18 summarises the data collection in the ethnographic fieldwork in Stage 2.

Table 18 Overview of Stage Two data collection

Stage Two	**Participant Observation** • Teaching activities≈60 hours • Clinical placements≈25hours • Extracurricular activities≈24 hours • Total amount≈109 hours	**Focus Groups** 1st=8 participants 2nd=7 participants 3rd=5 participants Total minutes=315 minutes
	Individual Interviews • 25 interviews • Total minutes=732 minutes	

3.2.2.4 Data analysis

In Stage Two, I employed an interpretative approach to analyse the ethnographic data, which involved iteratively, inductively, interactively, and reflexively reviewing the fieldnotes, interview transcripts, and focus group transcripts. Creswell (2007) described that data analysis in most qualitative inquiry, including ethnographic case studies, can be broadly classified into five steps: 1) organising the data; 2) reading and memoing the data; 3) describing the data; 4) analysing the data; 5) interpreting and presenting the data. The organisation of my analytic activity in this way allowed me to be confident in building an analytic structure that met my research aims. Creswell (2007) also described this process as analytic circles that spiral upwards. This was particularly helpful in terms of revisiting, revising, and refining details in a more encompassing way than, for example, a fixed linear approach.

First, data organisation referred to the device of a categorical system in which data can be retrieved following a reasonable and convenient order to prepare for analysis. Ethnographic data commonly refer to "unstructured" qualitative data, which include open-ended verbal descriptions in fieldnotes, and transcriptions of audio/video recordings. In this research, I categorised and organised my collected data according to the types of research methods that were utilised. NVivo 11 was used for data storage and management as it facilitated and enhanced the indexing and retrieval process. Fieldnotes, interview transcripts, and focus group transcripts were dated in a standardised format and categorised in separate folders, with fieldnotes further categorised based on the observational settings covering teaching activities, clinical placements and extracurricular activities.

The second step involved developing a sense of the whole data through repetitive reading in order to outline general thoughts and initial categories. Creswell (2007) suggested that qualitative researchers need to read the entire data several times by immersing themselves in the details and trying to get a sense of the data as a whole. Notes and memos, consisting of short phrases, ideas, or key concepts, were written down to assist with detailed analysis while reading the data. This is followed by revisiting, checking what and how emergent data has a relationship with "itself" and exploring such notions in more depth. Murchison (2010) explained that relatively mundane concepts were likely to be developed first followed by the addition of more analytically significant concepts at a later stage during this process. Bearing this in mind I meticulously read my fieldnotes and transcripts of interviews and focus groups to make sense of the whole dataset before examining unique and individual pieces of data. To increase my confidence in the data I revisited the substantial dataset a second time and made additional notes on points relating to the research questions that I had missed initially. This is an example of one of the iterative processes that demonstrates the intensive nature of the research process.

After getting a general sense of the dataset, data description was the next step. As the foundation upon which qualitative research is built, data description means that researchers need to describe what they see, with details provided within the contexts of the participants, places, or events (Creswell, 2007). In an ethnographic piece, the ethnographer becomes the story-teller, inviting the readers to see through their eyes by presenting a straightforward description of the settings and events (Creswell, 2007). The ethnographer describes progressively by presenting or chronicling the daily experiences of a group of individuals (Murchison, 2010). Other techniques involve focusing on describing the critical moments or key events, such as presenting a complete story with a plot and characters, examining groups in interactions, or showing different perspectives through the views of participants (Murchison, 2010). In this research, I started reporting the research findings with a detailed description of students' experiences and views of CC development contextualised in the

three settings. Purposely selected key moments were described as cases to explore students' learning experience in detail.

The fourth step focused on coding and theme construction, which were two major components of the analysis. The main objective of the analysis at this stage was to find constructs, themes, and patterns to better understand and explain how students can develop their CC. Coding can be described as noticing relevant phenomena, collecting examples of those phenomena, and analysing those phenomena in order to find commonalities, differences, patterns and structures (Wolcott, 2002, Merriam and Tisdell, 2015, Mason, 2017). In order to code, I began to work on the data that seem likely to be central to my analysis, with a view to clarifying their meanings and exploring their relations with other categories of data. The process also involved aggregating the data into small categories of information, seeking evidence for the codes from all relevant data being collected in this study, and then assigning distinctive labels to the codes. In addition to coding, this step of analysis involved the simultaneous development of a set of analytic concepts/categories that capture relevant aspects of these data, and the assignment of particular items of data to those concepts/categories. This contributed to the development of concepts or themes, which are broad units of information that consist of several codes aggregated to form a common concept. In conducting analysis in this step, it is worth mentioning that coding was a recurrent and iterative process through which more refined data sets were developed. This continually spiralling process contributed to the generation of a detailed analysis of contextualised themes, constructs, thick descriptions, which were used to explore students' experience with a comprehensive view.

The last step involved interpreting and presenting the data in order to generate relevant accounts or narratives in order to answer the research questions. Data interpretation requires researchers to abstract out "beyond the codes and themes to the larger meaning of the data" (Creswell, 2007, p.187). An interpretive reading of data entails the construction and documentation of the meaning of data and concepts or ideas that one can infer from the data. The interpretation stage involves the ethnographer to make sense of social phenomena taking into account the contextualised elements such as time, space and personnel. Bearing this in mind I read through the data aiming to produce fruitful ideas by linking my interpretations with the larger research literature. Ultimately, the data were presented in ethnographic accounts, or narratives, that were augmented by texts, tables, figures and sketches. These accounts or narratives provided useful information to explain the themes supported by direct quotations from the participants and my interpretations as to how the themes relate to the proposed research questions. In this step, interview and focus group excerpts were edited for improved readability. Incomprehensible or not germane texts were deleted, shown by three dots in square brackets […].

3.3 Reflexivity

Taking a social constructive point of view, I have maintained a reflective mind and undertook an active approach in understanding the representation or interpretation bias of this research taking into account my philosophical and methodological worldviews, as well as the research dynamics between me and the participants. Reflexivity prompted the ways in which my own cultural backgrounds, professional backgrounds, experiences and social identities shaped or influenced the research process.

I feel that my personal cultural background could have influenced the way I interacted with potential participants during participant selection and recruitment. As a female international student with an East Asian background, I felt it was easier for me to establish rapport with students who share some common cultural elements with me. Throughout the research progress, I felt slightly nervous when I needed to approach male medical students with ethnic-cultural backgrounds other than my own (e.g. students with Middle Eastern or African Caribbean cultural backgrounds). This was because I was afraid that my limited prior knowledge of certain cultural topics would obstruct our communication. On the contrary, I was comfortable to initiate conversations with female medical students, students whose first language is not English, and students with cultural origins from Asia, particularly East Asia. This selection bias might to some extent have resulted in a strong representation of participants with ethnic backgrounds from Asia. Being aware of the potential bias, I aimed to cover a more diverse demographic representation of participants by using a range of recruitment strategies in this research (e.g. snowballing or recruiting participants through official university newsletters). The snowballing and public research advertisements helped me recruit a group of participants with more diverse sociocultural backgrounds.

In addition, my professional background has also contributed to my initial anxiety in conducting research in the clinical setting. With no prior clinical background, I feared that my limited clinical knowledge would potentially impair my understanding of students' learning experiences, which would then affect the quality of my research. Yet all these anxieties could be traced back to my lack of confidence to conduct research in a medical environment due to my initial unfamiliarity with the UK healthcare environment. Culturally, I am an international student with limited exposure to the UK healthcare service, which may have affected my self-perceived confidence in researching in a hospital setting. Nevertheless, this anxiety was soon diluted with my excitement to explore a new field and was eased through receiving suggestions from clinicians. Tips given by on-site clinicians were crucial at this stage. For example, I received useful suggestions such as to "wear a whatever kind of lanyard to distinguish yourself from a patient", and "report to the doctor/nurse-in-chief

before your observation". I was also not advised to wear a white coat so that patients would not mistake me as the medical staff. I gradually realised that my initial unfamiliarity with a new environment was never a weakness as an ethnographer. Contrarily, this position allowed me to be a humble learner to learn about and from the students. This served the prime task of ethnographers well—to "get inside" the way a group of people see the world and document their culture, perspectives and practices from an outside perspective.

Being reflexive also required me to actively reflect on the dynamics between the researcher and participants during the process of data collection in different research environments, particularly during interviews and focus groups where face-to-face communication took place in a created environment. I feel that the positive relationships between the participants and me were evident in the interview and focus group process. As for the individual interviews, I and my participants were able to discuss topics and ideas frankly and there was no evidence of conflict or discomfort at this stage. One regret when conducting the interviews was that I failed to make further exploration regarding the details of one homosexual student's proposed teaching content regarding ChemSex. This was because I did not want to make culturally inappropriate remarks due to my unfamiliarity with this issue.

As for the focus group discussions, they generated significant results judging from the natural interaction among the participants and the content of the data. However, it was necessary to note that the three focus groups had different dynamics with the presence of different facilitators. As Creswell (2007) stated, the representation or interpretation bias that ethnographers possess can not only be attributed to the researchers' philosophical, cultural or methodological paradigm, but also because of the research dynamics between the ethnographer and participants. As both academic staff and PhD students facilitated the focus groups, it was noticed that the focus group that was facilitated by a university lecturer tended to be slightly hierarchical, and participants were more likely to agree with his opinions, with frequent use of terminologies throughout the discussion. As for the other two focus groups that were facilitated by PhD students, participants were more likely to voice critical opinions and the language tended to be less formal with constant reference to their inside stories as medical students. The participants in these focus groups also mentioned that they would not discuss some of the topics if the focus group was facilitated by a regular university staff who also teaches them as they fear some of the remarks might put them "in a difficult situation".

Moreover, I acknowledge that I have used some of my personal feelings as a participant during my observation to analyse and interpret the research findings. This was allowed as reflexive data analysis locates the researchers as part of the data and seeks to explore their roles and perspectives in the

process of data interpretation and theme generation. This means sometimes my understanding as an observer may conflict with my feeling as a participant, therefore, it required me to make sense of the potential discrepancies in order to gain a more comprehensive view of students' learning. For example, "putting on" the identity of a medical student in the occupied hospital setting, I felt excited to learn all the relevant clinical knowledge and skills but neglected some cross-cultural encounters that were taking place simultaneously (e.g. talking with parents who may have a gender preference due to cultural backgrounds). However, as a relatively objective observer, I was able to note down these meaningful encounters. Phenomena as such required me to constantly switch between the two roles and attempt to achieve a healthy balance between my participation and observation. Taking this into account, I noted down my feelings and interpretations of my observation from both perspectives. Moreover, in the data analysis process, besides doggedly recording the criteria and my decision-making process, I "wallowed" in the data (Glaser et al., 1968) in order to be more familiar with the data. By constantly thinking between a participant and an observer, I managed to use my data analytical framework in a flexible manner, to remain open to alterations, to avoid overlaps, and to consider previously unavailable and unobservable categories. To deal with my potential bias in the process of data analysis, I also sought help from other PhD students who cross-checked my coding scheme. We randomly selected and checked content under certain coding categories to ensure consistency. Regular discussions were held on how to understand the codes and emerging themes (see Section 3.4).

To summarise, the awareness of keeping a reflexive mind allowed me to reflect on my own bias which can be related to any past experiences, preconceptions, prejudice and cultural orientations that could impact my approach and interpretation of this study. Reflecting on my researcher's impact throughout the research process helped me evaluate my impact as a researcher. It also helped me put efforts to enhance the trustworthiness of my research as discussed in the following section.

3.4 Efforts to ensure trustworthiness

Since the concepts of "validity" and "reliability" are more obscure in qualitative studies (Kelle and Laurie, 1995), the term "trustworthiness" was suggested to judge whether a qualitative study is credible, transferable, confirmable and dependable (Welsh, 2002, Silverman, 2015). The trustworthiness of this research was strengthened by undertaking the below procedures:

1) The participatory approach by building a team of key research informants shortened the distance between me as the ethnographer and medical students as the participants. The prolonged and extensive engagement with daily observation offered me opportunities to learn students'

experiences through gradual relationship building while cross-checking and cross-validating the results with participants.

2) The utilisation of a range of research methods enhanced the trustworthiness of this research. On the one hand, the multi-method ethnographic design was able to include more diverse participants so as to reduce the impact generated by the individuals who did not agree to participate in any research activity. For example, whereas two students expressed that they did not wish to be observed in the clinical placements, I was still able to learn their experiences in a confidential one-to-one interview environment. On the other hand, to supplement the potential subjectivity aroused from my position as a participant observer, my other research activities (e.g. interviews and focus groups) enabled me to capture the perspectives of participants and triangulate the results with my personal observations. The multi-method design achieved data saturation when no new themes were discovered. The synthesis of the qualitative data was able to more comprehensively address the research questions.

3) The two member-checking focus groups strengthened the trustworthiness of this study. Preliminary findings were shared with participants so that the research involved a series of "member-checking" (Teddlie and Tashakkori, 2009) in which participants were asked to verify the emerging themes and supplement the results through the group interaction. This design enhanced the trustworthiness of the study when my findings and interpretations were tested credible by students.

4) Thick descriptions of my observations in a few key events/moments in great depth enhanced the trustworthiness of this ethnographic research. Instead of exploring students' experiences at a superficial level, a detailed description of key events enabled a nuanced understanding of students' experience through providing detailed, contextual and multi-layered interpretations, such as the selected cases described in Chapters 5-7.

5) I have discussed and debriefed on a regular basis throughout the research process with my supervisors, two other PhD students, and a thesis progression committee made up of three panel members who have research expertise in this field. These academic discussions helped me address questions and challenges about my research design, methods, data collection, analysis and interpretations. Their feedback allowed me to constantly refine my research which further ensured trustworthiness.

6) Transparency was demonstrated throughout the research process. Procedures and decision making in every stage of this research were documented and justified in the writing process, which also enhanced the research trustworthiness.

3.5 Ethical considerations

Ethical Approval for this research project was granted by the University Research Ethics Committee in November 2017 (reference number: LRS-17/18-5013, see Appendix 15). Gatekeeper Approval was granted by the director of Educational Research and Innovation of the chosen medical school in August 2017. NHS R&D Approval (IRAS Reference: 234940, see Appendix 16) was granted in April 2018 to allow me to conduct participant observation on designated NHS grounds. Information sheets targeting different research activities were designed to explain the purpose of the study, the participant recruitment, data collection process and data management (see Appendices 4-7). The information sheets also provided information on whom to contact if the participants had questions or concerns about the research. Participants were assured that they could withdraw from the study at any time for any reason during their participation or within two weeks after their participation. Consent forms were signed (see Appendix 8).

As data collection took place in a number of settings, my role as a researcher had different implications. Although it was difficult for me to judge what effects I might have had on the research settings or any of the participants, I aimed to conduct my research taking into account the nature of the research environments. To begin with, during my general observation in the educational activities on campus, my observation was conducted without causing obstructions to normal classroom teaching or other teaching activities. I managed to maintain a low profile by behaving as a participating student and took my fieldnotes throughout the observation in an unobtrusive way. To achieve this, before observing lectures, I obtained verbal permission from the lecturers. Before observing seminars or workshops, I obtained verbal permission from the instructors and made all students aware that observation was taking place. When observing in a small-group environment such as workshops, I, with the help of the instructors, made sure that all parties involved in teaching were aware of the purpose of my research and the intention of my observation. When further information was needed from participants, I only sought clarification during the break or at the end of the sessions.

When conducting my participant observation in clinical placements, patient safety was my prior ethical concern. Although the focus of the research was not about patients and I would not have any direct contact with them, observation could take place when patients were present. Therefore, in order to be non-obstructive to students' learning in the hospital, I maintained a low-profile when shadowing students and only asked questions during their breaks or at the end of their placements. This was allowed after I explained my purpose of research to the clinicians/nurses-in-charge. During my observation, I was aware that I was sometimes mistaken as a medical student because of my

relatively young appearance and observable unfamiliarity with the clinical environment. Nevertheless, I judged it was more appropriate to retain this low profile rather than overtly giving clarification, which might obstruct students' learning by drawing attention to me as a researcher. Moreover, to guarantee patient safety, I strictly followed the research protocol submitted with the application for the NHS R&D approval. Before any circumstances involving patients, I asked for verbal permission to stay and explained the purpose of my observation. The observation would not take place unless all involved parties gave consent for my presence. During my observation, whereas I did not take the initiative to ask patients questions, two patients started conversations with me by showing interest in my research. The information was not documented as my collected data only included students' learning instead of any information about patients. Furthermore, to deal with any potential ethical issues that might arise in clinical settings, I sought advice from two clinicians, who had extensive research experience in the hospital setting. My academic supervisors, both with experience in researching on NHS grounds and collaborating with clinical staff, also trained me on how to conduct ethical research in clinical settings. The professional advice (such as tips mentioned in Section 3.3) prepared me for any potential ethical challenges that may take place in the clinical setting.

As for shadowing students in their extracurricular activities, observation did not proceed without getting permission from individual students and anyone else who was present in the observational setting. This was because the observation of students' extracurricular activities in a non-academic environment usually involved their families and friends, and private/sensitive issues may arise. A low-profile participant observer was not possible under these circumstances, so I joint students as their peer during the activities they undertook. As expected, it was difficult for me to gain permission from students, or even to find opportunities to ask, if I could "act as" their friend for one day during their extracurricular activities. More importantly, students also told me that they would not feel comfortable if a researcher suddenly "intrudes" their personal life without established relationships. This was why I selected the participants from within my key participant team as I had developed relatively closer and more established relationships with them. To gain consent, information sheets and consent forms were provided to the participants before the observation. Verbal permission was sought from anyone else who was present in the observational setting (except in public environments) and made sure they allowed me to observe.

When conducting interviews and focus group discussions on campus, possible harms to participants, such as potential discomfort generated by sensitive questions, were thoroughly considered. All interviews and focus groups took place in a pre-booked library room or teaching classroom on campus. A safe environment was created by setting up ground rules before the interviews and focus

groups. Participants were informed that they would be anonymised when reporting the research. Participants were also made sure that they could pause or stop the interview or focus group if they think the research had upset them in any way. Referral services to the Head of Student Affairs and Pastoral support may be offered when necessary. Moreover, permission to use participants' direct quotes were also sought, but these quotes would not have identifiable information.

Safe data management is another ethical concern I actively considered throughout the research process. During data collection, the names of medical schools are anonymised. Personal data of each participant was collected anonymously, and all participants were pseudonymised. If direct quotes were used, permissions were sought from the participants and these quotes were doubled-checked to make sure to contain no identifiable information. The interviews and focus groups were audio-recorded by an encrypted digital recorder (Olympus DS3500) and my password-protected mobile phone. The focus groups were also video recorded by the camera equipment owned by the university. The video recordings were immediately transferred to my password-protected laptop in an encrypted file after the focus groups were completed. The SD card was emptied when I returned the camera to the university. Only I have access to the recordings. As for data storage, the Participant Demographic Questionnaires are archived in a safe-guarded office at the university together with the signed consent forms. All electronic data about this research are regarded as strictly confidential and encrypted and held securely on my password-protected personal computer. Files with sensitive/personal information are encrypted and kept apart from anonymised data in a separate file structure. The research data will be held for 5 years from the completion of the research.

3.6 Methodological limitations

This research has several limitations. One limitation is that the majority of participants in this research were Year-1 or Year-2 medical students, particularly for my observational activities. This was because most associated CC and diversity teaching sessions in the chosen medical school take place in the early years of the medical curriculum. Also, it was pragmatic for me to recruit medical students in the early years of their training because they spend relatively more time on campus and have shown stronger interest to participate in university-wide research activities. The recruitment was valid because I was able to capture students' learning in both the pre-clinical setting (Year 1) and clinical setting (Year 2 onwards). The results may shed light on students' learning in the later years of their medical training. However, bearing in mind this imbalanced representation in participant observation, I recruited Year 3-5 students (including students undertaking an intercalated degree) to take part in the interviews and focus groups so that I was able to select more balanced participants that are more presentative of the diverse student population.

Like many qualitative studies, another limitation of this research is in its transferability to another setting as it is in nature a single-site ethnographic case study. The findings of this research cannot be simply generalised in other medical schools; nor is it the intention of qualitative research to achieve that aim. Nevertheless, the case study approach allows in-depth, multi-faceted examination of the complex issues in real-life settings and is considered a robust research method when a holistic and in-depth investigation of the culture or social behaviours of a certain group is required. The in-depth qualitative understanding of one medical school with a diverse student body and healthcare environment can provide pedagogic insights to medical schools and identify important indicators to understand medical students' CC development in general. The results can also shed light on understanding medical education in countries or regions that are experiencing an increasing phenomenon of cultural diversity in healthcare.

Another limitation is that I did not have a chance to observe students' learning in clinical placements outside the hospital setting. As the National Health Service (NHS) care in the United Kingdom is provided in primary care (general practice and community services), secondary care (hospitals and specialists) and tertiary care (national or regional specialist centre), a more systematic approach would cover all the settings. In this research, the turndown of the contacted primary care clinics to host my research may result in a gap for me to explore students' experiences via first-hand immersion in the primary care setting. The limited timeframe for a PhD research project was also a practical restraint. This explained why one of my focuses on conducting the interviews and focus groups was to explore students' learning in clinical placements beyond the hospital setting. The results revealed that students can develop their CC in similar ways in primary care centres or clinics as in hospitals. Students also mentioned that they experienced more cross-cultural encounters in the primary care setting as in-depth interaction with patients and their family members is more noticeable during the consultations or community visits. However, the lack of first-hand data collection in these settings indicates that ethnographic approaches can be utilised in future research to explore students' clinical learning beyond the hospital setting.

4 Cultural competence and diversity education in UK medical schools

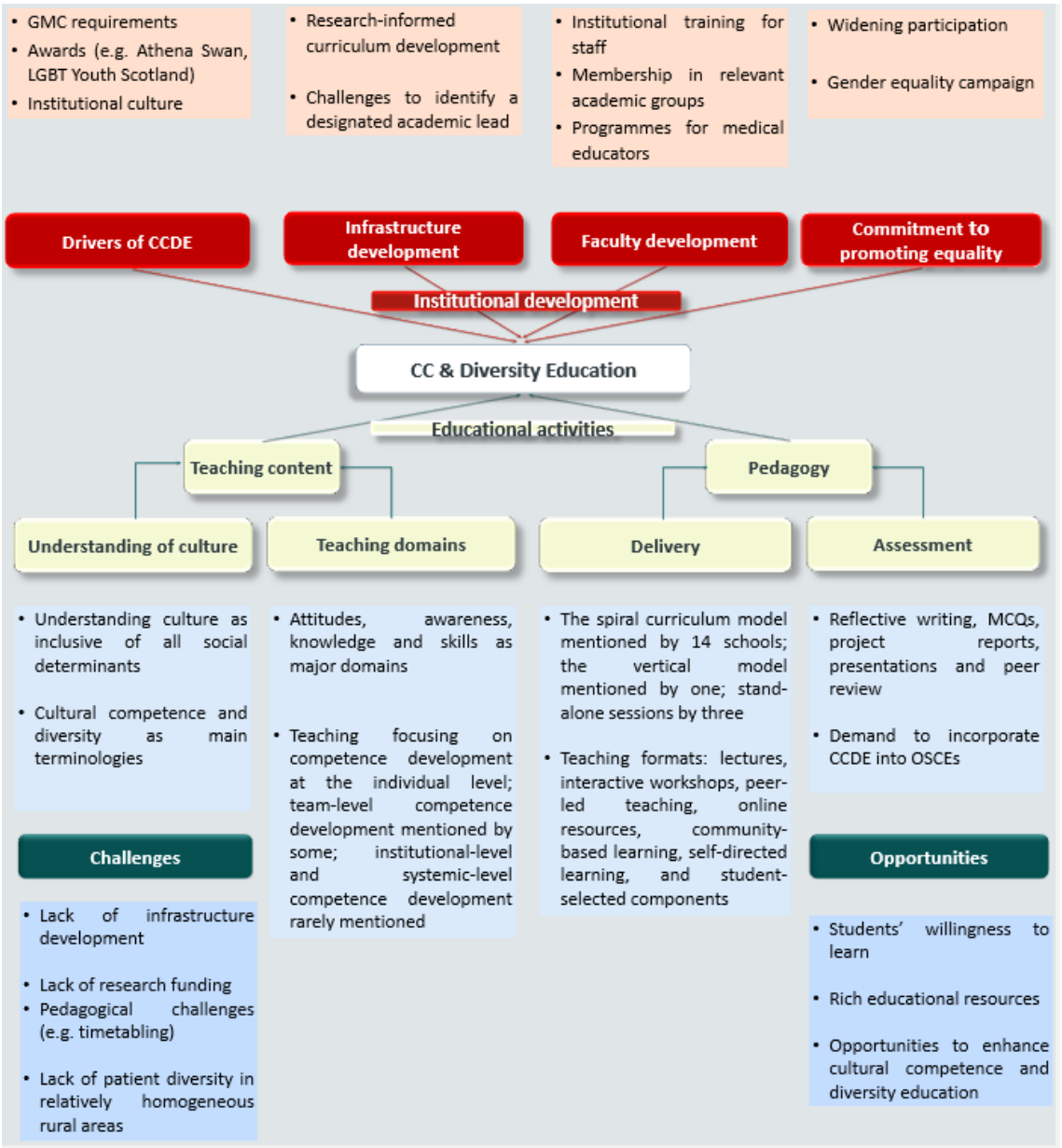
This chapter provides a general overview of cultural competence (CC) and diversity education in UK medical schools based on the review of two types of documents (DIMAH posters and official university website information). For this review, I undertook a social constructivist standpoint by viewing documents as social products generated within specific contexts. Starting with the introduction of the background of the collated documents, this chapter presents the results of the document review and discusses how the review has informed the subsequent ethnographic case study.

A constructive examination of documents requires researchers to look at why and how the documents were produced. As mentioned in the previous chapter (see Section 3.2.1), DIMAH is a national organisation made up of academics and healthcare practitioners that supports CC and diversity education across UK health schools. In the DIMAH 6 May 2016 Conference organised by DIMAH and the UK Medical Schools Council, all UK medical schools were approached to showcase their CC and diversity education at a national level. The purpose of the poster presentation was to present the achievements of CC and diversity education across UK medical schools and facilitate academic exchange by sharing good educational practice. In response, a series of posters from 24 medical schools were collected. These posters included information such as infrastructure development, teaching content, and pedagogical issues around CC and diversity contextualised in each medical school. Although this was a national-wide call for the participation of all UK medical schools, 24 out of 33 schools shared their experience through poster submission. In order to explore current educational development in the other nine medical schools that did not submit posters, the term “cultural competence” and “diversity” were searched on the official websites to gather further information for review.

Results show that CC and diversity education varies across UK medical schools. According to the 24 DIMAH posters, 23 medical schools reported their educational activities around CC and diversity whereas 17 medical schools focused on presenting their institutional development such as their commitments to promoting equality and diversity. 16 schools reported on both. For the nine medical schools that did not submit posters, whilst all of them have information regarding their institutional commitments to promoting equality and diversity on their official websites, only two schools have information regarding their educational practice and research around CC and diversity. The aggregative review of the documents generated seven themes: drivers of education, infrastructure

development, faculty development, commitment to promoting equality, teaching content and pedagogy, as well as challenges and opportunities to enhance CC and diversity education. These themes can be divided into two overarching categories: institutional development and educational activities (see Figure 6). The dark red-shaded themes summarise the institutional development to support CC and diversity education, and the light yellow-shaded themes specify the pedagogical issues that are relevant. Within both categories lie in challenges and opportunities. The two main categories are combined to formulate a general overview of CC and diversity education in UK medical schools.

Figure 6 Themes around CC and diversity education



Note: MCQs stands for Multiple Choice Questions; OSCE stands for Objective Structured Clinical Examination.

4.1 Institutional development

4.1.1 Drivers of CC and diversity education

The review shows that the main driver of UK medical schools to deliver CC and diversity education is to meet the requirements of the General Medical Council (GMC). Five medical schools highlighted the need to provide CC and diversity education in alignment with GMC regulations, which require students to develop competence in order to provide culturally appropriate care taking into account the various needs of patients from diverse social, cultural and ethnic backgrounds (General Medical Council Education Committee, 2015). Nevertheless, how the GMC requirements are followed in practice differs among medical schools. Two schools highlighted the specific GMC regulation they follow. Medical School D emphasised the teaching of clinical communication as the core, which is to "communicate clearly, sensitively and effectively with individuals and groups regardless of their age, social, cultural or ethnic backgrounds or their disabilities, including when English is not the patient's first language". Medical School F reported that the provision of diversity education is based on the necessity to provide culturally appropriate care allowing for patients' personal beliefs in order to meet GMC's regulation, which is to "adequately assess the patient's conditions, taking account of their history (including the symptoms and psychological, spiritual, social and cultural factors), their views and values".

In addition to meeting GMC requirements, seven medical schools linked their CC and diversity education with the application of diversity-related awards. Linking diversity education with relevant awards demonstrates that many medical schools perceive their institutional achievements as part of the work to promote equality towards a diverse working environment. Three awards were mentioned: Athena Swan, LGBT Youth Scotland and the City of Sanctuary Health Award. Receiving an Athena Swan institutional award, a charter established to encourage and recognise the commitment to advancing the careers of women in science, engineering, maths and medicine employment in higher education and research (ECU's Equality Charters, 2018), was reported by six medical schools. Medical School E mentioned the legal requirement to build equality and diversity into its school culture with reference to its ongoing project working towards gaining recognition from LGBT Youth Scotland. This recognition is awarded to organisations that have policies, practices and training that create an inclusive environment for the LGBT youth community. Medical School A reported that it delivers CC and diversity education to address the specific needs of refugees and asylum seekers and has received the City of Sanctuary Health Award.

Besides, Medical School A reported that delivering CC and diversity education is driven by its institutional culture to promote equality and diversity. By setting up policies and guidelines, the school aims to prevent discriminatory practices and outline reasonable accommodations the university may offer for reasons of culture and religious belief. All students in the medical school are required to sign an ethical code on an annual basis which reads, “I will treat patients, professionals, teachers, and fellow students politely and considerately, respecting their views, privacy, and dignity, ensuring that my personal beliefs do not prejudice my dealings with them”. This contributes to creating a culturally inclusive institutional environment that advances educational development around CC and diversity. For instance, a teaching component named “Religion and Belief Policy and Guidance” was developed with input from medical students across all years. During the training, students are trained to act and treat patients and colleagues without discrimination based on age, sex, colour, gender, race, religion, nationality, culture, sexual orientation, disability, or socioeconomic status. Furthermore, embracing diversity institutionally also means acknowledging the impact of diversity within the student body. Medical School K pointed out that the various backgrounds of medical students (including the growing number of international medical students) are also drivers, as the diversity within the student body voices a stronger need in delivering training to equip culturally different students with competence to work with patients from diverse backgrounds.

4.1.2 Infrastructure development

Infrastructure development includes both the development of hard infrastructures such as physical facilities and the development of soft infrastructure that is essential to maintain an educational system (e.g. faculty structure and management support). Results show that infrastructure development varies across medical schools. Whereas some medical schools appointed full-time academic leads who are recognised through career promotion, other schools expressed the difficulty to have designated academic leads to challenge “thorny issues”. As for the appointment of academic leads, Medical School O raised a doubt in the poster whether or not there should be an academic lead for CC and diversity education. To gather a comprehensive understanding regarding the necessity of designating academic leads, I discussed this matter with over 10 members in a DIMAH general meeting. The 10 DIMAH membersagreed that academic leads are indispensable in overseeing CC and diversity education. They also pointed out that the argument of not naming an academic lead is possibly based on the limited understanding that the under-performance of an academic lead may produce standalone teaching sessions instead of systematic integration across the medical curriculum. The document review also identified a medical school that showcases a strong infrastructure set-up to support CC and diversity education from three levels. On the

management level, the then arrival of a new Deputy Dean of medical education brought in an enhanced strategic approach to CC as a subject with formal recognition in the curriculum. On the faculty level, a designated academic lead for CC oversees the development and delivery of the subject. On the research level, there were reported ongoing projects to map out sessions in relation to CC and diversity and to explore attainment gaps among students of diverse sociocultural backgrounds.

4.1.3 Faculty development

Faculty development refers to professional development involving training and professional learning for educators. Among the 24 medical schools, six schools reported having faculty training in place. The training activities can be categorised into three types. The most common type is training provided at the institutional level to all staff, such as training on unconscious bias, teaching clinical communication for culturally and linguistically discordant consultations, promoting awareness and explicit teaching of diversity in the workplace and sharing good educational practices. Details of training at this level were not provided. The second type of training is joining relevant academic organisations such as DIMAH. Medical School N mentioned that academic exchange among educators in DIMAH general meetings is a good strategy to strengthen bonds and exchange opinions among professionals. The last type of faculty training is postgraduate-level training for potential medical educators. Medical School I reported that it runs a master's module on intercultural clinical education. This module is delivered to clinical trainers who are currently pursuing a master's degree, some of whom are teaching at the same institution.

4.1.4 Commitment to promoting equality

The document review identifies that widening participation and promoting gender equality are frequently reported institutional schemes to promote equality and diversity, contributing to building a culturally inclusive environment. Widening participation in higher education refers to opening up universities to young people and under-represented groups, including those from low socioeconomic groups, people with disabilities, and ethnic minorities (National Audit Office, 2018). In reporting CC and diversity education, many medical schools referred to their respective actions to tackle inequality during admission. For example, Medical School A mentioned that its admission process is based entirely on "merit and basis of ability", and its admission policies ensure equality of opportunity to all applicants. It also raised the concern of unconscious bias at admission interviews although no solution has been proposed.

In addition to widening participation, medical schools reported that promoting gender equality can help to build CC and diversity into its institutional vision, thus creating opportunities for educational development. In the poster, Medical School T reported issues around gender equality at its staff level. For instance, it stated the need to establish the effectiveness of the newly introduced Faculty Maternity Returnees Scheme to support new parents coming back to work. It also demonstrated the fact that there should be a higher proportion of women in clinical academic roles, and there is a need to increase nominations of women for future senior leadership development programmes to reflect the gender of faculty staff. Corresponding action plans were proposed to address each issue. Similar to widening participation, my interpretation is that promoting gender equality helps build a more culturally diverse and equal environment, creating a supportive environment for CC and diversity education. It also resonates with medical schools' endeavours to apply for Athena Swan awards.

4.2 Educational activities

4.2.1 Teaching content

Results show that 22 out of the 24 medical schools reported educational activities around CC and diversity. It is helpful as a starting point that most schools recognise culture as a multifaceted concept that captures all sociocultural determinants. This means that students are trained to view each patient as individually different with diversity manifested from multifaceted sociocultural dimensions such as race, ethnicity, gender, sexual orientation, socioeconomic status, age, physical abilities, religion and political beliefs. For example, Medical School L, with a strong demonstration of faculty support, emphasised that they teach students to acknowledge that "each person is unique and complex and cannot be pigeonholed based upon any facet of their culture or background". The lesson can be drawn from this is that CC and diversity education is not a tick-box exercise that relies on stereotypical information; instead, it expands from the traditional focuses of race and ethnicity to the gradual acknowledgment of cultural differences at an individual level. However, seeing people as individually different does not simply equate to a complete denial of the role of cultural groups/populations, as having a basic understanding of cultural groups is the first step to explore how individual cultural differences may interact with the social context. To enhance students' understanding of certain cultural groups, 18 medical schools reported that they deliver teaching specific cultural knowledge and skills pertaining to certain cultural groups/topics. Five medical schools showcased their teaching on LGBTQ+ groups, five on patients with disabilities, four on people with mental health, three on homeless groups and asylum seekers/refugees, two on migrants and patients with hearing/visual impairment, and one on patients with learning disabilities. Specific cultural topics were also mentioned including religion and beliefs, sexuality, gender issues, death and

dying, ethnicity, stigma and prejudice, abortion, chronic pain, female genital mutilation (FGM) and domestic violence.

4.2.1.1 Teaching domains

The review shows that the main teaching domains around CC and diversity include cultural attitudes, awareness, knowledge and skills (see Table 19). The teaching of cultural attitudes and awareness was reported by the majority of medical schools, but none has given an example of how teaching is been carried out. Key themes that were identified included demonstrating culturally appropriate attitudes such as respect, non-judgement, curiosity, openness and empathy with culturally diverse patients. It also included developing cultural awareness through gaining a comprehensive understanding of the non-clinical determinants of global health, such as the social, cultural, political, economic and environmental factors. Equally important was developing awareness in understanding stigma and stereotypes, as well as the linguistic barriers that may exist when patients accessing healthcare.

Examples of teaching around cultural knowledge and skills were reported by 18 out of 24 schools. Specifically, the teaching content of cultural knowledge included the general concepts of culture, culture and its implication on health, and knowledge about specific cultures (e.g. race, ethnicity, religious belief, sexuality and socioeconomic status). Topics falling into cultural knowledge included the teaching of alternative and multicultural medicine, cultural issues relating to death and dying, domestic violence and abuse, forced marriage, FGM, sexual violence, as well as racism and prejudice. As for cultural skills, clinical communication has been fully integrated into curriculum development among almost all medical schools. For example, Medical School F self-reported as having “very well-delivered clinical consultation skills training sessions” following a spiral curriculum model. It highlighted the teaching of telephone consultations skills, skills in using visual aid and decision aids, written communication, as well as verbal and non-verbal communication.

Table 19 Teaching domains around CC and diversity

Teaching domain	Focus	Specific teaching components
Attitudes	respect; non-judgment; curiosity; openness; empathy	• a welcoming approach to culturally diverse patients; • non-judgemental attitudes and perceptions of cultural groups; • a patient- and person-centred approach to interactions based on attitudes of respectful curiosity and empathy
Awareness	awareness of non-clinical determinants; stigma and stereotyping; linguistic barriers	• awareness of the non-clinical determinants of global health, including social, cultural, political, economic and environmental factors; • awareness of individual beliefs and values, unconscious bias, and self-prejudice; • awareness of stigma and stereotypes and their implications on healthcare outcomes; • awareness of challenges facing people whose language or use of language is a barrier to accessing healthcare; • awareness of potential problems that can arise when friends and family members act as interpreters
Knowledge	concepts of culture; culture and its implication on health; knowledge about specific cultures	• knowledge of alternative and multicultural medicine; • knowledge of cultural issues in relation to death and dying, domestic violence and abuse, forced marriage, FGM, sexual violence, as well as racism and prejudice; • specific cultural knowledge of cultural groups (e.g. race, ethnicity, religion, sexuality, disability, and socioeconomic status)
Skills	clinical consultation skills; clinical communication;	• clinical consultation, including telephone consultations skills; • sign language skills in using visual aid and decision aids, and non-verbal communication; • communication with specific cultural groups such as people with disabilities, language barriers or other communication difficulties

4.2.1.2 Associated teaching subjects

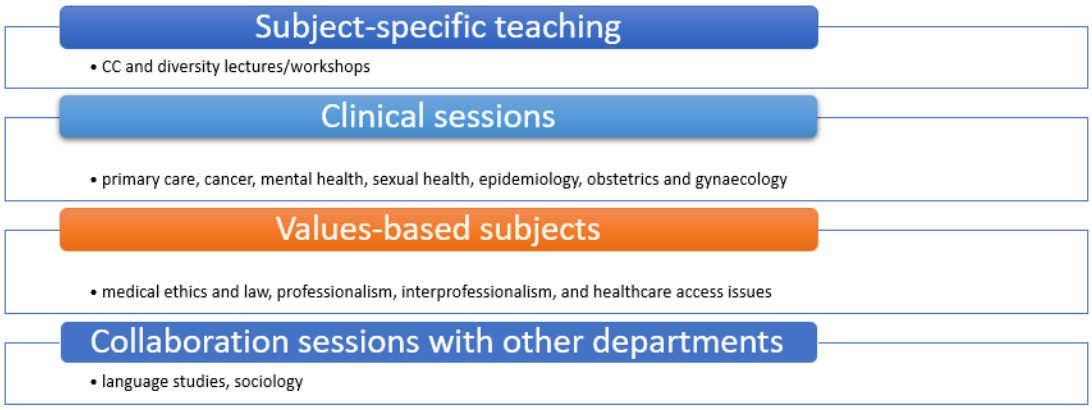
Results show that the teaching on CC and diversity is embedded in a wide range of medical subjects. Three medical schools reported that they deliver theme-specific lectures or workshops on CC and

diversity (e.g. equality and diversity training course, diversity and culture in healthcare, CC lectures and workshops). Except for subject-specific sessions, CC and diversity content is embedded across the curriculum in a range of teaching blocks that can be mainly categorised into three types (see Figure 7). The first type is clinical sessions, among which primary care, public health, cancer, mental health, sexual health, obstetrics and gynaecology are reported subjects. For instance, Medical School R has incorporated diversity content into its mental health teaching block by emphasising the relevance between mental health and the impact of race/ethnicity, culture, and age on the diagnosis of psychosis. Four medical schools mentioned that they have programmes associated with primary care that aim to open students to the diverse backgrounds of individual patients with a focus on issues around accessing healthcare. Courses such as Preparing for Patient Course, Patient voice, Social Context of Health and Illness were reported.

The second type is values-based medical subjects, including professionalism, interprofessionalism, medical humanities, and medical ethics and law. Results show that these values-based subjects are frequently mapped out as sessions that can contribute to CC and diversity education by medical schools. Among these subjects, medical ethics and law was reported as contributing to CC and diversity education by eight medical schools. For example, Medical School E specifically mentioned that medical ethics are repeating topics for their equality and diversity training. Medical School A reported that its medical ethics subject is closely linked with the subject-specific teaching (e.g. the diversity and culture lecture), as one learning objective is to explore how ideas of health, illness, and healing vary across cultures. Besides medical ethics and law, the teaching of professionalism was reported as relevant to CC and diversity education by five medical schools with medical school X remarking that developing CC is an essential requirement of the professional development of future doctors.

In addition, sessions delivered through the collaboration with departments outside the medical school were reported as one component of the CC and diversity curriculum. These collaboration sessions mainly include social science subjects such as language and sociological studies. Three medical schools mapped out their language training courses as part of their teaching on CC and diversity. For example, Medical School I reported a wide range of sessions that are collaborations between the medical school and the Foreign Languages Centre with a teaching focus on cross-cultural communication. The school also provides a range of learning resources such as the E-learning materials and cross-cultural and cross-lingual communication workshops. Medical School F reported that attending sessions around medical sociology can benefit students' CC development as students are encouraged to view medical practice from a social and cultural perspective.

Figure 7 Associated CC and diversity subjects



Moreover, when reviewing the educational activities shown from the official websites of the other nine medical schools, two schools have linked their CC and diversity education with intercalated programmes. Medical School A1 specified that its Intercalated Bachelor of Science (BSc) programme has a teaching component on discussing the concept of CC and diversity. Medical School Z reported its intercalated programme that covers a range of subjects in relation to culture in the context of medical and health-related topics developed within the traditions of the arts and social science subjects. For instance, for its intercalated BSc in Medical Humanities degree, it is remarked that students can learn from a diverse range of subjects within the Colleges of Arts and Social Sciences in order to construct a package of honours courses suitable to their own needs and interests. Former students provided positive feedback to the programme as they believe it is “an opportunity to experience a different style of learning” and “beneficial in revealing the humanity and frailty of both patients and doctors”.

4.2.2 Pedagogy

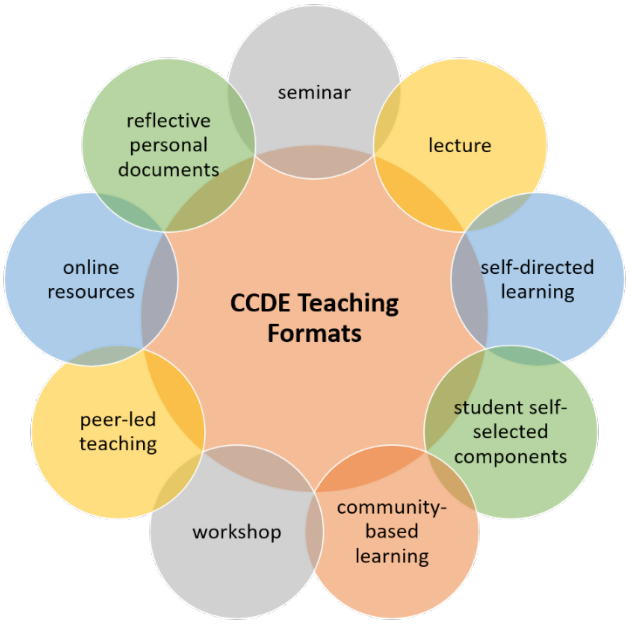
4.2.2.1 Delivery

The review shows that most medical schools follow a spiral or vertical model to teach CC and diversity, with three schools approaching CC and diversity education as standalone sessions. Among the 24 medical schools, 14 medical schools reported a spiral curriculum model, with content embedded in a range of subjects across all years. One school reported using a vertical model with integration across time from earlier years to more senior years. Three schools had one-off sessions without

reference to any educational models. Six schools reported specific approaches such as problem-based teaching or case-based teaching.

In terms of teaching format, the review shows that a variety of formats have been adopted to teach CC and diversity, including seminars, lectures, interactive workshops, simulated patients, patient educators, peer-led teaching, online resources, community-based learning, reflective personal learning documents, self-directed learning and student-selected components (SSCs) (see Figure 8). In addition to didactic lectures, integrated clinical scenarios and culture-relevant workshops/seminars are the most frequently reported formats. Four medical schools provided examples of the patient scenarios they have developed with an emphasis on developing CC. 11 medical schools provided examples of their themed workshops, such as a half-day disability seminar, or a half-day seminar on care after death. Nevertheless, although a wide range of teaching formats have been presented, the effectiveness of each type has not been discussed.

Figure 8 CC and diversity education teaching formats



The document review also identifies a range of personnel that can be involved to deliver successful CC and diversity teaching. Teaching can be led by internal lecturers, guest lectures, patients, simulated patients and patient educators. Peer-led teaching and supervised projects such as SSCs or scholarly projects also constitute a part of CC and diversity education. Compared with cultural education in other academic disciplines, collaboration with simulated patients and patient educators is prominent in medical education. In addition to the involvement of experts by different experiences, the supplementary role of online resources was emphasised by many schools. For example, Medical School C required students to complete an online equality and diversity training module. Medical

School G mentioned using a YouTube summary video as learning resources for its equality and diversity education.

The review also shows that students develop CC not only by participating in teaching sessions on traditional educational premises but also through academic activities such as community visits during their clinical placement or global internship programmes. For example, Medical School K reported its organisation of community visits for Year 1 and Year 2 medical students, and community special study placements for Year 2 and Year 3 students. This extensive community-based learning exposes students to a diverse community and may enable students to think holistically about healthcare. Insights generated from community visits can be further strengthened by reports and reflective writings, as well as after-visit seminars to share experiences. In addition to community learning, global internship programmes were reported as important ways to enhance students' CC. The benefits of global internships are further discussed in Chapter 5.

Furthermore, non-academic factors such as students' sociocultural activities were also reported as relevant to students' CC development. Three medical schools recognised the significance of the hidden curriculum in contributing to students' development of CC. The potential benefits of students' extracurricular activities were pointed out by two medical schools with reference to particular events, such as non-pub quiz, book clubs, or the students-organised LGBT History month and International Trans Day of Remembrance. Moreover, the effect of role-modelling was mentioned by one medical school but not discussed in detail due to limited space for reporting.

4.2.2.2 Assessment

The review identifies a variety of assessment methods that are currently adopted by medical schools to assess CC and diversity learning, including reflective writing, project reports, presentations, multiple-choice questions (MCQs) and scenarios in Objective Structured Clinical Examination (OSCE) stations. One medical school mentioned using ISCE (Integrated Structured Clinical Examination) stations for students' formative assessment. Among the assessment methods, reflective writing, such as portfolios, written reflections, or self-reflective pieces, was reported as the most commonly used method. The instructions of writing assignments were mainly related to reflecting on the issues around cultural awareness/stereotypes based on personal clinical experience. Most often, students were either given opportunities to record their reflective accounts or produce an essay based on a list of available cultural topics. However, the concern is that as some of the reflective written accounts are formative assignments that are not taken into summative assessment, whether there is an incentive for students to explore cultural issues remains unaddressed.

In addition to reflective writing, OSCE stations are gaining popularity as an assessment tool for CC and diversity education. Seven medical schools highlighted the need to develop or increase the number of culture and diversity-related OSCE stations. Eight medical schools showcased their existing OSCE stations with embedded cultural elements. Example station scenarios included requiring students to be culturally sensitive such as when discussing the death of a patient with their relatives and addressing their religious beliefs. For example, Medical School D mentioned that it currently assesses students' CC by using formative reflective writing assignments together with OSCE/ISCEs assessment. It also pointed out that "in the future students will have the opportunity to undertake work-based assessments, which will include meeting, managing and communicating with patients from a diverse range of backgrounds". Despite the feasibility of using OSCE as an assessment tool, the difficulty to incorporate cultural issues into OSCE stations was also mentioned, among which the issue of unconscious bias in delivering OSCE stations is reported as a major concern by Medical School H.

4.3 Challenges and opportunities

Medical schools reported ongoing challenges to integrating CC and diversity into their core curricula. These challenges can be summarised as, first, a lack of infrastructure development and faculty development. This is manifested by the fact that certain schools expressed the difficulty to have a designated academic lead, or a continuous academic post, to coordinate and integrate culture and diversity into different teaching blocks. For instance, Medical School V mentioned that even though they have achieved significant improvements in curriculum development, many are reliant on individuals instead of the whole faculty, resulting in a problem in continuity and sustainability. Medical School S pointed out that many of the issues identified earlier remain unchanged, including the lack of faculty buy-in and those with the responsibility for teaching feeling isolated and not sufficiently trained to deliver teaching. It summarised that "faculty development is probably the most effective way of developing and quality assuring" CC and diversity education in the curriculum.

Second, the review pointed out that pedagogical challenges run across curriculum timetabling, scenario building and assessment. The need to compete for a timetabled space was reported by three medical schools, making it difficult to integrate CC and diversity in all aspects of the curriculum. Also, building culture and diversity into clinical scenarios is a demanding task as some students reported that scenarios can potentially reinforce stereotyping. According to Medical School C, after its attempt to more overtly incorporate diversity (around race and religion) into roles, students expressed that "the roles are so stereotyped as to be counterproductive". As such, the medical school has moved away from "overt signposting of diversity as a learning objective" but attempting

to build individual cultural differences (e.g. age, sexuality, and mental health issues) into roles. When it moves to assessment, medical schools reported the challenge to build cultural differences into OSCE stations. This challenge is coupled with the potential presence of unconscious bias in OSCE assessment.

Furthermore, the review demonstrates that the geographical environments of medical schools have an influence on students' development of CC. Certain medical schools located in relatively geographically homogenous areas reported that a lack of culturally diverse patient population is a challenge for them to enhance CC and diversity education. For instance, Medical School E voiced that ethnicity, an important dimension of culture, is challenging to cover well in their region, where the ethnic composition of the patient population is considerably more homogeneous than the student body. Proposed solutions included increasing the diversity of simulated patients; however, the recruitment of more diverse simulated patients posed another challenge. Furthermore, students' individual experiences in clinical placements vary, making it difficult for educators to comprehensively grasp students' learning experience. Medical School C supported this claim by expressing the concern that the clinical setting is a fluid learning environment so there is no guarantee that all students are exposed to culturally competent clinical practices.

Opportunities were also reported along with an enhanced faculty recognition of CC and diversity as a medical subject. The majority of medical schools acknowledged that CC and diversity education in their institution has gradually moved from an "add-on" component to an essential subject following a more integrative manner. The gradually shifted understanding of CC and diversity education as an integral element of contemporary medical education provided opportunities to further integrate this subject across the medical curriculum. As for students' feedback, three medical schools reported that students expressed that certain sessions (e.g. teaching on disability, homelessness and LGBTQ issues) were generally positive, which in turn warranted further integration and enhanced teaching. In addition to students' positive feedback, the availability of online resources can be utilised to supplement CC and diversity education. For instance, Medical School M, which only has one standalone session on teaching culture and diversity, reported that a broader selection of online resources was available for students to utilise, including online teaching materials, university communication emails or newsletters that are relevant to diversity integration on campus. Moreover, as some schools mentioned that since they were undergoing curriculum changes or revisions, opportunities were noticed, and reforms were made possible in the challenged timetabling. The revisions of curriculum assessment also indicate that opportunities to integrate CC and diversity relevant content into OSCE stations may be possible.

4.4 Conclusions and discussions

The document review provides a general overview of CC and diversity education in UK medical schools and reveals that teaching varies significantly among them. This conforms with previous literature summarising that when CC and diversity teaching is included, it is often piecemeal and fragmented with a lack of consistency in structure and process across medical schools (Dolhun et al., 2003, Dogra et al., 2016). Previous literature also indicates that limited information is available regarding the key teaching areas and teaching methods in CC and diversity (Dogra et al., 2016). There is no consensus on what elements should be taught, and less is known about what is currently being taught. This document review adds clarity to the existing literature by providing details on what and how CC is currently been taught in UK medical schools.

As for "what" is been taught, reported teaching domains included cultural attitudes, awareness, knowledge and skills. The importance of teaching cultural attitudes and awareness was raised but few examples were given on how to conduct such teaching. The teaching of cultural knowledge included the understanding of culture, the relationship between culture and health, and knowledge pertaining to specific cultural groups. Highlighted cultural skills were predominately about clinical communication, which included the teaching of verbal and non-verbal communication, written communication, and skills to work with interpreters. Except for clinical communication, other cultural skills such as the skills to learn, interact, and self-reflect were rarely addressed. In terms of the levels of CC development, the results show that teaching mainly focused on competence development at the individual level. Some schools mentioned interprofessional education, which may contribute to CC development at the team level. Few medical schools mentioned developing competences at the organisational or systemic level. In terms of "how" CC is been taught, a variety of teaching formats were mentioned, including lectures, interactive workshops, peer-led teaching, online resources, community-based learning, reflective personal learning documents, self-directed learning and SSCs. Community-based learning and clinical placements were also reported by medical schools as learning in these premises may enable students to think holistically about healthcare. In addition, non-academic factors such as the geographical environment of individual medical schools and the personal experience of medical students, as well as extracurricular activities, were identified to have potential influences upon students' CC development.

The overview indicates that a comprehensive understanding of what constitutes CC and diversity education is needed to provide conceptual clarity to medical schools. The results point out the need to understand the differences as well as the intrinsic connections between educational activities (e.g. teaching content, delivery and assessment) and institutional development (e.g. infrastructure

development, faculty development and institutional schemes). As Figure 6 shows, to develop CC and diversity education, medical schools need to address both their institutional development and their corresponding educational activities. The two aspects are intertwined and yet distinctive entities. Whilst strong institutional development is conducive to building a supportive environment to develop educational interventions, educational development on CC and diversity can enhance institutional recognition and development. This lack of understanding is reflected by several medical schools only reporting on either their educational activities or institutional development. It also indicates the need to develop a comprehensive model such as Figure 6 to define CC and diversity education in order to provide pedagogical insights.

In addition, it seems evident that a stronger link between CC and diversity education and other values-based subjects is desired. Subjects, such as interprofessional education, medical ethics and law, professionalism, and healthcare access issues, were reported to cover elements on CC and diversity because they have overlapping teaching content around appropriate cultural attitudes, knowledge, and skills. However, in what ways and the extent of how these subjects can contribute to CC and diversity education remains unclear. The potential dilemma between subject-specific teaching and the associated subjects was further explored and discussed in this research (see Chapter 5).

On the basis of the above conclusions, it is seen that some medical schools are more advanced than the others in delivering CC and diversity education, which is manifested in the varied amount and depth of teaching these schools deliver. This, to some extent, is related to the level of institutional recognition of CC and diversity education and the infrastructure development, and whether there is a designated subject lead to oversee curriculum development. However, starting from a social constructivist perspective, it is also necessary to acknowledge the limitation that the posters are not standardised but only a partial reflection of CC and diversity education of each medical school. Considering these posters were produced for a national-level presentation, they may have different institutional agenda with a highlight of what each medical school does well, resulting in a collection of multifarious posters with distinctive focuses and levels of details. This means that content on the posters may be selectively chosen to present the “public face” of medical schools (Hamblen, 1995, p.28). This also drove me to conduct a subsequent ethnographic case study to explore the curriculum development around CC and diversity in greater depth.

4.5 The role of document review

The results of the document review shed light on how to conduct the ethnographic case study at Stage Two as they identified the institutional-level and individual-level elements that may have

influences on students' CC development. Therefore, when conducting my ethnographic exploration, I took into account the school-level factors such as the structured curriculum design and the institutional development around CC and diversity. I also took into consideration student-level factors including students' individual interest, prior experiences and their diverse learning on different premises. More importantly, the results reassured my plan to explore students' learning that may contribute to their CC development in three settings: campus-based formal classroom teaching, clinical placements and extracurricular activities.

First, this review demonstrates that CC and diversity education can be associated with a range of medical subjects, so the way how medical schools structure these sessions and the extent of connection it has established were further explored. Students' experience in attending the associated subjects and their views were explored to obtain a comprehensive picture of students' learning. In addition, as the document review showed that institutional development is essential to support CC and diversity education, I examined how institutional development on cultural competence can influence students' understanding and development of CC. Second, as the review highlighted the relevance between CC development and students' participation in extended engagement with culturally diverse patient populations, such as training in hospital settings or local communities, I further explored students' learning in the clinical setting. This included not only conducting participant observation in a London hospital but also using interviews and focus groups to capture students' views and experiences in different clinical environments more comprehensively. Lastly, several medical schools reported that non-academic factors, such as students' extracurricular activities, can also contribute to students' development of CC. This guided me to explore what extracurricular activities may be relevant and how they can contribute to students' CC development.

To summarise, the Stage One document review informed my Stage Two ethnographic case study. The results of the document review confirmed my plan to conduct my ethnographic fieldwork in three settings (i.e. campus-based formal classroom teaching, clinical placements and extracurricular activities) and pointed out some key elements I need to focus on during my observation. The results also informed my question guide for the interviews. What cultural competences and how students develop these competences in the three settings are discussed in the following three chapters.

5 CC development in campus-based formal classroom teaching

> This is a well-collaborated workshop on the topic of homelessness. A facilitator, a nurse, and a sociologist elaborated on the health implications of homelessness from their perspectives. Helen and Pete, who were homeless before, shared their experiences on how they became homeless, and what they had suffered after becoming homeless. Students were made aware of "homelessness" as a sociocultural phenomenon, along with its impact on health and healthcare. Attending this session, I felt more sympathetic to the homeless group and emotionally overwhelmed. As a foreigner living in the UK, I sometimes feel marginalised until I hear the tragic life experiences of others around us. I felt this topic to be so unfamiliar and yet so desperately need to be addressed. I noticed that some students seemed to feel the same way. When allowed to ask questions about Helen's and Pete's living experience, many students remained quiet but extremely attentive. I think this was because lots of them did not know what questions they should ask. Very possibly, they might have not realised the extent of the suffering of others until this session, or they did not want to make Helen and Pete feel bad by asking inappropriate questions.
>
> Fieldnotes, 24 November 2017

Both the literature review and document review suggest that medical students can potentially develop their professional competence, including cultural competence (CC), in campus-based formal classroom teaching, work-based teaching in clinical placements and extracurricular activities. Chapters 5-7 present my undertaking of research in each of the three settings using a social constructivist approach and ethnographic techniques, which include my observation, interviews and focus groups. This chapter features students' learning experiences that might contribute to their development of CC in campus-based formal classroom learning. Starting with the background of the institutional development at the chosen medical school, this chapter identifies the associated subjects and diverse methods that can benefit students' development of CC from earlier years to senior years. It also summarises students' general feedback to enhance CC and diversity education.

5.1 Institutional development at the chosen medical school

The institutional development around CC and diversity at the chosen London medical school is demonstrated through its institutional readiness to incorporate CC and diversity as a subject. It is also shown by the implementation of a new curriculum in which value-based medicine is emphasised.

5.1.1 Institutional readiness: academic leadership and faculty development

The chosen medical school's institutional readiness to support CC and diversity is manifested in its multi-level infrastructure and faculty development. On the management level, the then Deputy Dean brought in an enhanced strategic approach to integrate CC as a subject with formal recognition in the curriculum. On the curriculum level, CC is incorporated into the curriculum with an academic lead appointed to oversee its design and delivery. My conversation with the academic lead showed that there is subject-specific teaching on CC (e.g. one CC lecture and one CC workshop), but other

clinical subjects also have embedded teaching on CC and diversity. On the research level, there were undergoing projects to explore issues of gender equality among medical students, and the attainment gaps of the Black, Asian and Minority Ethnic (BAME) students. The multi-level institutional development helps to promote diversity and to create a culturally inclusive environment in the medical school which, in turn, has facilitated the recognition and implementation of CC and diversity in its medical curriculum.

In addition to setting up the multi-level infrastructure to address CC and diversity, a series of efforts were observed that may enhance the faculty development of the chosen medical school. The school established a committee for Development, Diversity, and Inclusion (DDI), aiming to provide staff with a platform to identify equality and diversity challenges in order to create an inclusive, fair and equal community where all staff can thrive. The university that the medical school belongs to has been a member of Athena Swan since 2007. It was awarded a Bronze institutional award in 2008 and Silver award in 2018. Designated staff in the medical school also take active participation in joining relevant academic groups on advocating CC and diversity education in healthcare, such as the Diversity in Medicine and Healthcare (DIMAH). In addition, the medical school has a Master of Arts (MA) programme on intercultural clinical education in MA clinical education, delivered to clinical trainers, some of whom are teaching at the same medical school.

The medical school described its CC training targets for its medical students as below:

> to demonstrate curiosity, openness and the ability to suspend disbeliefs about other cultures and beliefs about one's own as a way to avoid biased judgement and discrimination of others;
>
> critique intercultural health and healthcare events, drawing on both general and specific cultural knowledge;
>
> identify opportunities for continuous learning and enhancing cultural competence in any educational and clinical settings;
>
> advocate against and effectively handle any form of discrimination against self, colleagues and patients, based on disability, gender reassignment, pregnancy and maternity, race, religion or belief, sex, sexual orientation;
>
> demonstrate and sustain leadership that promotes culturally and linguistically appropriate services and health equity through policy, practices and allocated resources in the service area;
>
> engage with education and research to advance the understanding and implementation of culturally and linguistically appropriate health services;
>
> provide effective, equitable, understandable and respectful quality care and services that are responsive to diverse cultural health disbeliefs and practices, preferred languages, health literacy, and other communication needs.

5.1.2 Curriculum revision: the new 2020 curriculum

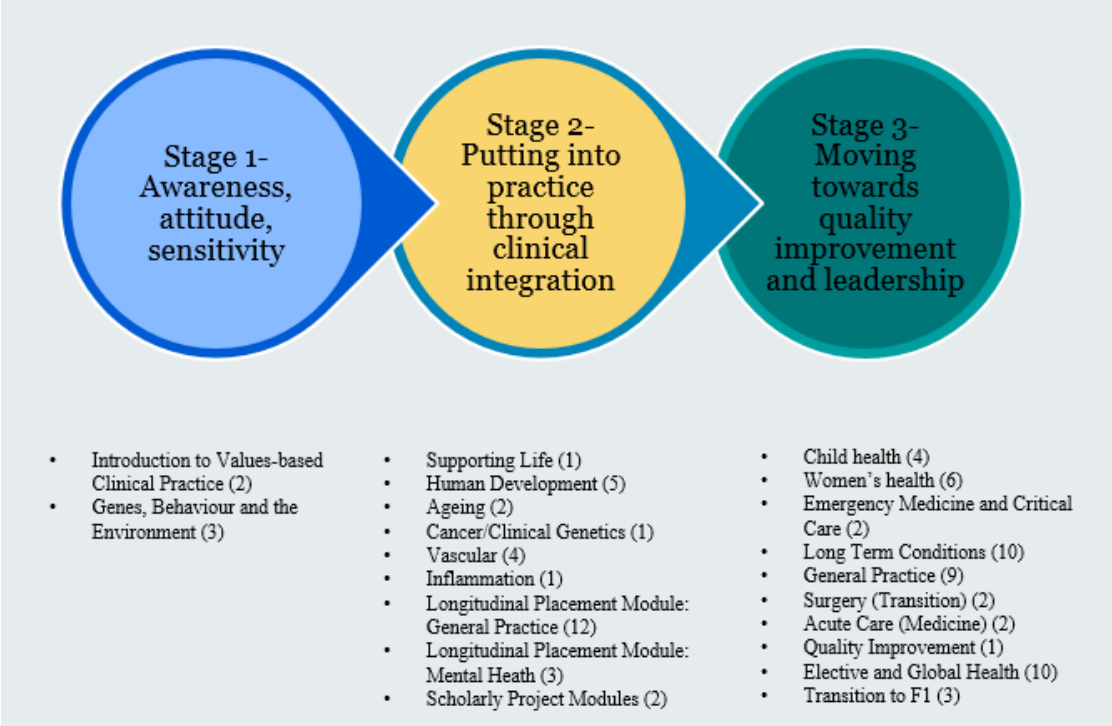
The chosen medical school was undergoing a curriculum review by the time this research was conducted. The new five-year Bachelor of Medicine, Bachelor of Surgery (MBBS) programme encompasses three stages of training. Stage 1 is a one-year (Year 1) training on *Foundations of Medicine* which aims to introduce the foundations of biomedical sciences, population science and risk management while students develop their clinical skills in safe simulated learning environments. Stage 2 is a two-year (Year 2 and Year 3) transition stage named *From Science to Clinical Practice*. It brings together science and clinical practice in blocks organised around common pathological processes and the human life cycle. Stage 3 is also a two-year (Year 4 and Year 5) training stage named *Integrated Clinical Practice*, which aims to help students integrate and consolidate their clinical capabilities and begin to contribute to the care of patients with acute and long-term conditions under supervision. All stages started implementing the new curriculum in the first year of each stage since 2016. The new curriculum will be implemented across all student bodies at the medical school by September 2020.

The new curriculum has a renewed focus on value-based medicine. It has a module named Value-Based Clinical Practice as a longitudinal theme delivered through all stages, among which Human Values (HV) is an introduction teaching block in Stage 1. Value-based medicine is the theory and practice of effective healthcare decision-making for situations in which legitimately different value perspectives are in play. It draws on philosophical value theory and is developed through careful attention to the needs of individual patients. HV is designed as a teaching block that aims to integrate the medical human values to healthcare practice within the UK context and bridge the gap between techno-centric and caring-based learning. The HV block serves as a strand to encompass subjects such as clinical communication, medical ethics and law, professionalism and well-being, cultural competence, interprofessional education, and medical humanities. Integrating these subjects under one block is aimed to strengthen the concept of value-based care and contribute to building connections among these subjects. It also provides opportunities for medical students to think conceptually, reflectively and practically through philosophical discussions and simulated patient scenarios.

Being aware that CC teaching content can be embedded in sessions outside the HV subjects, I thematically coded the learning outcomes (LOs) of all the modules across the three stages to identify LO statements that have CC relevant content (see Figure 9). The purpose is to map out where CC is potentially being taught to guide my participant observation. The results showed that, of the 19 modules across the three stages, 15 modules have CC related outcomes stated under 21 teaching

blocks. In Stage One, CC statements are noticed in the LOs of the teaching blocks "Introductions to Value-based Clinical Practice" twice (2) and "Genes, Behaviour and the Environment" for three times (3). In Stage Two, CC statements are found in teaching blocks "Supporting Life" (1), "Human Development" (5), "Ageing" (2), "Cancer/clinical Genetics" (1), "Vascular Diseases" (4), "Inflammation" (1), "Longitudinal Placement Module: General Practice" (12), "Longitudinal Place Module: Mental Health" (3), and "Scholarly Project" (2). Teaching blocks in Stage Three that include CC statements include "Child Health" (4), "Women's Health" (6), "Emergency Medicine and Critical Care" (2), "Long Term Conditions" (10), "General Practice" (9), "Surgery" (2), "Acute Care" (2), "Quality Improvement" (1), "Elective and Global Health" (10) and "Transition to Foundation Year-1 (F1)" (3). The incorporation of CC development as part of the learning outcomes in the listed teaching blocks indicates that CC and diversity education at the medical school is spirally integrated across the curriculum. In the following sections (Section 5.2-5.4), selective cases were chosen from the three stages and presented to elaborate on how students can potentially develop their CC by attending these sessions.

Figure 9 Continuous cultural competence development across the MBBS curriculum



5.2 An early start

Results show that students undergo staged learning during their development of CC. Three stages of learning are categorised: an early start, then deeper in the fields, and lastly, reaching out to

respective fields. The early start learning mainly takes place in the early years of the curriculum, among which a range of sessions are observed as relevant to students' development of CC. Subject-specific teaching on CC, including a theme-specific lecture and workshop, introduces the concept of CC to students. Other value-based medical subjects, such as professionalism, interprofessionalism and medical ethics and laws, further contribute to students' CC development by highlighting to students the significance of viewing medicine as a value-based profession. Teaching around public health, biostatics and epidemiology, continue to benefit students' development of CC by exposing them to population-specific cultural knowledge. Simulated patient scenarios, where learning takes place in a confined but simulated environment, are noticed as most effective to support students' learning.

5.2.1 CC lecture and workshop: a wake-up call

My observation shows that medical students' exposure to CC as a subject starts with an introductory lecture delivered under the HV block in Year 1. It was a recorded lecture taking place in a lecture hall attended by around 100 students, co-run by two lecturers and a Year 5 student sharing his experience on lesbian, gay, bisexual, transgender and queer (LGBTQ) issues. The primary lecturer, also the academic lead on CC, introduced to students the concept of CC and its related theoretical frameworks. With references to cases around cultural challenges in the healthcare setting, students were encouraged to explore the relationship between healthcare professionals' CC and patients' health outcomes. Online polls were utilised for students to reflect on their cultural stereotypes and unconscious bias. This was conducted by the primary lecturer using "pollev" to collect students' opinions on certain cultural groups. Questions such as, "What is your impression of men?" "What is your impression of doctors?" "What is your impression of black people?" were asked and students answered with their first-thought impressions. The online poll allowed students to learn the stereotypes people hold against certain cultural groups. The second lecturer, a GP and also the then vice-dean of the medical school, shared her experiences on how to communicate with homeless patients. She emphasised the importance of CC development for medical graduates by referring to the Equality Act 2010 (Act, 2010), the graduate outcomes of the Medical School, and the Medical Leadership Competency Framework (NHS Institute for Innovation and Improvement, 2008). The student representative shared his opinions on understanding the importance of developing CC to address the health disparity faced by the LGBTQ population. He also shared his understanding of the complexity and nuances in understanding CC as a life-long learning process.

Two months later after the introductory lecture, Year 1 students were allocated into small groups to attend a workshop named *Cultural Competence and Social Diversity*. The purpose of the workshop

was to encourage students to reflect upon their unconscious bias and revisit the theories around CC. The workshop contained two discussion activities based on one questionnaire and one video. First, students were divided into small groups of four or five to discuss a questionnaire. The questionnaire contained a list of potentially sensitive questions such as, “Do you have any disability?” “How do you describe your sexual orientation?” “What social class do you perceive yourself belonging to?”. Within small groups, students were facilitated to share how they would feel if they were asked these questions. This activity aimed to encourage students to think from patients’ perspectives and experience the discomfort of the potentially sensitive questions in the clinical environment. Whilst the majority of participants acknowledged the efficacy of this activity, a small number of students gave their feedback after the session by commenting that the questions were too “common”, which made them miss the purpose of the activity. The feedback revealed that the effectiveness of the questionnaire activity may differ among students due to their varied understanding of cultural sensitivity and different levels of openness towards sensitivity. Moreover, students’ learning is also a co-constructive process between themselves and their facilitators, who may bring distinctive teaching styles and allow different environments for discussion and reflection.

The second activity showed a video about a general meeting within a healthcare team in General Practice. The meeting was to discuss the possible reasons for the low intake of ethnic minority women attending smear tests. Students were facilitated to discuss the levels of CC among members of the healthcare team. This activity encouraged students to explore how CC is related to the daily practice as a healthcare professional. Students perceived the video-based discussion as a valuable learning strategy. Most students expressed in the feedback forms that the video allowed them to link CC theory with daily healthcare practice and the following discussion enhanced their understanding of the longitudinal development of CC.

Results show that the use of technologies and the inclusion of peers can enhance students’ learning. In the focus groups, participants mentioned that the relatively interactive lecture using online polls and video resources, coupled with the collaboration of two lecturers and a student representative, enhanced their motivations to learn compared to a traditionally didactic lecture. Inviting senior medical students as student representatives or student facilitators can shorten the distance between students and clinical teachers. Students acknowledged the generational gaps in perceiving cultural issues between students and many academics. Therefore, hearing the voices of their peers can potentially help them to understand the cultural topics of primary concerns among the student cohort. Particularly, one focus group participant expressed that the most beneficial part of the CC lecture for her was hearing the student representative’s perspectives on LGBTQ issues. This view was shared by three interview participants, all of whom agreed that having their peers sharing thoughts

on deep and sensitive topics such as CC is less magisterial than hearing from authoritative academic staff. This could establish rapport with students and pave the way for subsequent in-depth discussion.

My observation also shows that the sequential design of a lecture and a workshop benefits students' learning. The theoretical concept of CC is best explained in a lecture environment, along with the theoretical attributes that are required to achieve CC. The subsequent workshop provides a safe environment for students to revisit this concept and initiate in-depth discussions. Whereas the lecture served as a wake-up call to introduce the theoretical concept, the workshop encouraged students to reflect on their deeply rooted unconscious bias and enhance their cultural sensitivity and awareness. The sequence of delivery on subject-specific teaching was appreciated by students. According to focus group participant Abbie:

> They gave us […] a stepwise guide which I guess was good. I'm pretty sure we had a lecture on this where we explored the topic of cultural competence and […] introduced us to the topic and then at the workshop. So, I thought [the]sequence of events is very well laid out.

5.2.2 One healthcare system, many professional cultures: learning through interprofessional education

In addition to theme-specific teaching, results show that students develop their CC by attending value-based medical subjects, such as professionalism, interprofessionalism and medical ethics and laws. This section uses interprofessional education (IPE) as an example to elaborate on how students can develop their team-level CC by attending four IPE sessions: a lecture and three subsequent workshops.

In the lecture on "Introduction to Interprofessional Education and Collaborative Working", around 200 students undertaking health-related degrees, such as medicine, physiotherapy, dietetics and cardiology, attended. The lecturer elucidated the significance of effective collaborative working in improving patient care, in relation to the increasing rapidly demographic change in the contemporary global society. She also discussed the necessity to enhance interprofessional working because health and social care teams may have divergent cultural norms and expectations. Three subsequent IPE workshops were conducted two months later. The workshops aimed to offer students opportunities to practise teamwork with health students from other disciplines and to produce a group presentation to further understand interprofessional working. Students with mixed health backgrounds were divided into small groups to work on a presentation-based project. One workshop was facilitated for students to discuss issues around interprofessional working and decide on a topic for group-based presentation. Two workshops featured on students' self-directed learning supported by a trained facilitator.

My observation shows that through interaction within small groups, students have developed an enhanced understanding of the diversity within the student body, which can benefit their individual development of CC. For example, in the group discussion I observed, there were three students in their 20s and two mature students in their 40s. By working with their team members toward the completion of a project, the students learnt that individuals have different life commitments so efficient teamwork needs to accommodate these differences. Results also show that interprofessional working is inextricably linked with developing team-level CC. This is evidenced by students expressing in the group discussion that, to ensure good interprofessional working, healthcare practitioners need to be culturally competent to work within one team. During the presentation, one group of students adopted the cultural competence theoretical framework to inform their presentation on understanding interprofessional education, explaining from the aspects of cultural attitudes, cultural awareness, cultural knowledge, and cultural skills.

Moreover, peer experience-sharing in class can have an impact on students' internalisation of relevant medical values, consequently benefiting their team-level CC development. In one of the workshops, students were shown a video named "Julie's Story", which was about Julie's unsatisfactory patient experiences in the hospital due to poor interprofessional work. Whilst the video was aimed at generating discussions, a rare critical incident that happened in one of the workshops provided students with a chance to reflect on the importance of team-level CC. The facilitator of the session mentioned that after watching the video on "Julie's Story", one student had an emotional outburst by relating Julie's experience to her previous unsatisfactory experience as a patient. Though it is a rare case in class, peer experience-sharing caught the attention of students by witnessing a shared lived experience of how important interprofessional working and team-level CC are in the healthcare setting.

> Fieldnote: My observation of the IPE workshop following a group of students was expected but another group of students next door had an unforeseen incident. After the session, one facilitator shared with me that one student had an emotional breakdown by relating Julie's experience to her own. She shared with the class her unpleasant inpatient experience with dissatisfaction and even sadness. She was feeling so low that the facilitator spent some time comforting her after the session. Hearing the words from the facilitator, I feel that the group of students is very unlikely to forget this incident in the near future. I also believe many students have reflected on the topic by hearing the story from their peers.

5.2.3 Clinical communication: meeting the "patients"

Results show that integrated patient scenarios are the most effective teaching formats for students to develop their CC in the early years of their medical education. Scenario-based learning, a technique used to replace and amplify real experiences in the clinical setting, is utilised to develop health professionals' knowledge, skills, and attitudes with the protection of patients from

unnecessary risks (Lateef, 2010). My observation shows that case-based patient scenarios can support students to develop their value-based competence, including CC. This is also shown by the learning outcomes of the patient scenarios, where the development of CC is listed along with the development of professionalism, ethics, clinical communication, and clinical skills. In patient scenarios, students were facilitated to explore how simulated patients' personal values and beliefs can affect their health and healthcare-seeking. The interaction with simulated patients allowed students to explore the diverse situations of patients they might encounter in a clinical setting. Throughout the observation, I identified a number of patient scenarios that can potentially benefit students' development of CC, covering cultural elements such as autopsy and Jewish culture, arranged marriage and religious backgrounds, stroke and ageing, STI (sexually transmitted infections) and sex workers, and how to communicate with patients of limited English language ability.

By participating in simulated patient scenarios, it is noticed that students start to demonstrate an enhanced level of cultural awareness, attitudes, knowledge and skills. For instance, in the scenario of addressing the health needs of a simulated obese patient, the facilitator emphasised the cultural knowledge that an individual's diet can be culturally and socioeconomically defined. To communicate with a patient regarding a dietary change in a culturally appropriate manner, students were advised to take into account both patients' cultural backgrounds (e.g. their ethnic and religious backgrounds) and socioeconomic backgrounds (e.g. their occupations and affordable lifestyles). In my observation of the small group discussion, I observed that students began to demonstrate culturally competent acts through discussion and reflection. When discussing how to effectively communicate with the simulated patient, students in my observed group made culturally competent remarks. For example, in the process of exploring the family background of a simulated male patient, one student took into consideration the patient's sexuality and said, "Don't directly ask for the wife. We should use the word partner instead". Later in the simulated consultation, the student volunteer Nate, despite being respectful and polite, never phrased weight control as an achievable target. While other students commented on this, Nate replied by saying "Because I am very underweight, which people can obviously tell, so I don't want the patient to feel bad after hearing I comment on the easiness of losing weight". Nate's remarks encouraged students to share similar examples of showing care in their own way. According to one student who gave a take-home message after attending the session:

> I think having patient scenarios would really help because once again you're experiencing it, you're actively listening or asking questions. I guess that really helps because […] it can bring up a lot of topics you can discuss afterward or even with the patient there, and discuss with them their culture, their belief, and their views and thoughts. Therefore, I guess, having patient scenarios in that way […] would help a lot.

Almost all the interview and focus groups participants acknowledged that integrated patient scenarios could contribute to the development of their value-based competences, including CC.

Some students expressed that having those scenarios have prepared them to deal with similar cultural challenges in clinical placements. Through conducting a simulated clinical consultation within a safe environment, students are supported to demonstrate empathy to culturally different patients and develop non-judgmental attitudes through communication and understanding. Interview participant Maya shared how one patient scenario prepared her for interacting with similar patients in the clinical setting and demonstrating non-judgement through understanding:

> I once met a patient. She was a sex worker who was an immigrant. But when I first started talking to her, I didn't know about her occupation nor where she came from. The more I got to talk to her […] like when she first said she was a sex worker. […] She had an STI as well, I said like "Why are you a sex worker?" I couldn't really understand why she would choose to do this occupation here. But understanding her situation, like how […] desperate she was for a job, and how she wanted to meet more people from where she was, how she wanted that sense of community with the other sex workers as well. It got me to understand why she's living that way despite having those risk factors for illnesses, she still chooses that because she wants to be part of that culture, like yes, that community. That's interesting because that really reminds me of one of the scenarios we had, exactly the same scenario. Some of the patient's words are so familiar as these are what we have discussed in that scenario.

Furthermore, comparing my observation of students' participation in patient scenarios in Year 1 with the scenarios in Year 2, I noticed that the students' confidence levels have increased as they have obtained more experience in scenario-based learning. This is consistent with the findings of the focus groups. When asked to comment on the design of the patient scenarios across the curriculum, students mentioned that having relatively uncomplicated scenarios in the early years and gradually moving to more complicated scenarios at senior years fits their learning curve. According to focus group participant Walter, the design of the scenarios follows a reasonable sequence of complexity and can gradually build up his value-based competences, including CC:

> I think in the first year it's good when you get patients that are a bit more, like stereotypical and a bit simpler. [In the] second year, we still have them but you start getting bored, but then in the RCGP [Royal College of General Practitioners] days you get and with our GP specifically, they gave us really interesting complicated ones like, someone who does business, doesn't have time for themselves, taking drugs and they won't get off it so like, really complicated cases that you probably won't see as much as like a chatty patient like Patsy [the name of one simulated patient in Year 1]. But then, it's really complicated as well. So, I think, I think they did really well with that first year in making it as simple as the second year bringing that up.

5.3 Deeper in the fields

Moving from the early contact of CC in the pre-clinical year, students develop their CC by attending clinical sessions with culturally embedded content. The campus events under the General Practice longitudinal placement, population science and students' self-selected projects are used as cases to demonstrate how students can enhance their CC through formal classroom learning.

5.3.1 Campus events: we know less than we think

Results show that some campus-based teaching on clinical skills has embedded content on CC and diversity, such as the campus events under the module Longitudinal Placement-General Practice. The campus events I observed were two-day intensive training sessions for students to raise awareness and acquire knowledge on specific cultural topics. The events were comprised of four workshops guided by an introductory lecture on "the doctor as advocate-working with vulnerable patients". All the sessions are conducive to students' development of CC as the purpose of teaching is: a) to raise students' awareness in understanding the importance of providing healthcare access to vulnerable groups, b) to encourage students to understand the connection between health outcomes and various social determinants, and c) to provide students with information regarding how to interact and help vulnerable groups. To maximise the opportunities for students to attend, the introductory lecture was delivered four times across two weeks and the workshops were delivered simultaneously four times.

Results show that the campus events can benefit students' development of CC by exposing them to a diverse range of cultural topics. It was observed that a combination of didactic lectures and facilitated workshops within one training day can support students to achieve the best learning outcomes. As for the relatively didactic introductory lecture, online polls and useful video resources were utilised to make the lecture more interactive, as discussed in Section 5.2.1. The lecturer emphasised the need to understand culture from multifaceted dimensions and explained the connection between health outcomes and individuals' various social determinants. Students were guided to explore the health outcomes of vulnerable groups not only from a biomedical perspective but also from a sociocultural perspective. The following four theme-based workshops featured specific cultural topics, with some being case-based and some being discussion-led. The four themed workshops were "homeless and inclusion health", "LGBTQ issues", "identifying and responding to domestic violence and abuse", and "access to healthcare for patients with learning disabilities". A collection of resources was provided and discussed targeting specific cultural topics. For instance, in the LGBTQ session, studies such as the Stonewall Report were thoroughly discussed for students to understand the status quo of LGBTQ issues and the group's challenges in seeking healthcare.

Results also show that students can be supported to develop their CC by drawing on the experience from experts of diverse backgrounds, or experts by experience. In teaching cultural issues, whilst lead academics/clinicians are generally perceived by students as experienced in explaining overarching frameworks and cascading clinical knowledge, having patients/guest speakers with lived experience on certain cultural topics can bring learning to life. For example, the homeless session

was a well-collaborated example with teaching and experience sharing from five experts: a facilitator, a nurse, a sociologist and two individuals who were homeless. After the facilitator raised the issue that being homeless may be potentially linked with a range of healthcare concerns, such as mental health and drug abuse, the nurse explained to students the current situation of how homeless people with health problems can be identified, verified and reached for assistance in the UK. This was followed by a sociologist further elucidating this phenomenon by using statistics, such as the population of the homeless group in London, how fast this figure is increasing, and how this can lead to unsatisfactory health outcomes. The two individuals who had homeless experience shared their personal stories with the students. This collaborative session showed that from hearing guest speakers' life experiences, together with the professionals' explanation of homelessness, both as a sociocultural and health phenomenon, students enhanced their awareness and knowledge of how to work with homeless patients in a culturally appropriate manner. One student even wrote her feedback via email to the module lead after attending the homeless session:

> I would like to say how fantastic, moving and completely worthwhile the homelessness workshop put on this afternoon was. I hope to take this feedback as a testament to how brilliant the homelessness workshop was today. It is amazing for us to hear different voices from different people. They did an excellent job, one that I feel all students should get a chance to experience.

Furthermore, inviting facilitators beyond the field of medicine and clinical fields can bring varied teaching styles. In the learning disability workshop, I noticed that students took very active participation in the class activities partly because the facilitator presented a humorous, engaging, and eloquent style. After the session, I learnt from the facilitator that she has been in the media industry for ten years and has a marketing and sales background. She told me that sales share similar strategies with teaching whose goal is to "sell" the content to students in an engaging way within a limited time frame. Her teaching style was distinctive from most academics but nonetheless effective as student engagement was high. This shows that one's professional background and previous experience have a huge impact in forming one's teaching style and may subsequently influence students' learning. It also validated the need for inviting culturally competent guest lectures/facilitators to diversify students' learning.

5.3.2 Culture in population science: "we need baseline knowledge"

Results show that students can enhance their CC by acquiring cultural knowledge by attending sessions around biomedical science (e.g. epidemiology and biostatistics). Taking the workshop on Population and Disease as an example, the facilitator explained the general health patterns of diverse demographic groups by using a London borough as an example. Cultural diversity was an emerged discussion point. Contributing factors were discussed such as domestic and international migration,

the local culture, and the availability of working opportunities. The term Indices of Multiple Deprivation, a measure of relative deprivation for small areas, was introduced for students to explore the relationship between health outcomes and individuals' socioeconomic status. The connection between a region's socio-cultural demographic features and its health implications were elaborated by using cultural examples, such as an area with relatively younger residents can potentially indicate more severe health issues in alcohol use and sexually transmitted infections (STI).

My observation shows that this session teaches extensively on cultural knowledge, with an emphasis on exploring the connections between individuals' health and their sociocultural backgrounds. The London borough was used as a case study to encourage students to explore the various dimensions of culture and the relationship between culture and health. Some categorical cultural facts were provided. For example, the facilitator mentioned the biostatistical knowledge that people of black Caribbean backgrounds have a higher risk of strokes and Asians are more at risk of developing diabetes. Discussions around how these epidemiological patterns exist were addressed from the aspects of diet, health beliefs and other relevant cultural elements. More importantly, the facilitator emphasised that group-based cultural knowledge only applies at a populational level and does not immediately translate to individuals.

Although CC is not the focus of this session, it is seen that students have initiated discussions on acquiring cultural knowledge and rejecting cultural stereotypes during small group discussions. On the one hand, students acknowledged the importance of acquiring cultural knowledge. The group I observed unanimously agreed that acquiring cultural knowledge, such as understanding health patterns at a population level, is the first step to learning about cultural diversity and developing individual CC. A more advanced developmental stage requires the appropriate application of knowledge in a sensitive and non-judgemental manner. As one student in the session happened to be my focus group participant, I noticed that he was adopting the language and theories in the focus group to support his arguments. This reveals the nature of CC development as a co-constructive process and highlights the effectiveness of having themed discussions on CC and diversity. According to Adam:

> Looking at this [demographic] figure and its implications on health, as medical students, we need to develop cultural competence. Having knowledge such as Asians might be more likely to develop diabetes, young people have higher risks of STI, which is only one component. To be culturally competent, one needs to develop their cultural awareness, knowledge, and skills as a whole. Only by doing this can we become truly culturally competent.

On the other hand, students mentioned that when acquiring cultural knowledge, one needs to be wary that categorical information may also lead to cultural stereotypes. For example, in the group discussion, I observed that one Singaporean student tended to use the health behaviours of

Singaporeans to represent the population of Asians in general. However, another student in the same group who has an East Asian cultural background argued that some of the representation was untrue. This example demonstrates how students may enhance their CC by interacting with their culturally diverse peers. However, I argue discussions as such do not indicate that acquiring cultural knowledge holds no value. Instead, it reveals the fact that teaching and discussing cultural knowledge in a critical manner can motivate students to generate discussions on diversity and gain a more nuanced understanding of CC development. It also indicates that students can enhance their development of CC while immersed in a diverse student body.

5.3.3 Going deeper if you like: project-based learning

Results show that students can develop their CC through the involvement and management of projects, but this largely depends on students' individual choices of projects. As an innovative approach, project-based learning is central to curriculum development in contemporary education (Thomas, 2000). This approach encourages students to drive their own learning through enquiry and work collaboratively to conduct research that involves project designing, problem-solving, decision making and investigative activities (Jones et al., 1997, Thomas, 2000). My observation shows that students in the medical school were involved in project-based learning on various occasions after entering the clinical years. These included students' self-selected components (SSCs), scholarly projects and clinical humanities projects. Students had the autonomy to choose or initiate projects based on their interests, as a wide range of projects across subject areas was available to students, some of which might contribute to their development of CC.

Taking the clinical humanities projects in Year 2 as an example, the core of these projects is to train competent, respectful, resourceful and resilient doctors who are capable of critical thinking, managing uncertainty, responding to pain and suffering, acting with CC, and promoting health and advocating for change. Participation in these projects encourages students to think outside the box for health and healthcare by guiding them to understand medicine by using humanistic methods, such as photography, poetry, visual arts and stitching. Students attended workshops based on their areas of interest before working on their own projects. In one of the clinical humanities projects on clinical communication with visual methods, the facilitator, who is a graphic designer, discussed the merits of using visual skills to communicate public health information. When showing students basic drawing skills, the facilitator emphasised that visual communication is not about learning artistic skills but is about using simple images to facilitate clinical communication. She informed the students that using visual aids such as pictures can facilitate doctor-patient communication, especially with patients whose first language is not English, or those with learning disabilities, low literacy levels, or

other potential communicational problems. Moreover, besides gaining effective skills to communicate with culturally diverse patients, it was also observed that students can enhance their cultural sensitivity by involving themselves in project-based training. When showing students how to use visual images for representation, the facilitator mentioned that it is necessary to use simple generic features so that these images can culturally relate to the general public. She further explained that sensitivity needs to be taken into account in communication by using visual channels. For instance, she gave an example of drawing home images for patients by saying that when drawing a house, a luxurious detached five-bedroom house with a spacious garden might not relate to patients who do not live in such environments.

By scanning through the titles of students' proposed projects through a summary shared by the facilitator, I noticed that some of these projects may potentially contribute to students' development of CC as they cover cultural elements. Examples included students' proposed projects on how to enhance clinical communication with culturally diverse patients, such as "using arts to enhance communication with recreational drug users", "using music to communicate with homeless people", "how to enhance communication with the ageing group", and "using portraits to communicate with patients with bad diagnoses". Nevertheless, the nature of project-based learning means that students have varied learning experiences due to the nature of their chosen projects, and how their learning may benefit their CC development remains dissimilar.

It is also noticed that there is weak signposting on utilising project-based learning to develop value-based competences such as CC despite their potential relevance. The lack of signposting can potentially lead to students failing to identify the various opportunities that may be relevant to the development of value-based competences. As interview participant Abbie said:

> I have never realised that the different projects, such as the SSCs and clinical humanities projects, can also help with my cultural competence development. I never attempted to explore the link until been asked this question. But I would vote yes. Yes, for example, my clinical humanities projects, I and my teammates co-conducted a project on how to enhance clinical communication with people of different religious backgrounds. We gathered information on how religious differences can influence patients' health-seeking behaviours and choices, and how their diet can affect their health outcomes. Thinking back, this actually helped us get more cultural knowledge and improved our cultural competence. But I never realised this until you asked.

5.4 Reaching out to other areas

My observation shows that the curriculum at senior years presents a reduced amount of mandatory teaching, but more clinical exposure and opportunities to reach out to other fields. It means students start to have more diverse and dispersed learning experiences based on individual choices, some of

which may contribute to their development of CC. Examples include students having intercalated degrees or global placement programmes.

5.4.1 Intercalated degrees

Results show that having intercalated degrees can potentially contribute to students' CC development, as cross-disciplinary learning in a diverse range of subjects exposes students to cultural training in other academic contexts. Intercalated degrees, offered by medical schools in the United Kingdom, provide an option for medical students to have time out and study a specific area of interest. Students expressed in the interviews that their intercalated degrees have enhanced their understanding of cultural diversity and expanded their relevant cultural knowledge and skills. The intercalated subjects may also bring students distinctive learning experiences depending on the subject culture. Students who had intercalated degrees in health-related subjects voiced that the cross-disciplinary learning within the field of healthcare has enhanced their CC through enhancing their cultural awareness and gaining more cultural knowledge. This is evidenced by interview participants sharing their intercalating experience in dietetics, nutrition, physiotherapy, and public health. For example, according to Penny who did an intercalated Bachelor of Science (BSc) in nutrition:

> I did a year of intercalated BSc in nutrition, and then there was where it was talked about how different cultures have […] different cuisines, and some are more naturally nutritious than others, and you have to then speak to the patient quite respectfully about [it]. You know, I know this is what traditionally your culture eats but maybe nutritionally it's not the best for your diabetes or whatever. I did find it very helpful, and it was relevant to, you know, being a medical student and eventually being a doctor, but I only got that because I decided to do a nutrition degree.

Students also expressed that having intercalated experience in non-health related subjects, particularly in social science studies, also benefits students' CC development. Immersing in a subject culture that values critical awareness and thinking allows students to reflect on cultural issues in depth. The benefit of training on critical thinking and awareness on individual CC development was mentioned by students when they intercalate in social science degrees, including cultural studies, language studies, media, and history studies. For example, interview participant Rachel mentioned that having an intercalated year in history has enhanced her critical thinking and critical awareness, which are key qualities to becoming culturally competent. She supplemented that training in these areas, however, is somewhat lacking in traditional medical education. Another interview participant Jun, who did an intercalated degree in language studies, mentioned how learning a foreign language has helped him to understand a culture in great depth through the systematic learning of its language along with its shared values, beliefs and ways of behaviour:

> I suggest that everyone should try to learn a different language. It's really not about speaking a foreign language with people from that culture. Instead, it is about understanding how the language came into being, what are the associated social and cultural elements. Also, in language studies, we are certainly been taught about the cultures of certain regions, which asked us to reflect on the cultural differences, […] and even our personal cultural bias. I guess through this I have developed my cultural competence in a way that I haven't expected.

5.4.2 Global health placements

Global health placements, as a way of international education, were reported by students as a useful strategy to develop their CC as having clinical placements in a foreign context can widen students' focus to a culturally different healthcare setting. The chosen medical school has a Year 5 module named Global Health Elective during which students have global placements arranged for them in areas such as Africa, Asia and Oceania. Through the extended immersion, students mentioned that they have become more "modest" when facing diversity and started to understand that being sensitive to another culture requires being open to its dynamics, acknowledging the social and political structures, and incorporating other people's beliefs about health and illness. The results conform with existing studies (Watt et al., 2002, Torsvik and Hedlund, 2008, Sandin et al., 2004, Ruddock and Turner, 2007, Koskinen, 2003, Kokko, 2008, Keogh and Russel-Roberts, 2009) on exploring health students' experience during global exchange or placements, which concluded that transition and adaptation to another culture are effective for students to develop an enhanced cultural understanding of self and personal culture, as well as an improved level of cultural sensitivity with the targeted population. According to interview participant Wei, who finished his global placement in New Zealand:

> I think in New Zealand they're doing quite good in terms of cultural awareness, especially to the Maori population. But well just based on my brief observation of four weeks there, I see they actually put quite a lot of effort […], like learning the Maori people, the local garments. […] The medical professionals, the nurses and the doctors, I think just from my brief observation, they seem quite well prepared in the way to talk with them, the Maori people. And also some of the leaflets, and because their cultural background is very different from the European one […] the Caucasian European […]. In the medical setting […] like when the patient is ill and the way how they should convey the information to a Caucasian family, or a Maori, or a Chinese family is different. […] I think they, they're quite considerate. There is quite a lot of information available and guidance about interaction. I think they pay quite a lot of attention.

Results also show that students demonstrate a strong desire to develop CC before embarking on a global placement; nevertheless, there are limited teaching resources for them to utilise at the final stage of their medical education. This is because subject-specific teaching on CC normally takes place in the early years, but later teaching is more covertly embedded in senior years. Under these circumstances, students reported that they would normally self-search on the Internet or seek help from friends who are familiar with the destination culture, in order to develop a basic level of

understanding of the cultural background. This points out the need for the provision of sufficient educational support when students are most strongly motivated to develop their CC. As Wei said:

> Before the elective [the global placements], which is quite interesting, the students are very excited to come to electives [the global placement electives]. And they can't remember what happened in their first year, the second year, what they have learnt [in the cultural competence lecture]. And then in the elective, for me luckily, I went to Singapore and New Zealand. New Zealand is just like western society. Singapore is very western as well. But some of our students went to Africa or South America that would be totally different. It's like if they have this continuous learning and training of their cultural awareness, they can put it like into a real setting to test and to further practise which is quite beneficial to reflect as well. So, I think that's, the [Global Health] elective will be quite a useful window to reinforce and to, to introduce or to refresh [the topic of cultural competence] to students again.

5.5 What do the students say?

This section summarises students' feedback as voiced in the interviews and focus groups on how to improve cultural competence and diversity education.

5.5.1 "Fewer theories but more case studies"

Students suggest that the proportion of theories and frameworks can be reduced in subject-specific teaching on CC but more cultural cases or examples can be incorporated. Several students mentioned in the interviews that the teaching of cultural theories weakens students' interests to learn as students are more motivated to explore how medical practitioners can translate cultural training to practice. Furthermore, whereas students value case-based teaching, they also voiced that the occasional use of outdated cases can potentially lead to stereotypical cultural understanding. It is further noticed that the teaching of stereotypical or outdated cultural information may make some students with certain cultural identities uncomfortable, jeopardising the goal of providing a safe environment to initiate constructive discussion. This has been mentioned by four interview participants. For example, a homosexual participant Ross said:

> I remember […] feeling very angry in the first year, rolling my eyes a lot. Um, yeah, I think my sexual health lecture this year, [the] induction session was a bit […]. It was kind of like, here are diseases that gay people get. Very stereotypical. There was no mention of […] like ChemSex, LGBT mental health, which literally just could have been an extra slide on that, because in, in sexual health, clinics and stuff, they are trained to spot this. And they receive a lot of kind of ongoing education. It is, it is embedded into urinary medicine as a specialty. But that was not delivered to us at all in the teaching session. It was just very much like gay men get these diseases and gay men do these sexual practices.

5.5.2 "Stronger links and more overt signposting"

It is suggested by students that stronger links, or integration, among teaching sessions with culturally embedded content need to be made to present more continuous teaching. Taking the Human Values

block as an example, it is observed that other sessions under the Human Values block, including professionalism, interprofessionalism, clinical communication, and medical ethics and law, are all to some extent linked with CC, and vice versa. Students gave positive feedback by saying that grouping these value-based subjects under one module enabled them to explore the interconnected links among these subjects. However, links to bridge the teaching content beyond this module are weak. This view is voiced by interview participant Lilys:

> I think they do recognise that it's really important. We've had a lot of cultural competence teaching. Like workshops or tutorials that are like, they are designed around […] or considering cultural competence, so I think they do recognise that it is important, but I think it could be integrated a little bit better. In terms of, when we talk about cultural competence its often talked about, almost kind of like separately so like this is its own individual topic, without directly integrating into how this would be considered in real practice. Does that make sense?

The integration of teaching content dispersed in a range of sessions may also improve the signposting of the learning opportunities. My observation showed that CC and diversity teaching not only existed in subject-specific teaching but was also embedded in clinical sessions. Nevertheless, when asked where CC is addressed in the curriculum in the interviews, most participants would only recall theme-specific teaching. With further elaboration, they would bring up other sessions of relevance. This incomprehensive understanding of their experienced learning indicates that stronger signposting on CC and diversity education is needed. According to interview participant Ronan:

> And I think all it would take is like a little bit of explicit signposting on behalf of the medical school or tutors […] just to make you aware of that sort of additional layer. The opportunities are 100% there, but I think that frequently, maybe it's just not completely obvious that, you know, this is something you should be doing, and you are doing, and you should also be developing. It's important to develop this.

5.5.3 "An insider's voice" with attention to students' lives

When teaching about specific cultural topics/groups, results show that students benefit the most when they hear insiders' voices from certain cultural groups or demonstrate personal interests in certain topics. Students mentioned that having facilitators from certain cultural backgrounds or guest speakers with expertise/lived experiences on certain cultural topics can contribute to their understanding of certain cultural issues in great depth. Moreover, the likelihood that students will be motivated and engaged can be increased if students have personal interests. For instance, it is noticed that a student from the LGBTQ community took active participation and challenged the existing research by asking profound questions in the workshop on LGBTQ issues. Similar active engagement was also observed when students encountered teaching regarding a cultural topic in which they have established a certain level of previous understanding. On this basis, diversifying instruction by involving teaching staff beyond the field of medicine and healthcare and showing an

interest in students' lives can potentially motivate students' engagement. According to focus group participant Abbie:

> Getting an academic who's either part of that community or who's studied that culture to explain it to us and to explain why certain things the way they are, I feel that it's a lot more beneficial than just a discussion. Because you need a bit of both, like you need to be taught but you also need a discussion. So just going back to the GP workshop that we had and the LGBTQ plus community, homelessness and all of that. So I was put in the LGBTQ+ workshop and I thought that was really good, well it wasn't really a lecture but the lecturer, I could say she was a member of LGBTQ community and she was also a healthcare professional, and she went through like so systematically, like what are the problems they face at every step of the way and it's something that I hadn't really considered because I was like "Oh you know they're just like us why should there be like a difference. There shouldn't really be a problem", but then she kind of like expose it, I guess my sort of ignorance, in my case? Being like no, these are the problems that we face are, like prejudices and judgements that are placed and that we're not aware of. It was a very well taught workshop because she got us to do little mind maps. […] She gave us situations and she was like, what would you do or how would you go about doing this. And she kind of explained the differences between how we would face the healthcare assistant and someone from the LGBTQ+ community would face it and I thought that comparison is really like eye-opening. It was insightful, and I thought that was like miles better compared to just being taught like a didactic form of learning.

5.5.4 Don't forget peer influence

Students mentioned that they can develop CC through peer influence by immersing in a diverse student group. This means that educators need to create platforms, or signpost existing learning opportunities, to facilitate peer-led learning. Peer learning refers to the acquisition of knowledge and skills through active helping and supporting among "status equals" or "matched companions", involving people from similar groupings helping each other to learn and learning themselves by so doing (Topping, 2005, p.631). For example, peer learning that can contribute to students' development of CC is noticeable in the tutor groups. The chosen medical school adopts a tutoring system with 4-5 medical students from the same year randomly allocated within one group under the supervision of one academic member of staff. Students of different years form a larger group with senior medical students acting as "parents" for medical students at lower grades. Within the tutor groups, medical students are allowed opportunities to interact with their peers from other cultural backgrounds. This interaction is perceived by some medical students as conducive to their CC development as they are "forced" to communicate within a culturally diverse student population. According to focus group participant Taran:

> I think the tutor groups are quite helpful. Because the fact when you're put in a group of people, or all from different backgrounds and you got so much teaching all together that you just end up bonding and being friends and that's when you were talking earlier about learning through your friends. I know personally, I had a really good friend who is Muslim in that group, so I could actually have a conversation with him like "I know nothing. Can you please just teach me, walk me around what you believe in and everything and that was really helpful?" and that was helpful.

In addition to signposting peer learning opportunities, educators need to take into account that the diverse tutor group dynamics also influence students' learning, resulting in varied or sometimes negative peer learning experiences. Students mentioned in the focus group that whether students within one tutor group bond or not depends on a range of factors, such as students' personalities, timetables, and the extent of supervision they have received from the staff. According to focus group participant Damian:

> The thing is, tutor groups are great when they're great and terrible at this when they're terrible. It's a random, random chance or randomly selected. You have no idea how people are gonna interact in that. There are groups incredibly tight net, we still talk about "parents" [senior medical students] and most of us turn up to tutorials and things like that. I say most but about sixty percent but that's still like seven or eight people and so you still get good discussion and good discourse. But if you have a tutor group that where you don't have that, then what can the school do to get people to those tutor sessions?

5.5.5 E-learning resources: "not everyone uses that"

Results show that online educational resources provide students with the chance to supplement their in-class learning, but students may not be aware of these learning opportunities or demonstrate limited engagement. In this research, some students expressed that module-related online learning resources can benefit their development of CC. Examples included students mentioning they have acquired a better understanding of the cultural topics on "homelessness" "LGBTQ" and "domestic violence" after accessing the online materials. However, despite the ready access to these materials, the use of these online resources varied among individual students. Conversations with the academic staff showed that they were concerned that students have not fully utilised online resources to assist with learning. This was noticed from my observation in a patient scenario. When the facilitator asked a random question that was shown in the pre-class online learning, none of the students were able to answer that question as they said they had not had a chance to view the online resources. A small number of students mentioned that they were not aware of the online resources, or did not deem these resources as a priority, taking into account their busy timetable. However, a few students who have the habit of checking online learning resources commented that the utilisation of online resources expanded their knowledge of a range of cultural issues that may be present in the healthcare setting. According to interview participant Karen:

> That [the online resources around LGBTQ issues] was very useful. Yeah, statistics do speak. You might know in your head, the LGBT are more likely to be, you know ostracised, or whatsoever. You don't really see how prevalent it is until the number is in front of you. You are like I can't believe it's that bad. I feel like it was high statistics even in London. I was just like shocked because London is so diverse, so open and you see like, actually like 50% of people feel, like don't feel comfortable enough telling their peers their sexuality, things like that. That helps. But you know, as medical students, we are very busy, and there are so many resources out there. I'm not sure if other students have a chance to check the resources as well.

5.5.6 Cultural competence: "we have different needs”

Results show students demonstrate different levels of engagement to developing individual CC. The differences in students' desires to learn are partly attributed to their divergent understanding of CC as an essential medical competence and their self-perceived CC level. On the one hand, a small number of students expressed that the sessions traditionally described as “soft skills” (Joubert et al., 2006), such as CC, are not medical students' learning priorities. According to interview participant Andy:

> I mean speaking as medical students, having dedicated sessions on cultural competency is going to turn us off as we really have so much, so much work to do. We have no Easter break, so this kind of session is really going to turn us off. It won't be interesting to have. I'd rather be in the library and studying.

Besides not attaching dual importance to the subject, students' narrow understanding of CC is also reflected by the fact that some students consider CC an intuitive rather than a competence that can be enhanced through systematic training. Particularly, results show that some students growing up in culturally diverse metropolises tend to demonstrate “cultural minimalisation” (Hammer et al., 2003), a false sense of cultural sensitivity that assumes people are all the same. This is because less culturally competent individuals, with some prior exposure in a diverse environment, are likely to equate CC to cultural awareness. This misunderstanding can potentially lead them to believe that people living in culturally diverse areas are intrinsically culturally competent so there is no need to undertake further CC training. This also explains why a few students commented that existing teaching on CC tends to be a “heavy-handed”, “technical”, “magisterial” and “less enjoyable” way to teach what is known as “common sense”. For example, Mandy's comments represent the thoughts of some medical students:

> I don't want to say that, but honestly, some of my friends, who grew up in London, would consider learning things like cultural competence as a joke. They say growing up in a culturally diverse place, they already know that different people have different cultural values, and this is not something new. You would be happy to hear that I attended the cultural competence lecture, but I would say some students do not understand the real significance of being culturally competent.

On the other hand, another group of students growing up in relatively homogenous areas demands more cultural learning. They expressed that existing cultural teaching is not sufficient as the medical curriculum focused on the teaching of culturally respectful attitudes but not enough on cultural knowledge and skills. In particular, this need is expressed by international medical students who face a potentially culturally different patient population after moving to London to pursue a medical degree. According to French-born focus group participant Taran:

> In cultural competence, so we were saying earlier is, if you want to be aware, if you want to be able to understand people “well”, you need to be aware of the kind of the basics of their cultures. For

example, I was raised in a very like traditional Catholic area in France. […] I'm not personally Catholic or anything but it meant before coming to university, I hadn't seen many Muslims or even other religions. And then coming here and having so many patients. The cultural competence, sort of, in the module where I started it, I expected it to be sort of going over the basics that you need to know as a healthcare professional on different cultures, that you are going to encounter every day as a clinician here. Instead, I kind of had to ask friends and read around and everything, to become, to develop a bit more cultural[ly] competent because otherwise, completely, your job's completely out of the blue. You're told you need to be culturally competent, but you're not given enough teaching to make you culturally competent.

5.6 Summarising students' experiences in formal classroom teaching

This section summarises students' learning that may contribute to their development of CC in campus-based formal classroom teaching. In addition to subject-specific sessions on CC, results show that CC teaching is spirally embedded across the three stages of the curriculum ranging from value-based medical subjects, clinical skills teaching, biomedical science sessions and cross-disciplinary teaching outside the medical curriculum. The teaching formats include lectures, workshops, simulated patient scenarios, project-based learning, as well as medical intercalation and global placement. Accumulatively, teaching at the medical school involves training students with appropriate attitudes to be culturally respectful and emphatic. The school also teaches the awareness of how culture shapes individual behaviour and thinking, the impact of socioeconomic context on patients' health, and individuals' prejudices and tendency to stereotype. The teaching of cultural knowledge is generally observed in public health or epidemiological sessions. Teaching also includes the training of cultural skills, such as how to transfer information in a way that patients can understand and the ability to adapt to new situations flexibly in a culturally appropriate manner. However, except for the CC lecture and workshop, most teaching content is embedded without overt signposting.

As for students' learning experiences, they perceive didactic lectures as a good way to introduce the concept of CC. Workshops are helpful for them to reflect on their cultural bias and to enhance awareness. Some students consider workshops as useful and a safe environment for discussion, others find it difficult to engage due to the potential difficulty in translating learning into clinical practice. Simulated clinical communication sessions the most popular among students. This format allows students to translate internalised cultural knowledge and attitudes into clinical interactions with patients. However, due to the multiple learning outcomes to be achieved in simulation, learning of culturally sensitive communication and clinical care might take place unconsciously. Engaging with self-selected and scholarly projects allows students to develop a more in-depth understanding of cultural issues that interest them, but their learning varies depending on the nature of the projects. There are other formal experiences where students might develop cultural competence, including intercalated BScs and global health placements.

Students' feedback included their proposition of incorporating more recent cultural cases to illustrate cultural diversity. They also suggested that stronger links can be built to facilitate students' all-around understanding of value-based medicine. Inviting guest speakers or insiders with lived experience on certain cultural topics is a powerful tool for learning, as is adopting interactive technologies, such as videos and student polls. The effectivity of peer influence and peer-learning is identified. Concerns about the insufficient use of online resources are raised by both the teaching staff and students. It is also pointed out that the one challenge for students to develop their CC is cultivating appropriate attitudes and attaching dual attention to the topic.

Whereas this chapter reveals that students can develop their CC through participation in campus-based formal classroom teaching, the next chapter will explore and discuss whether students can enhance their CC in clinical placements.

6 CC development in clinical placements: there is more than you think

> When I was shadowing a medical student in the ultrasound scanning room in the Prenatal Ward of Hospital A, one thing caught my attention. One middle-aged man went inside the room together with two young women, one of whom was the expectant mother. When the sonographer showed the fetus to the expectant mother on the screen, the two women burst into happy tears whilst the man remained indifferent and played his phone throughout the process. It was difficult to tell the relationships among the three. After they left, the medical student asked the sonographer whether things like these happen a lot. The sonographer replied, "just by sitting here in a small scanning room, you can see the whole world. Whereas you will witness people of certain cultural backgrounds sharing the happy news by video chatting with their relatives throughout the whole world, you also learn unpleasant things such as domestic violence, or different cultural practices such as polygamy or even FGM (female genital mutilation). So as medical students, you need to embrace these challenges and respond accordingly".
>
> Fieldnotes, 15 May 2018

In addition to campus-based formal classroom training, clinical practice is a vitally important component for medical students. This chapter describes students' views and experiences in developing cultural competence (CC) in clinical placements drawing on the synthesis of the results from my observation, interviews and focus groups. Starting with the background introduction of my observation at Hospital A in Section 6.1, Section 6.2 discusses the ways students can develop their CC in clinical placements. Section 6.3 describes the unique features of students' learning. Section 6.4 summarises this chapter.

6.1 Setting foot in Hospital A

Located in central London, Hospital A is a busy environment with local and international patients. Walking around I could see a variety of cultural elements, such as people of different ages, ethnicities, language backgrounds and dressing styles. Advertisements featuring cultural events and posters about public health information could be seen on the wall. Walking around the hospital I heard cheerful talk and laughter in some parts such as the postnatal ward and the Children's Hospital. In other areas, I sensed stress and grief from people's appearances and expressions, including in the waiting rooms.

Year-2 medical students from the London medical school were required to attend a seven-week rotation on Human Development, during which period they were expected to learn about the basic science applicable to women's and children's health and relate this to their clinical experience in Obstetrics, Gynaecology and Paediatrics. The learning themes for the Human Development Block are fertility, pregnancy, birth, growth, development and adolescence. Students would ideally rotate in

different hospital units each week including the Early Pregnancy Unit, the Gynaecology Ward, the Antenatal Ward, the Antenatal Day Unit, the Postnatal Ward and the Children's Hospital. All students started their rotation by attending a briefing session in Week One given by four clinicians, one of whom described students' experiences to be "fun, fulfilling, challenging, emotional, embarrassing, exciting, life-affirming, difficult and confusing". Each rotation day consisted of the morning ward rounds and an afternoon workshop led by clinicians, taking place either on Tuesday or Friday. To collect data, I followed five medical students for one rotation day each. The table below shows the sociocultural background of each participant and their views on developing CC.

Table 20 Personal profiles of shadowed participants in clinical placements

Usher: Born and raised in Wales, Usher has a Bachelor of Science degree in Pharmacology from a university in North England. He appeared to be an outgoing, confident and friendly white young man in his early twenties. Usher was in Year-One, but his study was equivalent to that of Year-Two in the standard undergraduate medical degree. He was in the Medicine Graduate/Professional Entry Programme (GPEP), a fast-track degree in medicine for those who already had a degree prior to entering medical school. The GPEP students finish their undergraduate medical degree in four years instead of five. Talking with Usher, I found out it was because of his paramedic gap-year working experience in India that he became motivated to pursue a further degree in Medicine. Working as a paramedic in a small town in north India for one year, Usher witnessed the shortage of professional healthcare workers and the impact that doctors can bring to society. He also related his gap year experience to my research topic, as he said that this experience allowed him to develop a renewed understanding of culture and diversity. He acknowledged that it is vital for medical professionals to practise in a culturally competent way so that "one can adapt one's own conduct with sensitivity to others' cultural identity".
Simon: Growing up in Italy, Simon is a Year-2 medical student undertaking the standard MBBS programme. After I contacted him to arrange a date for shadowing, he sought permission from his clinical partner, Andy, to see if he would allow me to join them together for one day. Simon expressed that he considered being culturally competent very important as it allowed healthcare professionals to tailor their care in a more personal way, which would always be appreciated by patients. By linking his CC development with his clinical placement, he expressed that his previous rotation experience in the Ageing Block vividly presented to him how diverse patients could be due to their gender, age, language and socioeconomic background. He also mentioned that being culturally competent to a large extent is linked to being "a good person" and remaining "curious" and "tolerant" to cultural differences.
Andy: My conversation with Andy (Chinese Singaporean) disclosed that he seemed to attach less importance to developing cultural competence, compared with developing other clinical competences. It seemed to me that Andy considered himself quite culturally competent. He mentioned that growing up in a diverse place such as Singapore has made him aware that people can be different, so he would not be shocked by any differences. Although he verbally acknowledged the importance of developing cultural competence in order "not to offend patients", he equalled cultural competence to "common sense" by saying that "for most people, if they are of certain EQ (emotional intelligence), they should be able to understand what is acceptable or not".
Harry: Born in the UK, Harry is from a white British middle-class family. He lived in a medium-sized city in South West England until he started his university life. Harry considered London an ideal place to study medicine because of its tremendous diversity. He deemed that medical students in London are exposed to a diverse range of population and diseases whereas medical students who study in relatively homogenous places normally do not have access to. In addition

to English, Harry can speak French, German, and conversational-level Mandarin. He also explained that he chose to study Mandarin at a later stage because his girlfriend is Chinese. I found Harry almost an "ambassador" for Chinese culture. He even introduced to me lots of reputable Chinese restaurants in London.

Mandy: Emigrated to the UK at the age of 10, Mandy is Indian British. She is a Year-2 GPEP student who has a bachelor's degree in Chemistry from a university in central England. Mandy considers that being culturally competent is extremely important when working in diverse places such as London. She also mentioned that culture needs to be understood from different sociocultural determinants, going beyond an individual's race and ethnicity. Mandy expressed that being multilingual is a great advantage for healthcare professionals to be culturally competent by quoting one multilingual doctor as her role model. Mandy also mentioned that some medical students do not seem to attach due importance to developing cultural competence. She said some of her London friends even consider developing cultural competence a "joke" because they deem themselves already culturally competent as they are immersed in a multicultural society such as London since childhood.

The night before I started my observation, I prepared all the approval documents, including my University Ethical Approval and NHS R&D Approval. I expected my presence in the hospital to be questioned because not all the clinicians would know me or understand why I was there. A pair of comfortable but professional shoes were necessary as I would be doing more than 20,000 steps every day. I also prepared a clear and succinct way to introduce myself and my research so as not to burden the busy clinicians and cause distress to patients. However, this turned out not to be the best approach. I eventually left the introductions to the students I was shadowing. This was because medical students were required to report to the clinicians-in-charge or nurses-in-charge before they started their placements every day. As I was not granted card access to enter the wards and could not immediately recognise those in charge, shadowing the students and leaving the introduction task to them seemed to be the most sensible choice. Having them briefly introduce my research was time-efficient. It also shortened my time with other personnel (e.g. patients and their families) from whom I needed to obtain consent to be present.

I developed my strategy for my interaction with the different personnel that may be present in the clinical setting. I decided not to disrupt the students when they were interacting with staff. Nevertheless, verbally informed consent was required when patients or their family members were involved. This strategy was decided by relating my research to relevant literature addressing the ethical complexities of conducting participant observation in hospital settings (Van der Geest and Finkler, 2004, Oeye et al., 2007). It took into account the busy nature of the clinical environment where students were interacting with a range of people on a daily basis making it impossible for them to introduce me and my project every time we met someone new. Initially, I was concerned when I was mistaken for a medical student and I was never sure whether to interrupt the conversation and state my position or whether to remain quiet. However, after shadowing my first participant for two

hours and meeting about 15-20 new people, my anxiety was significantly eased as I became more comfortable in the hospital setting.

This strategy allowed me to obtain informed consent from different personnel and to gain access to most clinical environments. When interacting with staff, a group of students would normally gather around an available nurse or clinician to seek advice or to ask questions. On these occasions, it was easier to act as an undisruptive observer rather than trying to seek consent which would have caused an unnecessary burden to staff and students. The benefit of this practice for students was that their learning process was not constantly being interrupted by an observer. The only time my presence was challenged was when one clinician questioned me, "why you not wore your white coat and put your stuff in a locker?" The confusion was immediately cleared up when I explained my identity as a researcher. It would not have been appropriate to give my introduction as it would have interrupted the clinician who was in the middle of answering a student's questions. Nevertheless, when patients were involved, I strictly referred to the medical ethical guidelines approved by the NHS R&D Office to obtain verbally informed consent. The observation was only conducted when the patients allowed me to be present. My fieldnotes only captured students' learning experiences rather than any personal information about patients.

6.2 Unexpectedly I learn: developing CC in clinical placement

Data collectively show that medical students can develop their CC by immersing in a diverse working environment, observing culturally appropriate/inappropriate practices, interacting with different personnel, and reflecting both individually and within a group. Sections 6.2.1 to 6.2.4 describe students' views and experiences and elaborate on how CC can be developed via these approaches.

6.2.1 Immersion

6.2.1.1 Environmental diversity: having culturally inclusive exposure

It is observed that immersion in a diverse healthcare environment can expose students to a variety of cultural differences and enhance their understanding of diversity in healthcare. The multicultural immersion takes place when students receive influence from the public presentation of culturally diverse health information and events that target not only linguistically different communities, but also culturally different groups based on religions, age groups and life choices. During my observation, I witnessed the Spiritual healthcare team at Hospital A offering voluntary support for patients and families of different religious beliefs. Cultural events, such as celebrating Buddha's birthday,

contribute to building a culturally diverse and inclusive healthcare environment. These phenomena increase the likelihood for students to actively consider cultural issues in relation to health and consequently, enhance their cultural awareness.

> Fieldnote: Next to the marble statue of Queen Victoria in the central hall of Hospital A, a Buddhist event was taking place, celebrating Buddha's 2,562nd birthday. Two monks in robes were giving a presentation about the life stories of Buddha, with constant reference to many of his wise quotes. By their side, an NHS staff member was distributing brochures covering content such as an introduction of the event, information about the Spiritual Healthcare Team, and the development of Buddhism as a religion. On the notice board among the different pictures of Buddha and the contact information of the NHS Spiritual Healthcare Team, three eye-catching words read "Happy Buddha's Birthday". Around 8-10 audiences of different ages and ethnicities sat on the benches.

In addition to immersion in the multicultural and multilingual artefacts, my observation shows that students receive cultural exposure by meeting and working with culturally diverse staff and patient population. Taking Usher's placement in the Early Pregnancy Unit as an example, the phenomenon of diversity was prominent both among the staff and the patient body.

> Fieldnote: Nurses of different ages and ethnicities were seen working together. In the waiting area, patients of different ages, ethnicities, language backgrounds, and dressing styles were waiting for their numbers to be called. There was a television in the waiting area. Some patients were watching the non-sugar campaign broadcasted on the television. Some were talking with their companions in a low voice. Different languages were constantly heard. One woman was wiping her tears silently with her husband/partner trying to comfort her.

Students mentioned in the interviews and focus groups that working in an environment with healthcare professionals from distinctive cultural backgrounds can facilitate discussion and communication regarding diversity. In Hospital A, 40% of the staff are from the Black, Asian and Minority Ethnic (BAME) backgrounds. The hospital is also recognised as a healthcare leader by Stonewall (2019), the charity which campaigns for lesbian, gay, bisexual, and transgender equality (LGBT). Over 100 staff are among the LGBT staff network. Hospital A is also acknowledged by the BBC as being a leader in encouraging people with autism into work. It has widening access to employment and skills strategy and has won a number of awards, helping homeless people and those with disabilities into jobs. The diverse workforce has a positive impact on students' CC development. Students mentioned that the occasional celebration of cultural festivals within the healthcare team created a culturally inclusive environment and helped them recognise the diverse backgrounds of professionals and their perspectives on health and healthcare.

In addition to a diverse workforce, students expressed that constant exposure in a diverse patient body enhances students' cultural awareness and expands their cultural knowledge. Demographically speaking, Hospital A is geographically close to three central London boroughs, embracing some of the most culturally diverse populations in England. Taking one of the boroughs as an example, 42% of the population are from ethnic minorities and over 150 languages are spoken within the borough.

This means the diversity within the patient population demonstrates a broader representation of cultural differences from multifaceted aspects such as age, gender, sexuality, disability, mentality, religion, educational levels and socioeconomic status. Taking age-related challenges as an example, participant Simon mentioned that he had encountered many cultural and communicational challenges by quoting his own experience in the Ageing Block. As a student of an ethnic minority background, he mentioned one of the biggest challenges was to gain trust from elderly patients as some patients tend to bestow lower levels of trust to clinicians with ethnic minority backgrounds. Moreover, these challenges could be intensified by the fact that some elderly patients may have hearing difficulties or symptoms such as dementia or Alzheimer's disease.

6.2.1.2 Implicit learning: taking place without knowing

A synthesis of the results of my observation and that of interviews and focus groups shows that the effects of immersion apply to students of different levels of CC, often occurring in an implicit manner. Immersion contributes to the CC development of students who understand the lifelong learning process of developing CC and are willing to make behavioural changes. It also benefits the students who are less culturally competent or possess a low-level of cultural awareness. Usher's case demonstrates how a culturally aware student can utilise opportunities in the clinical setting to enhance his CC. During his rotation, he used three languages within a day to communicate with different patients. Although the medical consultations were conducted in English, the different languages Usher used to open up the conversations helped with rapport building, which increased the likelihood of gaining trust from patients.

> Fieldnote: I followed Usher for one day at the acute gynaecology and early pregnancy units. It was a busy and fruitful day for Usher as he talked with six patients and discussed three medical cases with nurses. Patient diversity is a big theme. Different cultural elements [e.g. different linguistic backgrounds, health literacy] were noticed. Communication challenges [e.g. linguistic difficulties, difficulties in understanding professional, medical English] were observed. Usher was able to help with some of the communication problems as he also speaks French and Spanish. It was observed that Usher was willing to engage with cultural differences as he tried to explore patients' individual circumstances such as their linguistic and occupational backgrounds.

Apart from culturally aware students, immersion can benefit the CC development of students who possess a relatively low-level of cultural sensitivity, or "cultural minimalisation", a false sense of cultural sensitivity that assumes all people are the same (see definition in Section 5.5.6). While following Andy, I noticed that he has a simplistic standpoint to CC as he verbally expressed that developing CC is not of equal importance to developing other clinical skills. Nevertheless, it is important to note that through immersion in a diverse healthcare environment, Andy has developed a renewed understanding of culture and diversity, which could potentially contribute to his CC. The evidence of this can be seen in my subsequent conversation with Andy. When expressing his view of

cultural differences between Singapore and London, Andy said that although Singapore is also a diverse place, the degree of diversity in London far exceeds that of Singapore. When filling out the participant demographic questionnaire (see Appendix 17), Andy jokingly said that he was not aware that so many choices for gender and sexuality existed until he came to London, demonstrating that he has acquired more cultural knowledge in this respect. He added that people never openly talk about sexual orientations in Singapore. He commented that the LGBTQ group is "an underground thing" in Singapore and this group is heavily discriminated against in many social aspects, such as marriage and public housing. Andy also mentioned that even movies about homosexual relationships are banned in Singapore. In comparison, he considers London a more culturally inclusive environment to embrace greater diversity in genders and sexual orientations. Andy's example shows that although a student's previous immersion can form undue confidence in self-assessing his or her CC, continuous immersion in a more diverse environment can still enhance one's CC.

The results of the research also show that the benefits of cultural immersion are evident in regions of dissimilar levels of geographical diversity: both in metropolises and relatively homogenous areas. On the one hand, immersing in culturally diverse metropolises allows students to experience multifaceted sociocultural determinants that may influence individuals' health conditions, including one's gender, sexuality, disability, health literacy, and socioeconomic status. The merits of pursuing a medical degree in places such as London have been widely acknowledged by medical students. In Simon and Andy's case, during their conversation with the Irish patient, they both agreed that rotating in a culturally diverse environment in London has contributed to their personal development to become an all-round doctor. On the other hand, it is also acknowledged by participants that cultural diversity is never restricted to big cities but exists in any area or region, especially the individual-level cultural differences. These cultural differences, such as age, educational levels, and socioeconomic differences, are ubiquitous and require CC to cope with. The benefits of immersion in relatively demographically homogenous areas were mentioned by four interview participants. For example, Timothy said:

> Just by meeting patients from different backgrounds helps. My GP placement was in Dartford, Kent [a county in South East England which borders Greater London to the north-west, Surrey to the west and East Sussex to the south-west]. The population is more homogenous compared with London. […] And I met a lot of people who I guess I wouldn't normally like to meet. In terms of that, I think we had very different political views and very different ideas of what it means to […] live in a society. But having to sit down with them and listen to their stories, it made me more aware of how they think about things, and how they think about healthcare. So, I guess I learned a bit from that.

One feature of immersion is that it may contribute to students' learning in an implicit manner, with some students not realising its positive influence or recalling the influence at a later stage. This finding is shown by the results of the focus group and interviews. In the third focus group, all five

participants mentioned that with so many targets to achieve in their clinical placements, the importance of developing CC is sometimes underestimated or neglected. However, it was unanimously agreed by them that through constant immersion in the clinical environment, they are developing their CC unconsciously. Similar views were expressed by the interview participants. For example, Bentley's opinions are representative:

> I think you may not feel like you are learning, much of cultural competence, but then when you compare yourself to how you were at the beginning of the year, you realise how much you've learned. […] You realise how, how you develop your cultural competence.

6.2.2 Observation

Results show that observing cross-cultural encounters in clinical environments helps students develop their CC. Observation in the clinical context includes seeing not only how healthcare staff in different healthcare settings approach cultural issues in relation to health, but also their interaction between patients, family members and among themselves. Observational learning enables students to acquire culturally appropriate attitudes, values and ways of thinking and basing their behaviour on their observation of the examples set up by senior clinicians. Through observational learning, students may develop their cultural attitudes such as enhancing their sensitivity and cultivating respectful behaviours towards diverse patients. They may also enhance clinical communication and cultural skills such as seeking available technological support when necessary.

> Fieldnote: The nurse-in-charge in the Early Pregnancy Unit was very supportive and allowed Usher to join her in the triage, a process of determining the priority of patients' treatments based on the severity of their conditions. Usher sat at the corner in a triage room temporarily built with curtains and observed four consultations with women having different symptoms during their early pregnancy. The four patients were of very diverse backgrounds in terms of age, race, ethnicity, nationality, health literacy, and linguistic background. One patient mentioned to the nurse that she could understand English but did not speak good English. One patient brought a medical document in French which the nurse could not understand but the patient was able to translate. Another patient who had minor bleeding the night before was anxious because she was a mother-to-be of advanced reproductive age. The fourth patient was a teenager and did not know she was pregnant until she was sent to the hospital. Holding a pen and a notebook, Usher observed the triage consultations quietly. However, he still had chances to greet some of the patients in their native languages as he speaks both French and Spanish.

6.2.2.1 Attitudinal inspiration: enhancing sensitivity and respect

Through observing culturally appropriate behaviours, medical students can develop culturally appropriate affect such as enhancing their sensitivity and respect. In Usher's case, he mentioned that from his observation in the Human Development block, he has learned that patients of certain cultural backgrounds can be more sensitive than others when addressing issues related to fertility and pregnancy. The level of sensitivity can be intensified if a male clinician/medical student is involved. In the process of seeking patients' consent, Usher observed how experienced clinicians, in

a culturally understanding way, asked for patients' consent on behalf of him to see if the patients would allow a male student to join activities such as ultrasonic scanning. Similar views were expressed by my interview participant, Maya, who told me that she has observed how patients from certain cultural backgrounds can be "uncomfortable" when talking about gynaecological problems or symptoms such as Urinary Tract Infections (UTI). She said observing these cases showed her the importance of being culturally sensitive and paying extra attention to the nuances across cultures. According to Maya:

> When I was in GP, one of our patients […] was Somalin and she felt so uncomfortable. […] It was clear by her symptoms that she had UTI, but she was so uncomfortable talking about it or even discussing it with the nurse, who was a female, and I was female in the room. […] She was still very uncomfortable, so I guess it's important to be just aware of the culture. […] So, we can be like a little bit more sensitive than we usually are, I guess, to the differences, to the nuances of different cultures.

Results also show that respect towards culturally diverse patients is another area of competence that can be enhanced through the observation of culturally competent behaviours in clinical placements. Although this attitudinal domain of competence can be intrinsically liked with one's upbringing and early-stage education (Pérez and Luquis, 2013), it can be constantly developed through later education and life experiences. My observation shows that when medical students rotate in different wards, they are likely to witness clinicians and nurses interacting and caring for patients in a culturally respectful way. In Usher's case, he told me that he thought it was worthwhile to see the senior nurse was friendly and non-judgemental to all the pregnant ladies during the triage despite their age of pregnancy and life circumstances. Interview participant Karen shared with me one of the observed scenes that helped her learn what real respect is as a doctor. She commented that observing culturally competent clinicians allowed her to reflect on her own attitude towards patients by building on previous knowledge and experience and to imitate by critically reflecting and internalising those respectful attitudes. According to Karen:

> Well, that was one of my consultants that I saw in the wards. I remember listening to him speak to the patients. I feel very impressed. I was following the physio. The physio was just basically trying to get a patient to sit up and trying to walk. Because it's really important, you can't lie there every day. He was just trying to convince the patient, sit up, sit up. Maybe like 10 minutes just get him to sit up. And you could tell that he [the patient] had the ability but his mental issues were pulling him down rather than physical. The nurse told us beforehand that it seems that the patient culturally believes it is best to remain immobile after an operation. And then the consultant came in and gave this really really empowering speech.
>
> And I was like tearing. Oh my God, this guy is so good. I wish I can be like him someday. He is just saying stuff like, "you are trying so hard. And I can tell that you are in such a dark place. You are really pushing yourself and just sitting up on your own is such an incredible feeling. None of us could even imagine what it was like to be you and the strength you must have". I remember he said something like, "what you are doing right now is like climbing Everest to us". And I remember when I heard that I was like […] his perspective really makes changes. You know, sometimes you are just watching, and in your head, you were thinking, "oh, please sit up". But then I hear that from a

> consultant who deals with these many patients impatiently every day, […] he must have a lot more respect for patients.

6.2.2.2 Learning while seeing: imitating tactics and adopting technologies

Data analysis shows students can also enhance their cultural skills through observational learning. Two areas of skills were identified, the strategies to interact with culturally diverse patients and the use of available technologies during critical moments. First, through observing how experienced clinicians approach and interact with patients, medical students may develop their CC via simulating or imitating clinicians' behaviours. In Usher's case, I found that observing the senior nurse conducting the triage consultations with patients of diverse backgrounds in a respectful and culturally competent manner helped Usher enhance his strategies of interacting with patients. This is because I noticed that Usher, in his interaction later with other patients, attempted to adopt similar linguistic terms and communication styles (e.g. assuring the understanding of non-English speaking patients). This view was also expressed by focus group participant Jun:

> Observing the interactions different people have within clinical placements, and not just observing patients themselves individually and healthcare assistants and doctors and all those things, but interactions between these two groups of people would probably help you develop [your cultural competence]. Because you know these healthcare assistants they have been through, they have seen these patients constantly, and they might have this instinctive way of reacting to things or replying to their patients that we haven't developed. […] So, seeing those nuances in their conversations might help us pick up something is it in their body language, the way they say things, even like oblique questions, what kind of questions they use, the tactics.

Second, students may observe clinicians using available means (e.g. seeking help from multilingual/multicultural colleagues, using information technologies) to solve cultural challenges in the delivery of patient care. In the clinical setting, whereas most cultural challenges are not immediately life-threatening and allow staff the flexibility to explore and remedy, rare cases involving critical moment rescue can lead to immediate hazards if not dealt with appropriately. Although I have not observed a case involving critical cultural challenges, examples were given by three interview participants, all of whom witnessed cases when non-English-speaking patients were in critical conditions with no interpreters being able to help with translation. On these occasions, smartphones provided accessible applications to aid immediate translation and were put into use in each patient episode. The three students reflected upon their experiences and mentioned that language-assisted applications, such as Google Translate and Eudic dictionary, have gradually become indispensable tools during cultural emergencies like these. According to participant Mandy:

> Being able to use smartphones in critical moments, basically the emergencies. […] I think it's about having learnt to approach people, not necessarily be able to, without necessarily saying the same language. So, I think I'm being very aware of the words that you used the terminology, and always be ready to google translate. Yeah, for that situation [a lung test] where the interpreter was booked

> but didn't show up. That's important, it's important to know what is available, to translate, and how to manage the emergency.

6.2.2.3 Unforgettable moments: role models or challenges to handle

Results also show that students' motivation to engage with cultural issues increases if they have identified any role models or witnessed cultural challenges in clinical placements. Having culturally competent role models allows students an opportunity to imitate by critically analysing and internalising the role models' behaviours. The observation of culturally competent behaviours by senior staff is known as role modelling, which refers to teaching by example and learning by imitation (Murray and Main, 2005). Role models who demonstrate positive attitudes, substantial knowledge and tactical skills serve an indispensable role in helping medical students to learn. Role modelling encourages students to explore the attitudes, knowledge and skills embedded in the daily clinical practice and to facilitate students' learning by linking the practice with relevant academic theories or concepts learned during their campus training. In my interview with Mandy, she expressed that her GP is an example of a culturally competent doctor that she aspires to become:

> My GP is kind of my role model. I think he knows the fine line between that being prejudiced and not using stereotypes to shape how you treat your patients. […] We had the experience that the GP has to explain to a patient why she didn't need antibiotics to treat her viral infection. The patient, a) she didn't [speak] English very well, and b) I don't think she was very well educated, and she came from a developing country where I don't think education is being very important for her. And then, c) she expected a pill […] to work on whatever illness you have. And that's what she wanted. Then my GP spent a lot of time trying to explain these terms the patient doesn't understand. But then, like he would get too frustrated that she didn't understand it. I can't remember exactly what he said, but it was explaining it to the patient in a way that we want you to feel as comfortable as possible. Because you have to take account of people's knowledge is very shaped by their own culture as well. So, I think that was one of the examples. That's the kind of doctor I want to be.

On the contrary, students mentioned in the interviews that they tend to reflect upon cultural issues if they witness culturally incompetent behaviours in the clinical environment. Observing occasions of such nature enables students to visualise how healthcare may be compromised if cultural issues are not dealt with appropriately. Under these circumstances, reflection-in-action is more likely to occur, leading to students' individual reflective activities such as reframing and reworking the problem from different perspectives and understanding the elements and implications present in the problem, its solution and consequences. Observation of these scenes may also increase the likelihood for students to have reflection-on-action after the occurrence of a culturally incompetent event. Reflection-on-action allows students to think back on what has happened in the situation to determine what may have contributed to the unexpected, and what has been learned from this situation may affect future practice. These reflective activities may move the surface learning of CC to a deeper level. In this research, three interview participants mentioned that they have witnessed cases with immediate cultural challenges that prompted them to reflect upon. The three cases were

about ineffective communication between a clinician and a patient believing in alternative medicine, a dangerous pregnancy delivery due to linguistic challenges, and a doctor's stereotypical assumptions of dietary preferences based on patients' ethnicities. Mandy reflected on how one of her observed scenes enabled her to witness and reflect on cultural challenges taking place in the clinical setting with real-time constraints.

> I was thinking if you [the researcher] were here last week, we had so many cases happening. For example, one patient came to the Postnatal Ward and she does not speak English. They had an interpreter booked via Language Line, but that interpreter was very late. What's worse, the clinicians and nurses were not aware that they were expecting an interpreter. As the lady was about to deliver, the staff asked around who can speak Spanish. Lizzy [the clinical partner], said she can speak some Spanish and tried to help. Unfortunately, medical English is not as easy as a daily conversation. At last, they had to use google translator to help the lady deliver. The delivery went OK. But the team was so nervous as being unable to communicate in the same language in a critical medical moment can be very daunting.

6.2.3 Interaction

Data analysis shows that through interacting with different personnel in the clinical setting, students can potentially add to the institutional competence of a healthcare organisation, re-think multilingualism, acquire cultural knowledge or practices, and improve clinical communication. Students benefit from interacting with patients and their family members, clinicians and peers.

Interacting with patients and their family members allows students opportunities to explore patients' culture in great depth and to rectify potential oversights caused by linguistic and cultural challenges. This type of interaction contributes to students' acquisition of cultural knowledge and the improvement of cultural skills. A high level of support from patients and their family members is important as it offers students chances to explore patients' sociocultural backgrounds in-depth, as demonstrated in Simon and Andy's case.

> Fieldnote: Andy and Simon were first introduced to a 32-year-old new mother who had just undergone a Caesarean section. The patient and her husband were supportive, encouraging, and willing to speak with Andy and Simon, even though their new-born was still in a critical condition in the neonatal intensive care unit. After finishing the clinically relevant questions, the couple offered to help answer any further questions from Simon and Andy to help them learn. The mother even said, "you guys are the future of this country, and this is the least we can do".
>
> A high level of support was also noticed from the second patient, who had just had a difficult vaginal birth the day before. The history-taking turned to a casual chat after Andy and Simon finished asking clinically relevant questions. The Irish patient told Simon and Andy that she had taken a midwifery training course before, so she felt a natural bond with medical students. The lady even shared with the students her previous learning experience in a nursing school, her family's cultural traditions in sharing parenthood, and the support she got from her families during childbirth. Learning that both Simon and Andy are international medical students, she responded by saying that London is a perfect place to study medicine and obtaining a degree here would qualify them as a doctor in several other countries, quoting her own experience as an example.

Interaction with clinicians, mainly nurses and doctors, offers students the chance to progress by receiving positive suggestions from their superiors. It is observed that the interaction with clinicians helps students to learn the working culture of a healthcare organisation, as well as the interprofessional collaboration between members. Particularly, results show nurses are essential in supporting students' learning, partly because my observation was mainly conducted in the obstetric wards and Children's Hospital where midwives and nurses play a leading role. Harry's interaction with a senior nurse demonstrates how he can improve his CC when working with child patients:

> Fieldnote: The clinical week-theme for Harry is "Growth". Arranged to practise at the specialist Children's Hospital administered by Hospital A, Harry mentioned that his task was to practise measuring height, weight and blood pressure for child patients. Harry used child patients as an example to explain the challenges in dealing with patients of different age groups. He said children at different growth stages have different needs and interests and learn in different ways. When working with child patients, Harry said that communication could be a potential obstacle especially considering many children referred to the hospital might have severe health problems, such as deformation and defective brain development.
>
> Challenges indeed took place while Harry was observing one senior nurse measuring the weight, height and blood pressure of a patient, a seven-year-old boy who seemed very anxious, movable, and shy. With her mother being present to help, it was still difficult for the nurse to keep him seated for any measurements. The nurse tried measuring his blood pressure twice but none of the readings were accurate as the child kept moving restlessly. They had to let go of the child in the end.
>
> The conversation between Harry and the senior nurse afterwards was important as the nurse shared her skills with Harry on how to work with child patients. After the boy and his mother left, the senior nurse said that she speculated the boy might be suffering from a learning disability. She also shared her "trick" with Harry on how to approximately evaluate a child's general development through verbal communication. In this case, when she repeated to the child questions such as "How old are you?" "What's your name?", the seven-year-old child replied with nothing relevant, suggesting that he did not fully understand the meanings of the two questions. The nurse told Harry that she would usually ask simple questions like these to obtain a basic understanding of children's general development as she did not want to make assumptions by judging from their appearances. While expressing her empathy for the child patient's condition, the nurse emphasised to Harry that the trick of "asking basic questions" to approximately determine whether the child patients are of normal cognitive growth is generally useful according to her over 20 year's working experience.

Lastly, interaction with peers is indispensable as peers offer medical students emotional support in a stressful clinical environment. Peer interaction also provides opportunities for students to discuss and exchange issues in relation to cultural differences when relevant. Story-telling or case-sharing, present vivid clinical examples to medical students and may trigger a constructive discussion within a safe environment. Moreover, besides the morning ward rounds, peer interaction was also observed in the afternoon workshops where students were able to share and discuss their clinical encounters. The important role of peer interaction is stated in the learning guidelines of the chosen medical school.

> Fieldnote: We [med school] believe that in Human Development, much will be gained by small group peer teaching. In clinical medicine in Women's Health and Child Health, much of the important teaching which trainees and consultants engage in is based on small group self-directed peer interaction. Based on this model, we believe that students will gain much on developing these skills

early in their medical school career. Some of the skills which they will attain during the sessions will be the ability to work in a small group, maintain communication with their group and present to their colleagues.

The table below presents some selected quotations from students to explain how they can develop their CC through interaction with patients and their family members, clinicians and peers in the clinical setting. This is followed by Sections 6.2.3.1 to 6.2.3.4 that elaborate on the areas of cultural competence that can be developed.

Table 21 Developing CC through interaction in clinical placements

Interactional parties	Quotes from students
patients/families	Lily's (interview): Listening to what they're [patients] telling you. It's gonna help you understand them a lot better. I think that's something I did learn over the last year, sometimes you make assumptions in your head, you don't even realise it, because I thought I was a very open-minded person until I actually went out and started talking to people on ward, and I realised I was holding assumptions in my head, that I didn't even necessarily realise I had, and I was like "oh! That's actually quite surprising," and then I realised "okay why am I so surprised by this" because I had this assumption already and I don't know, they defied that assumption that I had of them.
	Ted (interview): There are patients who have cultures that are so detached from my own and so different. I'm not sure how I could ever possibly expect to understand their culture from reading it. I'd much prefer talking to someone from that culture or, you know, or practising conversations on sensitive topics, based on peoples' different cultures. I think that would be more useful.
staff	Kyle (focus group): Talking to the staff, so doctors and nurses and any other healthcare assistants around, could quite improve everything, because they have years of experience in communicating with patients, so they already have the knowledge and hopefully the cultural competence as well, so they can just pass on their experiences to you without you having to experience all of them.
	Harry (interview): In medicine, people with different levels of training work together, so a doctor would also work together with a nurse or a nurse assistant, work with physiotherapists, so different specialties often […] maybe [have] people come from different walks of life. They are also different ages as well, and interaction with them, that's important.
peers	Paige (focus group): Storytelling is definitely something that happens between friends. I also wouldn't be surprised as long as it's [the stories are] interesting. […] Then let's say some cultural events happened and that was interesting seeing how they changed the interaction, seeing how they changed the management. [Then we share the stories.] That is something that could actually happen.
	Dante (focus group): You know today I saw this patient who was of this characteristic and this happened, so full [of] stories. Because everybody is going to have their own unique experience, whether or

	not you're placed in a ward, another hospital. We all get to see very different things, so sometimes if we get an interesting case where possibly culture played an important role in it.

6.2.3.1 Adding to organisational competence: learning opportunities for others

Results show that students can enhance their CC by interacting with patients as the interaction enables students to gain a further understanding of the associated factors that may affect patients' communication with clinicians. The interaction also helps students to understand patients' perceptions of power relationships in a clinical setting. Students' participation can, in turn, add to the institutional CC of healthcare organisations, creating learning opportunities for others. This is because students' participation may potentially bridge the gap between individuals and healthcare systems and balance the power asymmetry between clinicians and patients. The diversity within the student body also enhances the representation of diverse healthcare providers. Usher's case demonstrates that his interaction with Patient Ms A can potentially improve his individual CC and adds to the organisational CC of the hospital.

> Fieldnote: while waiting to observe an ultrasonic scan, Usher decided to practise history taking with a Spanish lady, Ms A, whom he met earlier during the triage. Wearing a loose grey T-shirt and a pair of old sports trousers, Ms A seemed happy to talk with Usher. Usher soon built rapport with Ms A by greeting her in Spanish, and their conversation immediately moved from an English conversation to an English-Spanish mixed conversation. Ms A suddenly became very talkative and shared with Usher her previous medical and pregnancy histories. She mentioned in English that she gave birth to a young healthy son but also had a miscarriage before. She described her miscarriage by using English phrases such as "explosion of my belly", "I saw blood all over the bed", and "I thought I am dying". Ms A also shared with Usher her feelings after having completed a blood test with a mixture of English and Spanish. Covering her injection spot in the left arm with her right hand, she complained to Usher that she had always been afraid of "needles", by which she meant "injections". However, she mentioned none of this information to the nurses.
>
> Though constantly apologising for her limited English, it seemed that Ms A was capable of understanding and communicating in English, until Usher realised her limitations in her proficiency when he saw her filling out her pregnancy history form in the waiting area. Usher "caught" Ms A using her phone to search for the answers to the questions on the form such as "How many previous pregnancies have you had? Have you had a miscarriage before? Are you allergic to any food?" Walking closer, Usher noticed that Ms A was using Google Translate to help her with the answers and that many of the answers were not appropriate as she did not fully understand the questions. For instance, Ms A did not seem to understand the difference between the English word "pregnancy" and "miscarriage". Also, she wrote down "shell" for her allergy but then clarified that she was allergic to all kinds of seafood. Usher told me later that it was at this point that he realised that although Ms A could communicate reasonably in verbal terms, she had difficulty in reading and writing in English. Usher then sat down in the waiting area and helped her to go through the form once again, correcting some of the mistakes that had resulted from her limited English.

In this case, Usher's interaction with Ms A can potentially enhance his understanding of the relationship between health communication and patients' linguistic backgrounds. Ms A's limited communication skills in English reading and writing unveiled the complexities of understanding patients' linguistic backgrounds and their ability to enable effective health communication. Limited

English Proficiency (LEP), in the healthcare context of English-speaking countries, refers to the restricted ability to read, speak, write or understand English by patients for whom English is not the primary language (Singleton and Krause, 2009). In this case, Ms A's limited proficiency in English reading and writing affected her ability to understand the questions on the pregnancy history form. This limitation became a hurdle to effective health communication but could have been easily overlooked by her relatively proficient English listening and speaking skills. The realisation that Ms A could communicate in verbal English but not adequately in written terms helped Usher to develop an enhanced understanding of potential healthcare challenges brought about by linguistic differences.

In addition, Usher's interaction with Ms A revealed the nuanced power relations between staff and patients, as well as patients' varied perceptions of individual rights based on their own cultural backgrounds. When Usher asked Ms A if he could join her for the ultrasonic scan, she immediately said "yes" and then asked "oh, can I even refuse it?", revealing that she was not aware that patients have the right to refuse certain things in a clinical setting. She later mentioned to Usher that she had not dared to tell the doctors that she was afraid of injections, showing her deference to the healthcare professionals. It was reasonable to speculate that Ms A's understanding of her rights as a patient was partly due to her cultural background, as previous literature indicated that many cultures have an emphasis on showing "politeness" and "deference" toward healthcare professionals who are perceived as authorities (Singleton and Krause, 2009, p.3). The imbalance in the power relationship between patients and healthcare providers is more noticeable in high-context cultures (Singleton and Krause, 2009), where individuals tend to place importance on the implicit meanings behind the actual spoken words and rely on their common backgrounds to explain certain situations (Hall and Hall, 1989). High-context cultures, such as China, Japan, Italy, Spain, Greece, as well as many South American and Arab countries, have a preference for conflict avoidance and this preference can lead patients to say what they believe the health providers expect them to say (Singleton and Krause, 2009). People from these cultural backgrounds are less likely to ask questions or self-advocate but are more likely to voice agreement or show understanding regardless of whether or not they agree or understand (Singleton and Krause, 2009). This is consistent with the comments made by Indian-born interview participant, Abbie:

> Because I know in India, most people there […] They almost put them [doctors] up on a pedestal. Whatever the doctors say, it's the end of all. There's no other option, and they have given you the best. So, whenever doctors say anything to the patients, they just accept it wholeheartedly, which in one way is good because sometimes the doctor does give the best advice. But then in other ways, it's not so good because it can lead to a lot of malpractice issues. Doctors can almost manipulate their patients in a way to get them to do certain things. But then when you come over here, you find that patients […] view the doctor as like […] the bearer of knowledge or whatever. But then they also view themselves as equal participants in decision making.

The diverse student body also increases workforce diversity, consequently contributing to the organisational CC of the hospital. Students' interaction with patients potentially balances the power asymmetry between clinicians and patients as they contribute their values and understandings through participation as training members of the professional team. Their participation also bridges the gap between individual practitioners and the healthcare organisations as demonstrated in Ms A's case. Nevertheless, a downside is that these occurrences can potentially burden students from multicultural backgrounds. In the focus group, participants mentioned that medical students with ethnic minority backgrounds are prone to encounter dissimilar levels of hospitality from patients, both positively and negatively. Whilst two participants mentioned that they have heard anecdotal cases of their colleagues encountering racist patients, three participants with ethnic minority backgrounds mentioned that they have had experiences of being over-welcomed by patients of similar cultural origins. This easily bestowed trust to healthcare professionals with a seemingly close cultural origin explains to medical students how patients' cultural backgrounds can affect their interaction with healthcare professionals and consequently, influence the quality of care. It also reveals the fact that students can shoulder extra "burden" merely based on their cultural backgrounds. According to Walter, a Pakistani British who has lived in East London since he was born:

> A lot of patients think I'm Pakistani Muslim, fair, and a lot of people think I'm Hindu-Indian, and patients would be super friendly. […] They would come out to you and just start speaking Urdu or Hindi, and then, luckily, I can speak it. So, I would speak to them, and they would want to just stick with you and just talk, even more, they'll tell you what's going on at home and personal things as well. Sometimes you're busy like "I really have to go and get lunch". [But] they're like "oh you can understand obviously". Sometimes patients who are joking like "I've got six sisters. You obviously know what it's like". And I'm like "yeah, yeah, having a big family". I think me just my ethnicity, and my last name is Khan, so they'll be so friendly to you, if you're like the same ethnicity. Even if they're older or there's generations thing. [Even] if it's a woman. But if you start speaking in Urdu, they'll be, they'll be really friendly. […] They will say anything.

6.2.3.2 In-depth exploration: re-thinking multilingualism

Results show that students can enhance their understanding of the relationship between developing cultural competence and multilinguistic competence by interacting with patients. On the one hand, it is not difficult to understand the assumption that speaking different languages can contribute to communication with patients from diverse cultural backgrounds. In most cases, sharing the same language can ease communication not only because it removes linguistic barriers but also because the experience of learning a foreign language can make individuals more aware of the potential communication barriers. According to Usher, he was able to spot Ms A's English language difficulty not only because he speaks Spanish but also because learning Spanish makes him understand the Spanish culture better. Usher emphasised that learning new languages is a good way for people to develop CC. He further commented that learning new languages can widen students' horizons to other cultures and expand their constrained thinking patterns:

> Even if you don't find that you're using that language every day in your everyday medicine, the idea that you have an appreciation that not everybody speaks English. [Knowing that] the same words can mean completely different things in different languages, I think helps. […] Because you can't learn a language without understanding that, you know, they [people using that language] have a different culture. My closest friend is from Finland and in Finnish they have twelve different types of words for snow. Because in Finland it snows every day. That gives you a sense of the culture of that country as well. So, I think definitely learning languages is an excellent way to learn cultural diversity.

On the other hand, students are likely to explore the nuanced relationship of being multilingual and being culturally competent by interacting with patients. Being multilingual can contribute to one's CC in some cases; nevertheless, it is never a prerequisite or a guarantee of CC. Speaking a foreign language does not necessarily mean that one can communicate fluently with a native speaker in medical terms, which are highly demanding and allow for minimal errors. My observation participant, Mandy, shared with me cases in which her clinical partner could speak the native language of a patient on a daily conversational level but was unable to communicate in sophisticated medical terms. Moreover, being culturally competent does not require one to speak the language of a linguistically different patient as many fundamental values are universally shared across cultures. Mandy explained to me her understanding of the relationship between being multi-linguistically competent and culturally competent:

> I don't think language is that much of a barrier, because [like I mentioned] you can use translators or there [are] always ways around it, like hand gestures and stuff. For example, I was helping out for–it's called Bedside Fun. It's basically we go to hospitals and we just entertain children who are in hospital for long-term conditions. Seeing the children interact with each other, despite they're coming from different places, sometimes they can't even understand what each other is saying. But still, when they play, they are like no different. I think that has helped me a lot because I used to think they've got a language problem [most children do not share the same language; some children have delayed speech development] they won't be able to play with each other. That really showed me, opened my eyes, to think that language isn't the only way we can communicate. We can communicate with hand gestures, facial expressions. Our tone is [also] important.

6.2.3.3 Knowledge acquisition: learning cultural practices

An integrated synthesis of my observation and students' viewpoints extracted from the interviews and focus groups shows that students can acquire cultural knowledge or learn cultural practices through interacting with different people in the clinical setting. When interacting with patients, students have opportunities to explore patients' cultural backgrounds in-depth and to acquire knowledge that might be relevant to patients' health. For example, when Simon and Andy were interacting with patient Ms B, the patient shared with them the Irish traditions when welcoming new-borns. Cultural knowledge can also be acquired through interaction with doctors and nurses. When Simon and Andy were rotating in the postnatal ward, they were informed by the doctors that families might have different cultural birth rituals to welcome new-borns, thus it is important to communicate with the parents-to-be beforehand. As for nurses, taking Harry's case as an example,

the knowledge and skills that the senior nurse shared with him helped him enhance his CC when working with child patients. Meanwhile, the conversation he had with the nursing team afterwards enabled him to understand the culture of the Children's Hospital and how to effectively collaborate with different members of the team. The knowledge he has gained regarding the different working styles of each clinician allowed him to enhance his interprofessional working skills, which can contribute to the team-level CC.

> Fieldnote: While waiting for a patient, Harry went out of the clinical room and spent some time chatting with the nursing team from whom he learned about the history of Children's Hospital and the culture of the local healthcare team. It was allowed as this was an extremely quiet morning. The head nurse introduced to Harry the history of the Children's Hospital since the Second World War. She also shared her own working experience since 2007, a very different environment compared with nowadays. She mentioned to Harry how her duties as a nurse have changed over the years and how the hospital has become a much busier place than it used to be, regardless of the exception that day. The head nurse even mentioned to Harry lots of the challenges the hospital was currently facing. As the number of patients is increasing annually, the hospital does not have enough space to accommodate patients. Doctors are constantly fighting for clinical rooms. More linguistic and cultural challenges are brought by the growing number of international child patients, whose parents travel all the way to London to treat their children's rare diseases.

In the interviews and focus groups, students used examples to explain how they could potentially acquire cultural knowledge in clinical placements, covering cultural topics such as religion, spirituality, life and death, ethnicity, diet, sexuality, gender and family cultures. Table 22 presents some of the students' views collected from the interviews and focus groups.

Table 22 The acquisition of cultural knowledge in clinical placements

Cultural topics	Data source	Participants' quotations
religion	focus group	Jun: The biggest one might be religion, quite a lot of different religious backgrounds in the hospital, like the Jehovah's Witness. So before you even see the patients you can just talk to the medical staff, see what their [patients'] stances are, so then when you interact with the patient, you're not just going in there completely blind, you have something to talk to and connect with them. And I think those are quite important knowledge to learn, and you can offer some because we all have different cultures and different belief systems. […] So, when you're talking to a patient you might be able to connect more easily.

spirituality	interview	Ross: For example, some people will have, hallucinations, they'll hear voices, but because of their cultural background, they will think that it's God, or that it's the devil or that it's a demon or something, or a Jinn or something like that […] And so they were, in psychiatry, they [clinicians] were excellent at talking about that, and saying, you know, for some people, it is normal. It is considered normal in their culture for, for people to have certain experiences and so you need to be aware not only of, the symptoms, but you need to be aware of their cultural background. […] And is what they're experiencing congruent with the background or is it incongruent?
death rituals	focus group	Kyle: When I was in hospice and I was reading through how to treat patients after death, and they go through the different religions. I was quite shocked by the differences that there were, because […] it never occurred to me that you had to treat them differently.
ethnicity	interview	Abbie: I think for my GP, the population is more the older, more Middle Eastern, African Caribbean population, so I'm exposed to more of those cultures in my GP, knowing that this population is more likely to get certain types of diseases.
diet	focus group	Simon: I was going to this patient with a rheumatoid with the pain on the knees and […] chat about the history. We [with his clinical partner] asked about the diet and then he said, "oh it's African food". It wasn't, it wasn't the main point of what I was trying to find, but in those cases, you get a passive sparkle, and you have to actively decide to "oh let me investigate that a bit more" because I'm curious, I want to know a bit more about it.
sexuality	interview	Rachel: For the LGBTQ community, there are going to be new terms literally every year, and it develops so quickly. It's not only about knowing all the new terms. Of course, it would be fantastic if you can. But it's more about knowing the healthcare consequences that different sexualities [can have], not assuming things based on take-it-for-granted grounds. For instance, one typical example is that people often assume, if you are a lesbian, then a smear test would not be necessary.
gender	interview	Arka: Gender. Normally people only think of the sensitivity of gender when talking of religions, for example, you need to be super sensitive when communicating with Muslim women. Always ask for consent first. […] But nowadays, to address gender issues, one also needs to attend to issues of sexuality. Future doctors like us need to understand the fluidity of gender, for example how you address the gender issue if your patient is a transgender person.
family culture	focus group	Emily: I've heard some really interesting things about how […] patient and their families' atmosphere [differ] based on culture. We've had [the experience]. [For example,] in some cultures, some families might prefer you don't tell the patients themselves about their diagnosis, but instead sort it with the family? Which is like completely against what we automatically thought in the UK? Also, [in other cases], if somebody is in hospital their family might like to come [to visit]. And ten different people might be on the ward at the same time. And then they're like super important to them.

Furthermore, students mentioned that they can deepen their understanding of the relationship between cultural knowledge and cultural stereotypes through accumulated interaction with people in the clinical setting. In the individual in-depth interviews, 13 participants expressed their willingness to acquire more cultural knowledge. In the focus groups, participants acknowledged the necessity of knowledge acquisition but added that merely gaining cultural knowledge cannot guarantee culturally appropriate practice. They also mentioned being culturally competent requires individuals to constantly self-assess their own assumptions, bias and stereotypes towards other cultures. Both acquiring cultural knowledge and challenging cultural stereotypes are essential components of CC development, but how to distinguish cultural knowledge from stereotypes is essential. To explain, acquiring cultural knowledge can be the first step to learn about an unknown cultural topic, as individuals who are willing to develop CC but have limited prior understanding of certain cultural topics desire to gather some baseline cultural knowledge. Interview participant Arka, for example, emphasised her desire in gathering knowledge on cultural topics she was not familiar with because she does "not want to suggest things that are obviously non-relevant". However, the challenge is that some less culturally competent individuals tend to adopt a relatively reductive approach by equating developing CC to simply acquiring cultural knowledge, without knowing the nuances between cultural knowledge and cultural stereotypes.

The intrinsic complexity between cultural knowledge and cultural stereotypes was emphasised by three interview participants. Rachel, a student representative involved in organising diversity events in the Student Union, expressed that culturally competent individuals tend to constantly reflect on their acquired knowledge to avoid falling into the pitfalls of cultural stereotypes:

> [One need to] stop for a second and think about your assumptions and your own biases are something that is not limited just to cultural competence in the clinical practice. […] There are many other things and factors which doctors often assume. There are sometimes mistakes to the assumption but being able to, be aware of that, will help you out like… not fall into this pitfall of stereotypes.

6.2.3.4 Hands-on practice: enhancing clinical communication

It is observed that interaction with people in clinical placements also contributes to medical students' clinical communication. When interacting with patients and their family members, students are likely to enhance their clinical communication by developing skills such as respectful questioning, the use of unsophisticated language, verbal and non-verbal communication, and the arrangement of interpreters when necessary. Practising these skills can contribute to the provision of care that is beneficial, safe and satisfying to the client. Through accumulated interactional experiences, students may constantly refine their communication with patients and their family members. For instance, when Usher noticed that Ms A had limited English reading and writing skills, he explained to Ms A

the clinically relevant questions in lay language and used body gestures to facilitate her understanding. The benefits of improving clinical communication by interacting with patients are mentioned by Amanda:

> So verbal communication. But a lot of people, like me, aren't aware of how fast they talk. But you tend to realise this when you communicate more with patients. You will learn to be quite clear about the words, that's definitely something that people can practise. […] And communicating in lay languages, like clearly and slowly.

In addition, experienced clinicians cascade communication-related information to medical students, which information sometimes includes advice on how to address culturally sensitive topics. The focus group participants agreed unanimously that they have received useful tips from clinicians in eliciting sensitive information from patients. According to Andy:

> We definitely have been taught how to phrase or ask some sensitive questions. We phrase these questions as the questions we ask everyone, and that is mostly for smoking, alcohol, and drugs because some people may feel a bit reluctant in saying that. […] Again, we phrase these questions [potentially culturally sensitive questions] as routine questions [we ask everybody]. For example, I think with the psychiatric thing there is a lot of social stigma in various cultures when people have mental diseases and stuff. That could be something where if you think about it. Suppose a patient has a mental issue, you might need to tailor your words in a better way or make sure to explain what [is] actually going on, what you really mean, rather than what they think you mean.

However, although information cascaded from clinicians on communication is generally useful, students need to view the information in a contextualised setting instead of viewing them as rigid guidelines. In Andy's case, although he has acquired the skill to "neutralise" potential culturally sensitive topics, I felt his abrupt question regarding a couple's preference for the gender of their new-born child was culturally insensitive.

> Fieldnote: Growing up in a culturally diverse country such as Singapore, Andy seems to consider himself quite culturally competent and has taken a rather simplistic standpoint to view culture as only including race and ethnicities. Nevertheless, as an outsider, I believe the opposite. Shadowing him I witnessed Andy asking insensitive questions regarding a couple's preference for their new-born child's gender, a possibly sensitive topic for people of certain cultural backgrounds. After a clinician introduced Andy and Simon to a 32-year-old new mother who delivered her fourth baby [all girls], Andy asked the couple the gender of the baby. Learning it was a girl he followed by saying "Is that what you've hoped for?" At that point, the atmosphere suddenly became awkward and the mother switched the conversation to another topic.

This abrupt inquiry is partly attributed to his lack of sensitivity in understanding gender as a culturally sensitive issue. This is evidenced by my subsequent interview with Andy as he deduced culturally sensitive topics to only include patients' marital status, alcoholic or smoking history, and the use of recreational drugs. He also implied that to become culturally competent, healthcare professionals just need to frame the above-mentioned topics by saying that "these are the standard questions we ask every patient". However, although the tips are routinely useful, the way Andy viewed them as a "tick-box exercise" has potentially led him to behave in a mechanical and reductionist manner to

develop CC. Andy's case shows that the development of cultural awareness, attitudes, knowledge and skills are interrelated. Whereas students' high level of cultural awareness and positive attitudes can lead to their reflexive acquisition of cultural knowledge and skills, a limited level of awareness and insensitivity can reinforce students' rigid intake of knowledge and skills, sometimes even leading to cultural stereotypes. The latter compromises students' CC development and patient care.

6.2.4 Reflection

Results show that reflective learning is another approach for students to develop CC as reflection may help students to actively self-assess their CC levels and internalise the significance of CC development. This also means reflective teaching as a pedagogic approach may trigger students' reflective learning, moving CC as surface learning into deeper learning. Two types of reflective teaching were observed: the interactive group reflective activities taking place in the afternoon workshops and the individual self-reflection that was prompted by writing assignments. The afternoon workshops were theme-based and led by clinicians who utilised different resources, such as videos and card games, to facilitate the discussion of a predefined theme relevant to human development. The themes for the six afternoon workshops were fertility, pregnancy, birth, growth, development and adolescence. In the workshops, students took turns to present a case of a patient they had encountered in the morning ward rounds for discussion. Although the focus of the workshops was on the clinical perspectives of medical cases, what was discussed varies depending on the topics and facilitators' styles. Cultural issues may be discussed if relevant. For example, in the workshop themed "development", the clinician emphasised the cultural knowledge that children's cultural backgrounds can potentially influence their development as children growing up in bilingual/multilingual backgrounds might be slow in terms of speech and development. These workshops offer opportunities for students to interact with their peers to share their experiences and to interact with clinicians and ask questions. Within a safe environment where individual culture and group dynamics are at play, students might enhance team working and communication which can further contribute to their CC.

Reflective learning also takes place when students are assigned with writing assignments (e.g. portfolio assessment, reflective pieces) in teaching sessions under different blocks. The writing assignments allow students the freedom to choose a wide range of issues including cultural topics. Unconscious learning may surface if cultural topics are chosen. When working on the assignments, students may actively reflect on their clinical experience in relation to cultural issues and self-assess their own CC, which process may enhance their cultural awareness. Two interview participants mentioned that by working on a reflective piece for the Human Values block as part of their

assessment, they were able to relate their experiences to CC development by reflecting on their cross-cultural encounters with some culturally diverse patients.

> Fieldnote: Through conversation with students I noticed that another potential way for students to develop their cultural competence is by writing reflective portfolios/pieces as part of their assessment. As the medical school uses reflective writing to assess students' learning in value-based medicine (among which cultural competence is a learning outcome), students mentioned that the writing process enabled deep thinking of their previous learning experience and encouraged them to reflect on a range of issues including CC.

6.3 Diverse learning in clinical placements

The results of the ethnographic case study show that students' learning in clinical placements is a complex and messy learning journey. Their CC development is a co-constructed learning process through medical students' interaction with patients, clinicians, themselves and exposure within the wider healthcare environment. This is evidenced by their diverse engagements in the clinical setting, such as their length of placements, the support they have received and the number of patients they have interacted with. Previous literature shows that students' learning experience in clinical placements varies based on a range of factors (Löfmark and Wikblad, 2001). Facilitating factors include taking up reasonable levels of responsibility and independence, having opportunities to practise, receiving useful feedback and encompassing a comprehensive understanding of clinical encounters and the practicing healthcare organisation. Obstructing factors that were identified include insufficient or discontinued support for clinicians as supervisors, lack of opportunities to practise, and students' perception of self-insufficiency and low self-reliance. Results from this study confirm that these elements have an impact on students' CC development. They particularly point out how their learning can be influenced by luck, their personalities and individual initiatives.

"Luck", a term by some participants in this research, defines whether students possess sufficient opportunities to practise in clinical placements. Students' "luck" is influenced by factors such as patients' willingness to interact, the continuity of supervision from staff and the organisational environment of a healthcare institution. According to Mandy, her clinical experiences at the hospital were generally well-organised but sometimes depended on "luck". For example, she had an "unlucky" morning the day I followed her as she had limited opportunities to interact with patients. One patient even declined to have a conversation with her because the patient was feeling low and "did not want to talk". This lack of opportunity to practise was also experienced by Harry, whose rotation day was followed by a public holiday with few patients turning up. The length of his placement was extremely short because Harry decided to prioritise his preparation for a coming examination.

> Fieldnote: Harry scheduled to practise at the Children's Hospital to explore the theme "Growth". After observing the senior nurse conducting measurements by using a machine, Harry wished to

practise the skills but was not lucky enough to do so on this occasion. There were surprisingly few patients that day. The senior nurse speculated that this was possibly because some people were still on holiday as it was an early morning after the Easter Bank Holiday. However, after waiting for one hour and a half and seeing no sign of any patients, Harry decided to call it a day at around 10:40 am. As it was the examination period, Harry said that students expected to finish their placements early so that they can make time to prepare for the coming exams. Harry also mentioned that students' experience varies significantly depending on lots of unpredictable factors; however, there are no detailed guidelines for them to follow. He deemed that students' learning experience also depended a lot on their own initiatives and judgment to utilise opportunities. As for today, he decided to finish his placement early as he thought it would be more productive to use the time to prepare for his examinations rather than waiting there with nothing to do.

On the contrary, Usher had a "lucky" morning as he was able to observe four consultations and interact with three patients. However, Usher's fruitful morning for his weekly theme "Fertility" at the Early Pregnancy and Acute Gynaecology Unit was not planned, which further reveals that "luck" is one element that can lead to students' varied learning experiences.

Fieldnote: The Early Pregnancy and Acute Gynaecology Unit is a nurse-led specialist unit providing emergency care for patients with acute gynaecological problems or having problems in early pregnancy. Patients are either referred by their GP or self-referred to the unit. The Acute Gynaecology Unit deals with the GP referral of gynaecological problems related to the female reproductive system, and hence a good rotation place for "fertility". The Early Pregnancy Unit focuses on sudden problems in early pregnancy, such as pain, bleeding or severe vomiting, and is arranged for the theme of "pregnancy".

It was very busy when we arrived at the Acute Gynaecology Ward at 8:55 am. Clinicians and nurses seemed very occupied and Usher had only a quick opportunity to introduce us to the nurse-in-charge. Knowing that Usher wanted to practise taking history with a patient, the nurse gave him a list of patients' names and suggested that he could try talking with the patients in Bed 11 and 13. However, not being able to find either Bed 11 or 13, he then returned to the clinician to ask for guidance. Constantly been called upon and dragged away by different colleagues, the clinician suggested, "We probably don't have much for you here this morning. Why not you try the Early Pregnancy Unit next door?" This officially turned Usher's "fertility" week theme to "pregnancy", which was planned for next week. However, moving next door to the Early Pregnancy Section was not a bad choice at all, because Usher had an extremely rewarding morning and interacted with six patients supervised by two senior nurses.

Rotating in the same block (Human Development), the shadowed five students had different learning experiences. Apart from the extremely "lucky" or "unlucky" students, Andy and Simon's case showcased a typical clinical day.

Fieldnote: putting on their white coats and line yards, Simon and Andy started their placement by meeting at the Postnatal Ward on the 7th floor of Hospital A at 9 am, ready for the theme week on "Birth". The ward was busy since early morning. Heavily pregnant women in hospital clothes hobbled around, with their family members constantly passing by the corridor. Staff dashed around. Crying of new-borns was constantly heard. This was not a relaxing environment, but most people seemed happy to welcome the coming of new lives. Occasional conversations could be heard from nurses checking with their colleagues about the conditions of patients, touching on patients' medical records, language backgrounds and conditions of recovery.

Simon and Andy were guided by a senior clinician to take a history from two patients. The first patient was a 32-year-old woman who just had a Caesarean section. The second patient was a 29-year-old woman who had an episiotomy during childbirth. Simon told me their typical clinical day was to spot opportunities to take histories from patients, and then to look for available clinicians to

> ask questions. He said one consultation was normally required for each student for one clinical day, but he always felt that he needed to take at least two patient histories to make him feel "complete". He also hinted that students' experiences in the clinical placements largely depended on their own initiatives as there were no clinicians or nurses to oversee students' attendance or engagement in a busy clinical setting. The only time to check students' attendance was during the afternoon workshops between 2 pm to 4 pm when students took turns to present a case they had encountered in the morning.

In addition to luck, three interview participants mentioned that their "personality" is relevant to their potential cross-cultural encounters as they believe outgoing and confident individuals are easier to connect with patients. The phenomenon was also demonstrated in my observation as more outgoing and extroverted students were seen as easier to build rapport with patients. For example, Usher and Mandy had contrastive learning experiences while rotating in the same ward. Their learning experience is partly attributed to their "luck", but also partly due to their personalities. This is because while Usher considered himself an outgoing person who enjoys talking with others, Mandy appeared relatively nervous and introverted in her placement:

> Sometimes the biggest barrier is, it's either the patient not being happy with a medical student seeing them, which you can't really help. […] The other one for me is that especially you know just me as a person, […] I'm a bit timid, not quite too keen on asking the patients for something if I'm not pushed for half the time.

Participants also mentioned that the self-reliant nature of clinical placements means that students' levels of willingness and initiatives in engaging themselves with cultural topics can also affect their learning. Although the opportunities to explore cultural differences are huge, willingness to take initiative to utilise the diverse opportunities varies substantially. Despite the fact that most participants recognised that their experience in clinical placements offered them opportunities to enhance their CC, a lack of incentives in developing the traditionally believed "soft skills" (Joubert et al., 2006) was observed among two participants. For example, Karen said:

> In our placements, this just involves us talking with patients most of the time. I have seen patients from different places, different cultures, but when I talk to them, it's a lot about their personal life and their condition. They rarely go explicitly to their culture and stuff, so I guess the difference is not something that comes in front of my brain when I talk about it. […] I do acknowledge there are cultural differences, but it's not something [that] is imperative to me, or to the scenario… So, I talk to patients, I ask them, take the history, take the social histories, where do they live? who do they live with? how is their family? what do they do? what is their job? And that's it.

In addition to my observation in the hospital environment, I used interviews and focus groups to explore students' learning in the primary care setting. The focus group participants agreed that their learning experiences in the hospital setting also applies to the primary care setting. Four interview participants mentioned that their placements in General Practice (GP) clinics could benefit their CC development markedly, as a GP clinic is often exposed to a specific region with certain cultural or demographic characteristics. Moreover, the nature of primary care allows students more

opportunities to observe clinical consultations and to interact with patients. It also requires deeper interaction with patients as a consultation in the primary care setting normally requires further exploration of patients' medical and sociocultural backgrounds. According to interview participant Penny:

> Actually, I would say that kind of cultural thing probably comes up more in GP, because you deal with a lot of social issues particularly in the GP. They have time, and often, you know, multiple members of the same family will be registered at that GP practice, so the GP I imagine over time would have to deal with the culture that is within that family, and that culture may be very different from the GP's own culture.

6.4 Summarising students' CC development in clinical placements

This section summarises medical students' learning in clinical placements that may contribute to their CC development. The learning environment in the clinical setting is busy, stressful, generally unpredictable, but full of learning opportunities. The analysis identifies that CC can be developed by medical students via immersion, observation, interaction and reflection. Immersion in a working environment, where diversity is manifested through the exposure to diverse workforces and patient populations, is shown as useful to raise students' cultural awareness. Observation of culturally appropriate or inappropriate practices enables students to enhance their cultural attitudes and develop their practical skills, including clinical communication. Interaction with other professionals, peers and patients, allows students to integrate attitudes, knowledge and skills into real-time care provision. Reflection, occurring both at the group level and individual level, helps students to actively think about culture's impact on health and to internalise the significance of developing CC.

The analysis highlights that students develop their CC both consciously and unconsciously in the clinical setting. Vast learning opportunities that may contribute to students' CC exist, offering them diverse learning experiences. It also begs a further question. Medical students, a group of people who are traditionally known as academically achieving and non-academically versatile, tend to engage themselves with diverse extracurricular activities. Therefore, in addition to the structured teaching at campus and clinical placements, can medical students develop their CC via extracurricular activities?

7 CC development in extracurricular activities: hidden in plain sight

> Paige (born and raised in the UK) shared with me some photos taken when she and her family attended her cousin's wedding in Mumbai, India. It was a grand wedding that lasted for a whole week, with different ceremonies scheduled for each day. Paige explained to me the cultural meaning behind the costumes the bride and her families were wearing, their Bollywood dancing, and the food served at the banquet. She also explained to me how to choose and wear traditional Indian dresses, as well as the meaning of Henna tattoos that the bride and many other girls had on their arms. As an Indian British who grew up in London, Paige said this was the first proper wedding ceremony she has attended in India. This experience opened her eyes to many previously unknown Indian cultural customs and strengthened her sense of belonging to the Indian community.
>
> Fieldnote, 24 November 2017

Outside the educational setting, students receive information from different sources and interact with people of diverse cultural backgrounds. This means students' extracurricular activities may have an influence on their development of cultural competence (CC). It also means the process of educational socialisation and students' exposure to medicine's informal and hidden curriculum may begin well in advance of students' formal entry into medical schools. This chapter describes students' experiences and views to illustrate how they can develop their CC in extracurricular settings. Starting with the presentation of a purposely chosen case to make sense of students' extracurricular life, this chapter discusses what extracurricular activities are available and how these activities may contribute to students' development of CC. The limited role of extracurricular activities is also discussed before giving a chapter summary.

Students' extracurricular activities take place in a flexible and fluid environment but make up a significant component of students' daily life, sometimes influencing students' learning in a hidden and implicit manner. Dante's case is presented to unveil how students can develop their CC in the extracurricular setting. His example shows that students can enhance their CC by taking part in culturally relevant student societies, such as a Japanese cartoon society. Although Dante's case only reveals a tip of students' extracurricular life, it sheds light on understanding students' experiences in general.

> Fieldnote: Born in a small city near Venice, Italy, Dante is an international student whose parents immigrated from mainland China to Italy over two decades ago. Italian is his native language, but he can speak other languages fluently including English, French, Spanish and Mandarin. He also started to learn Japanese. After agreeing to be shadowed for an entire day, Dante provided me with a list summarising his typical events on a weekly basis in Year 2. Perhaps having inherited the "modest" manner from his Chinese family background, Dante constantly "apologised" to me that he has a more "boring" life compared with other medical students. However, I noticed from his timetable that apart from his busy academic training, Dante attends a Japanese cultural society every Monday evening, practises mock OSCE with his peers every Wednesday afternoon, and plays Badminton in a sports society every Thursday evening. He also has a part-time job during weekends to teach maths

> to a student who is preparing for his General Certificate of Secondary Education (GCSE) examinations. With Dante's permission, I followed him on a Monday to learn about his experiences in the Japanese cultural society.

On our journey to the auditorium where the Japanese cultural society was based, we had a conversation from which I noticed Dante is a culturally reflective person. When asked whether his parents planned to visit him in London in 2018, Dante replied with a negative response as he thought it was not a good time because of the frequent terrorist attacks (e.g. the London Bridge attack and the Westminster attack) in London in 2017. While I invited Dante to comment on the frequent occurrence of the terrorist incidents, he said that he considered these terrorist incidents were particularly attributed to "a possible lack of cultural understanding", instead of the frequently mentioned "backlash of diversity". He mentioned that cultural stereotypes still largely exist in the contemporary globalised society and these stereotypes can potentially add to the global tension. He gave an example by saying that sometimes an added layer of meaning is attached to someone wearing a Hijab. He also commented on the potentially different perceptions of CC among medical students over the years. He said many medical students in earlier years, including some of his peers, did not consider CC a priority as many of them have a limited understanding by simply equating being "culturally competent" to "culturally aware". This phenomenon takes place because students' limited contact with diverse patients in the pre-clinical years may have led them to believe that merely the awareness of cultural differences can guarantee one's CC. Nevertheless, after students have gained more clinical exposure and experience in working with culturally diverse patients, they may encounter cross-cultural challenges and start to develop a renewed understanding of the importance of developing CC. As explained by Dante:

> As medical students, we might be confusing being culturally competent with being culturally aware. We have an idea about what should be done, and how we best treat the patient in an ideal world but fail to apply it to the highly dynamic clinical context. That might be when we realise [the need for developing] such competence to best deal with patients at a later stage of our study.

Arriving at 6:20 pm at a university auditorium, I was surprised to learn that Dante suddenly shifted his identity from a medical student to the president of the Japanese Cultural Society. However, he mentioned none of this to me but only said this would be a "boring" movie event, possibly again because of his modest personality. Students came in one after another, with some chatting and holding cups of bubble milk tea, a popular drink in East Asia. Around 20 students joined the event, representing a widely diverse ethnic group including whites, blacks, Indians and a few East Asians. It seemed that these students knew each other well as they were chatting happily before the event started. Dante, as the president, announced that they were going to organise a networking event afterward and have dinner in Eat Tokyo, a well-known Japanese restaurant in central London.

The event involved watching Japanese cartoon clips. I later learned from Dante that the members of the society are interested in learning Japanese or learning about Japanese culture, and this built the common interest. Four Japanese cartoon clips were shown to the students in the Japanese language with English subtitles. It was observed that the students were in extremely high spirits when watching the cartoons. In particular, when there were subtle romantic scenes shown through a Japanese cartoon style, normally with a female cartoon figure having blushing cheeks or speaking in a tender voice, some students would applaud and break into cheers. Before the end of this event, students formed into random groups and had a heated discussion regarding the cartoon characters, the content and the parts they enjoyed the most. They also decided on the cartoons they planned to watch the following week, with one student volunteering to bring the videos and do some editing to make it fit the time available to them. Although this event was primarily about watching Japanese cartoons, Dante told me that society also holds events that involve learning the Japanese language, costumes, food and cultural rituals.

7.1 The icing on the cake: CC development through extracurricular activities

Dante's case is used as one example to illustrate the potential connection between students' extracurricular life and their CC development. It demonstrates how students may enhance their understanding of a cultural group or its associated cultural products or practices through the participation of student events. This section identifies and discusses students' various extracurricular experiences that may contribute to their CC development.

7.1.1 Experiencing diversity within campus: participation in societies and events

Results show that students can develop their CC through immersion in a diverse campus environment. The campus diversity is reflected in the various student events held by student societies or organisations. It is also reflected in the demographic diversity within the student body.

Gaining membership in student societies or attending student events is seen as being beneficial to students' development of CC because these activities may facilitate students' interaction with people of culturally diverse backgrounds. Results show that joining student societies, or clubs, can help improve students' understanding of certain cultural groups or cultural phenomena. Two types of student societies were identified. The first type aimed to enhance the understanding of a cultural group or facilitate networking with members identifying with that cultural group, including societies such as Indian Society, Afghan Welfare Society, Albanian Society and Bangladesh Society. Students

sharing certain elements of the cultural background join these societies to network based on their shared cultural interests. The second type features certain cultural products or practices, including societies such as the Mexican Cooking Society, the Bollywood Society, or the Japanese Cartoon Society experienced by Dante. Joining these societies can enhance students' understanding of a cultural group or its associated cultural products or practices, such as food, festivals and arts. According to focus group participant Abbie:

> I feel that's where societies come into play. […] We have a lot of, you know, […] like Indian society. We have Pakistani [Society], we have the Africa[n] Caribbean society. So, I feel it would be, it would be good to join these different societies, to go for their events, to learn more. Because you know […] even if you are from the culture, you still go to events like there are so many new things that you can learn. So, I feel like joining societies and even being part of their teams or any society where you have to interact with other people, where you have to work in a group of students, are perfect.

Results also identify that students benefit the most if they participate in events with certain cultural themes. My observation shows that the chosen medical school runs themed cultural events on an irregular basis, such as the Curry Night, Celebrating Ramadan, Challenging Racism, or Black History Month. For example, I observed an Islamic themed week where a group of student volunteers put up a stand to distribute free traditional Islamic food and introduce festivals such as Ramadan. A friendly and open environment was created for students to acquire more knowledge about the Islamic culture (e.g. the festive reasons for practices of fasting). Within the campus, there are also themed events on discussing the issue of healthcare disparity and exploring the health concerns of marginalised cultural groups, covering topics such as female genital mutilation (FGM), LGBTQ health, deaf awareness, dementia and disability. Normally with a healthcare focus, these events aim to improve students' understanding of how individuals' cultural background may influence their health. According to interview participant Timothy, the president of the Global Health Society at the medical school:

> So, my society, Students for Global Health is very much involved in raising awareness of different marginalised groups and different experiences of healthcare, by different sorts of people, whether they live in the UK or globally. So, this past year we've had events on FGM, which is mostly in the UK experienced by people from East Africa who emigrate to the UK. And, I don't know, if you go to that event and you don't know anything about FGM, then obviously you're going to get some cultural competence. You will learn that, actually, this is a cultural practice. We did a talk about racism in healthcare. The government released some figures that showed that the health of black and minority ethnic people in this country is slightly worse than the health of white people in this country. And they have worse experiences of going to the GP and going to the hospital. We had a discussion about why that might be the case and what we could do about it. […] And that's, that's the cultural competence exercise, isn't it?

Besides participating in cultural events, students expressed that they can enhance their cultural awareness and acquire cultural knowledge through immersing in a diverse student group. In Paige's case, she informed me that joining the badminton society allowed her to interact with students from different programmes, such as law students, media students and maths students. Paige mentioned

that participating in the student society events offered her opportunities to learn about the life of students undertaking other subjects. She further commented that this can be beneficial to medical students as medical schools in many universities are located on separate campuses from the main university. Interview participant Rebecca's view resonates with the views of Paige:

> I think one of the most important things to develop cultural competence is to meet people who are not the same as you, so one way of doing that is to get involved in societies which […] something maybe slightly outside your comfort zone, so you can meet different people and understand the way in which they look at the world. […] Just generally spending time with friends, discussing differences in culture and how we think differently and act differently in different situations is really important. I found that to be really good at our university, as I've said before we've got a good mixture of people, which means we can learn a lot just by talking to people and learning from their experiences. And also, we have lots of diverse societies which is really good as a way to sort of developing that cultural competence.

My view as an ethnographer, which is consistent with that of the students, is that the innate diversity within the student body also has a positive influence on students' development of CC. The chosen medical school has a large student group of over 430 medical students with each student contributing distinctive cultures and perspectives. Students with black, Asian and minority ethnic (BAME) backgrounds make up approximately 60% of the whole population. The constant mixture of peers across years and programmes enables students to interact with a range of cultural elements. As such, some students expressed that immersion in the student group can positively contribute to their CC. According to Harry:

> For example, there is a big Asian community in medicine, particularly people from the Middle East backgrounds, and areas such as Pakistan. And there are a lot of like Islam, the Muslim communities, so, then, people can understand, for example, just like "now is coming up to Ramadan", which is a big […] festival and big time that quite important time of year for them. Obviously, it will affect them because time has been wasted, their exams, they have to, for example, they have to fast during exam time, which can be difficult for them, but, if other students learn about it, they can understand how they may have to kind of adapt [to] that time so that they can… maybe revise in the evening times when they can also eat drink and stuff. […] Someone may not always be able to attend something because of [the level of] activity, and then that way you can understand. But I think, to understand that […] medical students can sort of talking to each other, and […] take advantage of the already existing diversity.

In particular, results show that immersion in a diverse student body contributes to students' cultural understanding of a wide range of health-related sociocultural determinants such as individuals' socioeconomic status. Medical schools in many western countries are traditionally dominated by students from relatively socioeconomically advantaged backgrounds (Garlick and Brown, 2008), however, the growing diversity within student groups enhances students' understanding of socioeconomic diversity. Kyle, a Year-1 medical student who graduated from Winchester College (an independent boarding school for boys following a British public-school tradition), expressed how studying in London exposed him to a more socioeconomically diverse population. Kyle's case reveals that students' individual challenges in developing CC can be affected by their previous backgrounds.

Born and living in a culturally diverse place such as the UK, cultural challenges in terms of races and ethnicities are not new for Kyle. However, partly due to his relatively secluded early education in a private boarding school, Kyle faces challenges in adapting to the cultural diversity that is rooted in a wider range of socioeconomic determinants.

> Fieldnotes: Leaving home for Winchester College at 10 years old, Kyle does not have much time to spend with his parents. Kyle excitedly shared with me Winchester's unique housing system and the 12 boys in his house. He kept mentioning that he thought many of his peers from Winchester are very self-driven and motivated, and he looked up to them. After establishing a closer relationship with me, Kyle told me some of the cultural challenges after starting university. He told me that after coming to uni[versity] he realised people can be "so different". In Winchester, students are similar in terms of socioeconomic backgrounds. However, after coming to London, he noticed that people can be different not only in terms of nationalities and ethnicities but in aspects he has not considered before. He explained by using an example how he became aware of people's diversity in socioeconomic status by saying that "for example, I go to lunch in places like Wasabi [a fast-food restaurant chain] as a daily thing, but now I realised not everyone can afford Wasabi every day. Food was given to me before as it is, so I never thought about this". Kyle further commented that this is perhaps why sometimes people say they live in "a created bubble" when studying in Winchester. As such, he has been constantly challenging his attitudes and behaviours to adapt to this new environment. He also mentioned that he purposely avoided talking too much of his Winchester background as he does not intend to make himself appear more privileged than other students. Kyle also said he is trying to achieve a balance between socialising with his "boys" from Winchester and fitting in his new friend circle in the medical school.

In addition to immersion in a diverse study body, my interpretation is that the various institutional schemes initiated by medical schools (e.g. widening participation, promoting gender equality) are conducive to creating a culturally inclusive environment, which will raise students' awareness in appreciating diversity and internalising CC. For instance, the medical school is committed to widening participation by opening up the university to underrepresented groups and supporting them in accessing higher education. Among its various efforts to diversify its student body, it has established a six-year Extended Medical Degree Programme (EMDP) in order to "level the educational playing field" by supporting students from different sociocultural backgrounds to enter the medical school. Students' views regarding the diversity-oriented institutional schemes are generally positive as they consider such schemes offer them opportunities to enhance interaction with people from more diverse backgrounds. According to interview participant Rachel:

> I definitely think the widening participation is really really good, especially in medical school. […] Because that's such a private school dominated course. They do outreach sessions, basically to poor and disadvantaged schools to talk about "Do you want to get to medical school? We are going to help you with it". You know rich kids do get private tutoring, and UK CAP [Certified Authorisation Professional] teaching that you just don't have access if you are not in a very good state school or a private school. The more diverse a medical school, almost the fewer efforts you have to put into cultural competence [training] because people will learn from their peers. That automatically goes quite a long way.

However, there is also the possibility that the institutional labelling of students with certain backgrounds may reinforce unconscious cultural stereotypes and disadvantage the group of students.

Whether the unconscious stereotypes of students with certain sociocultural features may act as hurdles to students' personal and professional development remains unknown.

> Fieldnotes: as I have interacted with more and more students for the purpose of this research, I start to notice that many of them have mentioned that medical schools are a private-school dominated subject, with most students coming from advantaged socioeconomic backgrounds. Some students have talked about the need for widening participation to "poor and disadvantaged public schools" to diversity the student body. Institutional schemes such as "widening participation" can certainly contribute to educational equality and allow students to reflect on the issues of diversity. However, whether the overt language use from the institutional level reinforces unconscious stereotypes of students from certain backgrounds and brings disadvantages to the personal development of the already marginalised groups needs to be further explored.

7.1.2 Maintaining personal relationships: interaction with friends and families

By combining my ethnographic observation and students' opinions, it becomes clear that students can enhance their CC through the maintenance of their personal connections by interacting with friends and family members of diverse cultural backgrounds. The interaction allows students to develop an improved understanding of people's sociocultural backgrounds and gradually acquire competence to interact with diversity.

Results show that students can expand their cultural knowledge by networking with culturally diverse friends. Students can also obtain a better understanding of cultural boundaries through "battering" around with their peers. In the medical school, students make friends with peers from diverse backgrounds with differences reflected in races, nationalities, religions, ethnicities, sexual orientations, dietary preferences and socioeconomic status. Taking Paige's case as an example, her "little friends circle" has a positive influence on her development of CC as she can widen her cultural focus through interacting with her friends of different cultural backgrounds.

> Fieldnote: In a workshop on clinical communication, I remember how Paige explained her understanding of the differences between "being emphatic" and "being sympathetic" towards patients. She said "being emphatic" suggests an equal doctor-patient relationship whereas "being sympathetic" implies a potentially "condescending" attitude with doctors looking down at patients with a "sorry and pitiful" mind. After I informed Paige about the purpose of this research, she said she was willing to participate and wanted to take me to experience her "little friends circle". She told me that she and her friends formed an eight-person friend group for studying and hanging out. The eight students are all medical students but come from different backgrounds including French-speaking Africans, Indians, Chinese and British. They organise lots of activities. One thing on their weekly schedule is to meet and cook every Wednesday evening. After being introduced to her friends, I joined Paige and her friends to experience their "weekly Wednesday cooking evening". As the Chinese spring festival was approaching, the Chinese girl in their group hosted a cooking get-together event to make dumplings. The dumplings they made were not perfect-looking, but all of them enjoyed the event. During the cooking process, the Chinese girl occasionally introduced other aspects of Chinese culture to their friends, such as diet, festival celebration, family relationships, and the recent development of China.

During networking events among peers, conversations regarding cultural differences may pop out in a conversation unexpectedly. Within an intimate and safe environment, students become motivated to explore cultural topics with relevance. They may have enhanced their CC implicitly and unconsciously without knowing. This view was expressed by interview participant Lilys:

> It's really informal with friends. I think sometimes it just sort of pops up in conversation, but it's not, it's not something I would necessarily, actively be like "so tell me how you experience medical care, like with regards to your culture". […] I wouldn't actively ask about that unless the topic came up. But then, because we've got friends of different cultures […] even different social class or, or wealth status, races, religions. So personally, […] when they invite their friends for dinner, or we go over to their house, it's people of different cultures. And I think that's […] that was where probably it [developing cultural competence] started.

In addition to gaining cultural knowledge, networking with friends also enhances students' understanding of what cultural boundaries are. Several focus group participants mentioned that they can enhance their cultural awareness through "messing around" with friends. In particular, "bantering" by making culturally inappropriate or stereotypical jokes unconsciously, or in a self-perceived humorous manner, helps students to develop an improved understanding of cultural boundaries. This is because those culturally incompetent remarks, when accumulated, can trigger discomfort or complaints from their friends. Investigating the reasons for such discomfort or complaints can help students to reflect on what cultural "boundaries" are. Focus group participant Damian explained how messing around with friends can enhance his cultural awareness:

> It's what you were talking about earlier about banter thing. It's that boundary thing. If you're constantly with your mates, and you messing around, you are making jokes, and you say something that's totally unreasonable, your friends will say "that's totally unreasonable, what are you doing?" […] Everyone will stop laughing and look at you like you're an [ass] and so you learn that boundary and then you learn when something goes from reasonable to unreasonable. And I think that […] if you're constantly bouncing around inside that box, you find where the walls of that box are very very quickly. If you're messing with your friends, and in some ways, you are testing the limits of your friends. [You think] it's always an enjoyable thing to do, and then at some point, they'll say, "this isn't funny anymore". That's where you stop. And for me, it's where you start developing cultural competence.

Apart from "bantering" with friends, results show that interacting with family members can improve students' CC if they have family members who are international, children, elderly, or with certain health conditions. In Paige's case, travelling back to India and spending time with her Indian relatives improved her understanding of Indian culture and strengthened her cultural identity as an Indian British. Paige also told me that spending time with her two little sisters helped her develop her CC because age is an important dimension of culture. As the oldest child in her family, she said she sometimes took the role of parenting, such as dressing up her sisters for special events or bringing them to adventure play venues. While showing me the pictures of her taking her youngest sister to "Jungle Monkey", a children's indoor adventure play and party venue, Paige said that being an elder child has improved her communication with children. She added that the communication skills she

has developed while spending time with her younger siblings, such as gestures and language use, facilitated her communication with child patients in her clinical placement for paediatrics.

If students develop long-term friendship or an intimate relationship with someone from a different cultural background, it is seen that their CC can significantly be enhanced. In Usher's case, he acknowledged that maintaining a committed relationship with his French fiance has naturally improved his understanding of French culture along with his CC in interacting with French people. Similarly, in Harry's case, as he has been with his Chinese girlfriend for five years, he has acquired paramount cultural knowledge about China and Chinese culture through frequent contact with his girlfriend's friends and family members. Both Harry and Usher agreed that the cultural competence they have developed through their personal relationships can be applied to interacting with people from different backgrounds as that would require a similar set of mindsets and skills.

> Fieldnote: Harry considered London a fantastic place to study medicine because of its tremendous diversity. He deemed that medical students in London are exposed to a diverse range of population and diseases which medical students who study in relatively homogenous places normally do not have access to. Harry mentioned that, other than English, he can speak French, German, and conversational-level Mandarin. He also explained that he chose to study Mandarin at a later stage because his girlfriend is Chinese. I found Harry almost an "ambassador" for Chinese culture. He is very familiar with many Chinese enterprises in London. He also introduced me to lots of reputable Chinese restaurants in London.

Particularly, it is noticed that students can develop their clinical CC if they have previous contacts with family members who have certain health conditions. In the focus group, one participant brought up an incident where his clinical partner made inappropriate remarks toward a child patient with Down Syndrome by commenting on the child patient as "not too rare cases perhaps in your neighborhood and would be manageable for your family with some support". These remarks made the child patient's mother anxious, but his clinical partner was too insensitive to notice this. The student, who has a cousin with Down Syndrome, understood the efforts a family needs to make to care for a child with Down Syndrome, and therefore chose to apologise to the mother on behalf of his clinical partner. He also kindly reminded his clinical partner afterward by saying "my dude, you have to be a bit careful". This incident aroused a heated discussion among the focus group participants about how having prior contact with people with certain health conditions can help them with their CC development. They said living with someone with certain healthcare conditions, or cultural preferences, provides them with "a person of reference" because the referenced person can act as a marker for students to start learning about certain healthcare conditions or cultural phenomena. Participant Rajesh used his friend's experiences to explain that living with a family member with Down Syndrome, or even hearing about the experience, can improve students' competence in dealing with patients of similar health problems：

> Like your example of Down Syndrome, one of my friend's brother has Down Syndrome. She knows all the stuff around what's the situation to how to live with Down's, their suffering, and the associated health problems. […] So when you talk about Down's, obviously you affect her. Then you know "ok maybe I should tone down what I'm saying", or like it's not reasonable and then in that situation, you would know "yeah, I shouldn't say this, my bad". But, of course, your clinical partner wouldn't have had that [experience]. So, he wouldn't have known, "oh it's not a nice thing to say that to the mother or the child".

7.1.3 Reaching beyond campus: exposure through working and volunteering

Students expressed that professional work, including both part-time jobs and volunteering, allows students the opportunity to interact with people of diverse backgrounds, consequently adding to their CC. The benefits of having professional experiences are not only present when students work in health-related areas but are also noticeable when students work in non-health related fields. Through gaining professional experiences, students can enhance their cultural awareness, acquire cultural knowledge and improve cultural skills at an individual level. They can also enhance their understanding of team-level cultural competence.

Results show that part-time work or volunteering in non-health related fields affords opportunities for students to interact with culturally diverse people. Through the interaction, students can gain a nuanced understanding of how people might respond to things differently and develop skills or techniques to deal with the multifaceted differences in a culturally appropriate manner. Kyle's volunteering in the university museum shows how students can have extracurricular opportunities to explore cultural differences in an unplanned manner.

> Fieldnotes: Shadowing Kyle on a Wednesday, I observed that his job is to re-catalogue items in the natural history section with another volunteer, also his Winchester friend who studies at another university in London. With over 800 items to catalogue, Kyle and his friend were quietly doing data entry and item re-allocation surrounded by skulls of different mammals such as wombats and cow bones. This was a quiet working environment until another volunteer, an Indian girl, came to them for a random chat. The girl shared with Kyle some recent popular music. She also invited Kyle and his friend to attend an event on celebrating the Holi Festival, a major Hindu festival. The Holi Festival is also known as "the Festival of Colours", where people smear each other with colours and drench each other. Kyle told me later that this would be a fun way for him to experience the Hindu culture and joked by saying that the girl invited him and perhaps her friends only wanted to throw colour paint at him.

As for working in non-health related fields, the most frequent examples students gave are volunteering or part-time work in religious organisations, business outlets, educational institutions and public entertainment places. Examples were chosen from the interviews to demonstrate how professional involvement in the above mentioned four places can contribute to students' development of CC (see Table 23).

Table 23 CC development through professional working in non-health related fields

Theme	Data source	Participants' quotations
Religious organisations	Interview	Mikul: So, I volunteer with my local temple but also my local community as a whole. I used to do loads of work with the youth community in Brent. I think that definitely helped […] because obviously Brent, as all the other London boroughs, is very, very diverse in all aspects. One of the things I did was mentoring kids. And it's so important to be able to have that cultural competence [to] be able to mentor properly […]. I think that helped me a lot more than any other kind of medical education thing. And the stuff with the temple, there's a lot of outreach stuff. I teach a group of kids every Sunday for a language and also for just general culture. Those kids all come from different backgrounds. It's even more important because they […] because they're Year 1 kids, age five, age six. A lot of communication is nonverbal rather than verbal. And there's a lot more hands-on teaching. […] Community likes to make sure you have rapport with the child so that communication comes across effectively.
Business outlets	Interview	Ross: I do volunteer at a local bike shop. And because of where I live, there's a lot of people from South America. There are a lot of Colombians. So, for them, I think the cultural competence in medicine is more about thinking about the issues around immigration and how that can block them accessing healthcare and, and also about the language barrier.
Educational institutions	Interview	Lilys: I have a part-time job of teaching young people. I feel like that really helped as well, [because] again I see all sorts of kids and from different backgrounds. I'm not seeing them in a clinical setting, but I am seeing them in a teaching setting. It's interesting to see, [because] kids are very open, and they're very honest. They'll just tell you things… It's interesting to hear about what their life is like and how they experience their life. It might be something like "oh I can't come to teaching next week, because that particular day is a holy day" and I was like "oh cool! tell me more about that". So, you kind of pick up things when you're talking to kids, or it might be like you've asked them to do such as a piece of creative writing, and they've written about something that you weren't aware of before. But it's an integral part of their life, does that make sense? You kind of just […] pick up things just from spending time with them.
Public entertainment places	Interview	Mandy: I've also worked in Norwich. I was just a theatre support worker, so I push people to the theatre. And then I was there, that was before the theatre. I know they're going to be very anxious. And some of them didn't speak much English as well. So, I think you have to develop ways of not frightening people, because it's scary [for them], let alone in the healthcare setting. I think, just being exposed to the working world, helps. It's about exposure, really. You need to immerse yourself in a diverse environment.

Professional experiences in healthcare-related fields contribute to students' CC in similar approaches as students learn in clinical placements (see Chapter 6). It is concluded from interview participants that part-time work or volunteering in any kind of healthcare organisation may help students to enhance their cultural awareness, expand their cultural knowledge, or improve their cultural skills. According to interview participant Ross:

> I do a psychiatry extracurricular [thing] and that, so that's, that's called extreme psychiatry. And […] because it's psychiatry, they're very heavy on the cultural background of people. It affects how you approach them, how you diagnose and how you manage them. Um, and they've […] definitely sort of drilled, in a good way, drilled into me [why CC is] really relevant.

Moreover, students expressed that they may gain a deep understanding of culture's impact on health if their work or volunteering has a focus on certain groups of marginalised populations, such as the homeless, LGBTQ group, or undocumented immigrants. The working experience can potentially enhance students' CC by exposing them to health disparity issues caused by real-life cultural challenges. For example, Rachel's volunteering experience in various charitable organisations has widened her focus to culturally marginalised groups (e.g. undocumented immigrants, asylum seekers, and the homeless). She believed that volunteering has enhanced her competence in communicating culturally sensitive healthcare issues in a non-judgemental and culturally appropriate manner:

> I mean volunteering is really good. Everyone should probably do it. And within our university, the student union has a liberation association. So obviously their job is to get diversity represented within the student union. And getting involved with things like that and often societies would have different outreach to different things. They have different events every year. So like plastic surgery might have an event in transgender surgery, and mental health might have a thing on mental loneliness. So that going to those is really good. I recently went to an event by the deaf society, or what they call the BSL [British Sign Language] Society, which was talking about mental health in the deaf community.
>
> [Outside school], so I volunteer with the Doctors of the World and the international humanitarian organisation. They have a clinic in Bethnal Green, which sets up kind of undocumented migrants, asylum seekers, anyone won't access healthcare for some reason, and a couple of national homeless people. And we find them a GP, get them some kind[s] of social support. We refer them to immigration. We do contraception and STI (sexually transmitted infections) test, that kind of thing. And my job is basically to take history from them, which is full sexual history, which is like an hour. So, I do that twice a month at least. […] I also used to volunteer with sex expression, which we taught like sexual education mostly to students. So that was kind of development with sexual-related clinical cultural competence.

Results also show that students may demonstrate an improved understanding of the importance of developing team-level CC through gaining working experience. Several participants mentioned that they started to understand the challenges around team-level CC through their professional work, particularly the phenomenon of hierarchy in the healthcare environment. In Paige's case, she had a gap year after her A-Levels during which time she worked in a dementia care centre for three months. She said she was slightly overwhelmed by the job because she found it "an art" to work with other staff in the dementia centre. Paige said she was exposed to a "real-world working environment"

because she experienced senior staff pushing duties onto relatively new employees. She deemed this experience a positive process for her to develop her professionalism as a future clinician. It taught her the importance of understanding professional boundaries and developing team-level CC to manage efficient care for elderly patients.

7.1.4 Living in a mediated world: influence from media channels

Results show that students receive cultural information from media channels, including both mainstream media and social media. Cultural elements can be conveyed in different media channels including news, movies, documentaries and television programmes. Through exposure to media products, students can gather relevant cultural knowledge and widen their cultural focus. Participants mentioned in the interviews that information-oriented mainstream media products, particularly news and documentaries, are channels to acquire cultural knowledge. For example, Mikul mentioned that BBC has a variety of documentaries featuring cultural issues. Participants also voiced that they could acquire cultural knowledge through entertainment media products. For instance, when I showed my willingness to learn more about Indian culture during my ethnographic conversation with Paige, she introduced me to a few famous Bollywood movies to start with, such as *Three Idiots* and *Dangal*. Students also gave positive feedback when media resources (e.g. documentary clips, YouTube videos) were effectively used in classroom teaching to facilitate their cultural learning.

Besides traditional media products, digital media or social media networking sites, such as Facebook, Twitter, Instagram, and YouTube, are playing an increasingly important role in the communicative experience of young people (Crossley and Ibrahim, 2012). The communicative experience can facilitate students' participatory practices and networking and consequently expand their exposure to culturally diverse information. It also enables communication and interaction with culturally diverse people. The information gathering, along with networking, can potentially benefit students' development of CC. According to interview participant Mandy:

> There's a lot of documentaries on iPlayer, or Channel 4, I can't give any specific names. But there're other documentaries (about) cultures out there, but you have to actively seek out. I think, there's, if you actually seek these things out, I mean, so which you can learn by reading the news, I guess. And Internet exposure on social media. I think, what you see on social media…I think that has a big part to play these days.

Although the relationship between media and culture has been adequately discussed by scholars in the field of media and cultural studies (Baron, 2006, Entman, 2007, Kellner, 2011), attention is rarely drawn to medical educators. Kellner (2011) pointed out radio, television, film and other products of media culture provide materials for the mass population to forge identities, develop "sense of class,

of ethnicity and race, of nationality, of sexuality" and of "us" and "them'' (Kellner, 2011). Media culture provides the materials for constructing views of the world, behaviours and even identities (Kellner, 2011, p.8). Nevertheless, despite easy access to information on the Internet, whether students actively seek out the information to help them learn remains individually diverse. How students use or digest information also varies. From the interviews, I found that whereas many participants expressed their interest and curiosity in learning about the global cultural diversity and have regular habits of checking international news, a small number of participants mentioned they are too occupied to learn about what is happening globally.

Moreover, media outlets may also convey culturally biased information and influence public views (Baron, 2006, Entman, 2007). Baron (2006) presented the theory of media bias that originates with the selection of events and stories that are reported by journalists and news producers. This alludes to the fact that although media resources are influential for people to learn about the outside world, the potential biases that exist along with media products can generate or reinforce cultural stereotypes. Also, similar to networking in the real-life setting, interaction on social media platforms may also form groups of "like-minded" people, creating unknown environments that may either facilitate or obstruct students' development of CC.

7.1.5 Gaining international insights: travelling and overseas fieldwork

Data analysis also identifies other extracurricular opportunities through which students can develop their CC, such as travelling and participating in culture-related projects. Students mentioned that they can widen their focus and acquire cultural knowledge by travelling to other countries or regions. This is evidenced by several interview participants mentioning that immersing in a foreign culture, even for a limited period, can advance their understanding of cultural diversity. However, it was also mentioned by one interview participant that, despite the benefits of travelling, immersion within a limited period of time can sometimes lead to the understanding of a culture on a superficial level. The nuances of cultural differences and their intrinsic implications on health and healthcare require more committed immersion over a prolonged period.

In addition to travelling, students can enhance their CC if they actively participate in projects that involve overseas fieldwork, as these projects offer students opportunities to explore a different culture in more detail through field research. The interview participants named three projects that allowed them to learn about other cultures by conducting overseas fieldwork. One example is the Experience Award offered by University A won by Usher:

> So [our university] has the Experience Awards. And I did the Global Award a couple of years ago, and I used a trip to the Philippines. and I wrote about cultural differences between my own culture and their culture. When I first started, I wasn't expecting to get much out of it, but as I got further and further, I was surprised by the differences between cultures. And it's only when I sit back and think about it, then it does hit you about, the differences and how it makes a big difference.

However, although awards are offered by various organisations for students, it is unclear whether students are actually aware of these opportunities. The lack of signposting of potential learning opportunities is an issue, as expressed by Usher:

> So, opportunities like that exist, but they're not sort of presented to us as learning opportunities. They're things you have to go and do yourself. Likewise, I did the London Award looking at the different cultures of school children and their educational attainment, and whether they get to medical school. But that sort of thing isn't formally taught in the curriculum. It's just extracurricular. But even then, it's not widely promoted. They're sort of an add-on that you have to look up for yourself. And then actively go for it. Not something that's presented to us by the medical school. As this is an opportunity to develop your, cultural competence. […] So, there's not a lot of signposting within the medical school for opportunities like this.

7.2 Not all about benefits: looking at extracurricular activities critically

Although extracurricular activities offer learning opportunities for CC development, some students also raised the concern of the limitations of these activities. Student's extracurricular learning is also a co-constructive process with their connections contexualised in different settings, leading to varied experiences in developing CC.

One potential issue when developing CC through extracurricular activities is that students might form a superficial understanding of certain cultural topics or problems due to limited extracurricular exposure. Although short-term exposure can widen students' cultural focus, it may also lead to superficial understanding without prolonged engagement or self-reflection. This phenomenon may occur when students attend one-off cultural events, travel or receive culturally biased information from acquaintances or the media. The superficial cultural understanding, despite being useful for students to start learning about a culture, may lead to stereotypes without critical reflection. This highlights the importance of clarifying the relationship between cultural knowledge and stereotypes as discussed in Chapter 5 and Chapter 6.

Reflecting on my observation of students' activities, I noticed that some extracurricular activities are prone to having associated group cultures, which may either facilitate or obstruct students' culturally inclusive networking. This means students may be exposed to a culturally incompetent environment when networking with others. It applies to students interacting with their personal connections, members in student societies, and netizens on social media platforms. Taking student societies as an example, as societies tend to attract people with shared characteristics, certain "group atmospheres"

are likely to be attached to some student societies. Interview participant, Damian, a mature Year-1 medical student, who had worked in a London hospital for two years, commented that he believes societies tend to attract people with similar mindsets. He also reflected on the role of students' societies or clubs in influencing their CC development:

> In general, I think extracurricular activities are perfect. They get you out into a group of individuals who enjoy a certain thing. But the only thing that holds them together is the certain thing, […] but beyond that everyone is a different person, OK? So, a lot of people come into the central focal point, which is great, but if you have […] certain other activities that the people are attracted to the activity are a certain type of people. […] You get some positive reinforcement of bad behaviours, because they are all the same. A classic example that is I play rugby for about 20 years. The average "rugby boy", I have done quotation marks around them. They are very gregarious, robust, very outgoing. But that can lead to other things, but depending on the environment, the rugby club can be positive or negative, and so it's all the balance. I would say most extracurricular activities are mostly perfect, but it should be noticed that, depending on the dynamic environment of the group that the person joins, perhaps bad habits can be picked up or can be positively reinforced. And don't let me say this is indicative of the university rugby team because I play for them, I really like them, but other rugby teams I've been the part of in my history of my career of playing ruby have been more inclined to do the less culturally appropriate things. I think in general if you get a bunch of young men together, […] normally with alcohol involved for instance, to take a fairly back sit, fairly quickly, that's just a by-product of teenage men, unfortunately.

Moreover, students expressed that their motivation to explore extracurricular learning opportunities might be weakened if they encounter poorly organised events. Students expressed in the focus group that, despite the benefits of most student societies, some student activities are limited to social events such as drinking. This phenomenon may disincentivise some students from attending and exploring other extracurricular opportunities. According to focus group participant Taran:

> In fresher's week, a lot of the events are just about getting drunk [other participants show agreement] and so you got students coming, who like either for religious reason or other reason, just like, "oh yeah, you gave up your social life for three years or anything", but they're not […] they don't know anyone around them and they don't feel comfortable going out and getting drunk. I know, personally, I'm in fencing, and all our events in fresher's week we made a point, [which is] you can have alcohol but that it's not about getting drunk. And we don't make freshers get drunk or anything. Whereas some societies have forced students to drink and stuff [other participants show agreement], that doesn't push people to engage in extracurricular activities? And so, they might think "I wanna join a society" but then they might go to the rugby society for example and they're forced to play rugby [other participants giggled] naked with a dead chicken. […] Like in that case, you don't wanna join. And I am sorry to say that's also something more global within the university.

Similar to participating in students' organisations or societies, the influence of personal relationships on students' development of CC has its limitations as not all students have culturally diverse personal connections. More importantly, if the personal connections surrounding students are not open to cultural differences, they may act as hurdles for students to develop CC. This is because students' values and behaviours towards diversity may be influenced by the people around them. Receiving culturally incompetent influence from personal relationships, particularly at an early age, may act as a hurdle to individual CC development. According to focus group participant Abbie:

> It's [CC] not something you definitely learn in medical school. […] It's something you learn since childhood, that you grow up and depending on what you're exposed to, you know very fast. For example, you learn how you should react to people, how you should treat people and it's always. It's within your family and within your school before. […] But in a way it's a bit too late to learn in medical school in the sense that you've already got all of those habits and stuff. Even if you realise something isn't right, it's gonna take you so much more work to get used to it rather than being taught it throughout childhood and growing up.

Apart from receiving potentially culturally exclusive influence, I argue that the limited influence of extracurricular activities in contributing to students' development of CC needs to be acknowledged. As extracurricular activities possess a self-selective nature and are mainly based on students' personal interest, how students co-construct their learning through interacting with others and the wider contexts remain dissimilar. Results show that students with a willingness to explore certain cultural topics demonstrate strong engagement. In Paige's case, she mentioned that taking up dancing classes as a hobby helped her to acquire cultural knowledge and to enhance critical awareness.

> Fieldnotes: To make up for her limited exposure to the Indian culture because of her early immigration, Paige picked up some hobbies which she believes can strengthen the bond with her family's cultural background. She told me that she has been attending classical Indian dancing classes in London for ten years. She particularly mentioned that the theory exams in the dancing classes helped her learn more cultural knowledge about India. She also reflected on the internal diversity within a cultural group by quoting her dancing experiences. In her class which features South Indian style dancing, Paige said she sometimes could not understand the language and dietary preferences of her south Indian tutor as her families are from North India. In addition to dancing, Paige said she has been attending lessons to become a Henna artist as she considers henna a beautiful and important form of body art that constitutes a major part of Indian culture. She excitedly shared with me that she received her first order of bridal henna for the coming October.

Unlike Paige, the lack of impetus to engage in culture-related extracurricular activities was expressed by participants both in the interviews and focus groups, including Adam:

> Because there's no impetus for us to go and join a society. You do it because you enjoy going out and joining a society or going and seeing events and things like that you enjoy being. So, if somebody doesn't enjoy that stuff, then there's no drive for them to go and do it. I mean the university does say that you should go out and join societies. And especially get out of medicine because it's very easy to just interact with medics and spend your entire time going through it. […] But I imagine there are many students. […] That is just not an interest for them. So, they don't get the chance to go out and do other stuff because they've never really signed up for in the first place.

More importantly, although certain extracurricular events can contribute to students' CC development, involvement in these activities does not have a direct correlation with one's level of CC. In other words, participating in more extracurricular activities does not equate with a higher level of cultural competence. CC development is a lifelong learning process, as explained by interview participant Amelia:

> It's quite based on their own initiative. […] I'm not too sure, because there are some friends who don't have and some who do a lot of those, so there might be a spectrum based on how much

> they're exposed to. But I don't think there's a correlation between being in an extracurricular activity and having your cultural competence. It might be independent of extracurricular activities. So, let's say someone doesn't go to any and someone goes to, like, three or four, I wouldn't put that, the latter person as being someone who's more culturally competent.

7.3 Summarising students' CC development in extracurricular activities

This chapter answers the last research question on "how do students develop their cultural competence in extracurricular activities". Results show that students can enhance their CC by experiencing diversity within the campus by joining student societies and attending cultural events. Immersion in a diverse student body contributes to students' learning in an implicit way. Students can advance their understanding of culture and diversity by maintaining their personal relationships, such as receiving influence from culturally diverse family environments and networking with friends. Another important approach for students to develop their CC in the extracurricular setting is by gaining professional experiences, including volunteering and working part-time. This is because the work experience exposes students to the real working environment where they can interact with culturally diverse people. It also contributes to students' understanding of team-level CC. Moreover, students acquire cultural knowledge by receiving information from media channels and networking using various social media platforms. Their cultural awareness and knowledge can also be enhanced by travelling or conducting projects that involve overseas fieldwork.

Understanding students' extracurricular learning from a social constructive viewpoint also requires acknowledging the limited effects of the learning opportunities. Whilst most of the above-identified extracurricular events can contribute to students' CC, students may also receive potential negative influence by networking, or form a superficial level of cultural understanding due to limited exposure. There is no direct correlation between students' participation in extracurricular activities and their level of CC but signposting the potential extracurricular opportunities may help educators and students develop a more comprehensive view of students' learning. The results of students' learning in the three settings will be consolidated and discussed in the next chapter.

8 Results consolidation

The purpose of this chapter is to integrate the findings by relating to the research questions and address them in light of the results presented in Chapters 4-7. Based on the results, I propose a theoretical model to depict medical students' development of cultural competence (CC) in undergraduate medical education. I also propose the EDUCATIONIST Guide, which consists of 12 pedagogical tips, to enhance cultural competence (CC) and diversity education in medicine.

8.1 Varied understanding and delivery among medical schools

This research provides academics and educators with a general overview of the teaching content and pedagogy around CC and diversity education in UK medical schools. Results of the Stage One document review demonstrate that medical schools have varied understandings of what constitutes CC and diversity education. This conforms with previous literature (Dolhun et al., 2003, Dogra et al., 2010, Dogra et al., 2016), which shows that CC training remains patchy with a lack of consistency in structure and process across medical schools. There is no consensus on what elements of CC and diversity should be taught, and less is known about what is currently being taught. Results of the document review address this gap of knowledge by identifying the key elements of CC and diversity education and providing a clear picture of the current situation of CC and diversity education in UK medical schools. The results from the Stage Two ethnographic fieldwork in one medical school provide details to the curriculum design, delivery and students' feedback around CC and diversity education.

The contribution of this research is that it has pointed out the two essential aspects of CC and diversity education: institutional development and educational interventions. This means medical educators should pay dual attention to the two aspects as they are distinctive yet intertwined entities. Strong institutional development contributes to building a culturally inclusive working environment to support the design and delivery of CC and diversity education. In turn, educational development may lead to improved institutional support. Results of the document review unveil a lack of understanding of what constitutes CC and diversity education by medical educators as a few medical schools only reported on either their institutional development or educational interventions. The phenomenon indicates that a structured educational model (such as Figure 6) that underlines the key elements of institutional and educational development can facilitate medical educators to develop a comprehensive understanding of CC and diversity education.

As shown from the results of the document review, the institutional development provides the organisational support to deliver educational interventions, manifested from an institution's motivations to deliver CC and diversity education, its infrastructure and faculty development, as well as relevant schemes in promoting diversity and equality. First, drivers of CC and diversity education include meeting the requirements set out by healthcare regulatory bodies and applying for diversity-related awards such as Athena Swan and LGBT Youth Scotland. Second, different levels of infrastructure development exist. Whereas some medical schools have a research-informed curriculum supported by both the management and faculty level, other medical schools experience difficulties to identify designated academic leads to oversee the design and delivery of CC and diversity education. Third, three popular types of faculty development include a) the provision of institutional training for staff, which covers content such as unconscious bias and clinical communication; b) the membership of diversity-related academic organisations (e.g. DIMAH); c) postgraduate programmes for potential medical educators. Lastly, commitment to promoting equality helps create a culturally inclusive environment, which increases the likelihood for students to consider culture and diversity issues. Frequently reported schemes included widening participation and promoting gender equality.

As for educational interventions, the document review shows most medical schools undertake a dynamic perspective to understand culture as inclusive of multifaceted sociocultural determinants, including race, ethnicity, language background, sexuality, gender, educational level, and socioeconomic backgrounds. Both CC and diversity are commonly used terms used by medical schools. In terms of teaching domains, the document review shows that CC and diversity education includes the teaching of cultural attitudes, awareness, knowledge, and skills, with the teaching of cultural knowledge around specific groups and clinical communication as the focus. Other CC domains, such as unconscious bias, the skills to learn, discover, and self-reflect, remain under-addressed. Moreover, CC teaching primarily focuses on the competence development of individual healthcare professionals. Some medical schools mentioned integrating CC in interprofessional education, which is relevant to team-level CC. Teaching formats include lectures, interactive workshops, peer-led teaching, online resources, community-based learning, reflective personal learning document, self-directed learning, and student self-selected components. Existing assessment methods include reflective writing, multiple-choice questions, project reports, presentations, and peer review. The demand to incorporate CC and diversity education into Objective Structured Clinical Examination (OSCE) stations are expressed.

In addition to obtaining a general overview of CC and diversity education in UK medical schools, this study also provides an in-depth presentation of CC and diversity education by conducting an

ethnographic case study in a London-based medical school. It was observed that teaching across the curriculum in the chosen medical school covers 1) GMC's requirements, 2) concepts of culture, 3) equality, equity and discrimination policy, 4) doctor-clinical communication, 5) language, 6) socioeconomic status, 7) gender roles and sexuality, 8) knowledge on cultural groups (e.g. homelessness, refugee health, and LGBTQ health), and 9) cultural skills such as how to use interpreters during clinical encounters. It is concluded that whilst CC and diversity education across the curriculum comprehensively covers the essential attributes of CC development, subject-specific teaching has an emphasis on cultural attitudes and awareness. The details around curriculum design and students' learning in subject-specific teaching add to the lack of understanding of how medical educators may address cultural attitudes and awareness in teaching clinical CC. However, this also led students to voice a demand for gaining more cultural knowledge and skills, which is aligned with the multicultural/categorical and the cross-cultural approach to CC and diversity education (Betancourt, 2003) focusing on developing knowledge and skills. This phenomenon unveils a complex and nuanced relationship between acquiring cultural knowledge and forming cultural stereotypes. Although previous literature (Betancourt, 2003, Dogra, 2003, Dogra et al., 2016) has pointed out that teaching cultural knowledge with a narrow focus may possibly form cultural oversimplification and transform practitioners from conscious incompetence back to unconscious incompetence, I argue that cultural knowledge may be acquired in a critical manner rather than simply be refuted. This is because possessing knowledge regarding the health beliefs of certain communities can be helpful as a starting point for medical students to obtain a baseline understanding. Simply rejecting cultural knowledge to avoid pigeonholing might lead to another potential pitfall as students may develop cultural blindness if they see every individual is culturally different without the need to acquire any prior knowledge.

In terms of delivery, the chosen medical school adopts blended pedagogical approaches. This conforms with Dolhun's study (2003) summarising that most American medical schools combine didactic components with active student participation through case studies and group discussions. Teaching methods that were identified include lectures, workshops, simulated patient scenarios, project-based learning, as well as intercalated degrees and global health placements. Adding to previous literature (Long, 2012, Dogra et al., 2016) that shows there is little evidence to indicate which teaching methods are most effective, students' feedback generated from Stage Two of this research shows that most students perceived didactic lectures as a good approach to introducing the concept of CC. Workshops were reported as helpful for them to reflect on their unconscious bias and enhance cultural awareness. Some students considered workshops useful and a safe environment for discussion, others found it difficult to engage due to the potential difficulty in translating learning into clinical practice. The design of lectures followed by workshops was considered positive as

students expressed that workshops allowed room for self-reflection after first encountering CC as a subject. Simulated patient scenarios were the most popular among students. This format allowed students to translate internalised cultural knowledge and attitudes into clinical interactions with simulated patients. My observation showed that students started to demonstrate an enhanced level of cultural sensitivity when participating in simulated clinical scenarios. However, due to the multiple learning outcomes to be achieved in simulation, learning of culturally sensitive communication and clinical care may take place unconsciously. Engaging with self-selected research projects allowed students opportunities to develop an in-depth understanding of cultural issues that interest them, but their learning varied depending on the nature of their chosen projects. The results also identify other learning opportunities where students might develop their CC, including intercalated BScs and global health placements. In these learning opportunities, students with stronger motivations to explore cultural issues may benefit more as they demonstrate a higher level of engagement.

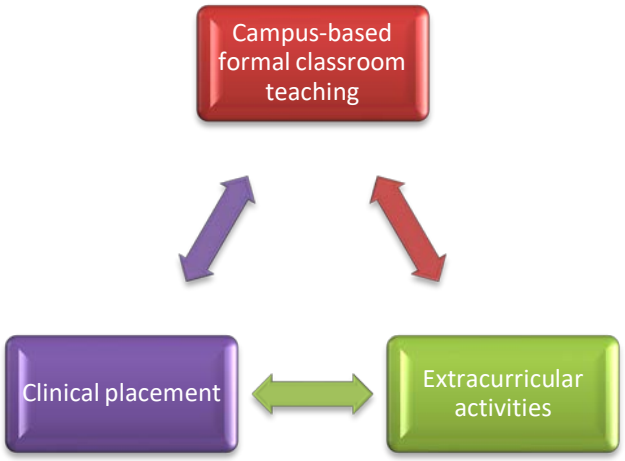
Students also expressed that they expect CC and diversity education to be clinically relevant, case-supported, expert-involved, and with lived experience. The need to make current teaching to be more clinically relevant was raised by Dogra and colleagues (2016). This research shows that integrating clinically relevant case studies can strengthen the link between CC and medicine as students voiced a preference for the use of case studies throughout teaching. Students also expressed that case studies need to be carefully selected so as to avoid the counterproductive influence from stereotypical or outdated cases. This concurs with Dogra and colleagues' (2016) argument that case studies need to be well developed and integrated into wider teaching. Moreover, the results also show that students deem the involvement of guest speakers with lived experience or external educators with expertise on a certain cultural topic beneficial to their learning. This reconfirms that a range of stakeholders may be incorporated as an element in many different parts of the curriculum, but there needs to be a "clarity about the purpose of their involvement and those delivering it need to be comfortable about the potential sensitivities the subject may raise and how to manage these (Dogra et al., 2016, p.330)".

8.2 Interactive CC development in three settings

Collectively the results from the Stage Two ethnographic fieldwork show that students develop their CC both consciously and unconsciously in campus-based formal classroom teaching, clinical placements, and extracurricular activities. Students' learning experiences in each setting are interactive and interrelated with each other, accumulatively contributing to their development of CC (see Figure 10). The campus-based formal classroom teaching of CC introduces to students the theoretical concept of CC and highlights the significance of developing CC as future healthcare

professionals. It contributes to students' learning as improved cultural awareness may encourage students to actively engage with cultural issues in other settings. Students' learning in clinical placements constitutes another significant component of their academic training as ample opportunities exist for students to apply their formal learning into real practice. Their experienced cross-cultural encounters may reveal to students the practical relevance between CC and clinical practice, allowing them to use real-life clinical examples to enrich their formal learning. Moreover, students' enhanced CC development resulted from their training in formal classroom and clinical placements can lead to increased initiatives in exploring cultural issues in an extracurricular setting. In turn, the general CC developed within an extracurricular setting may contribute to students' clinical CC development in the educational setting.

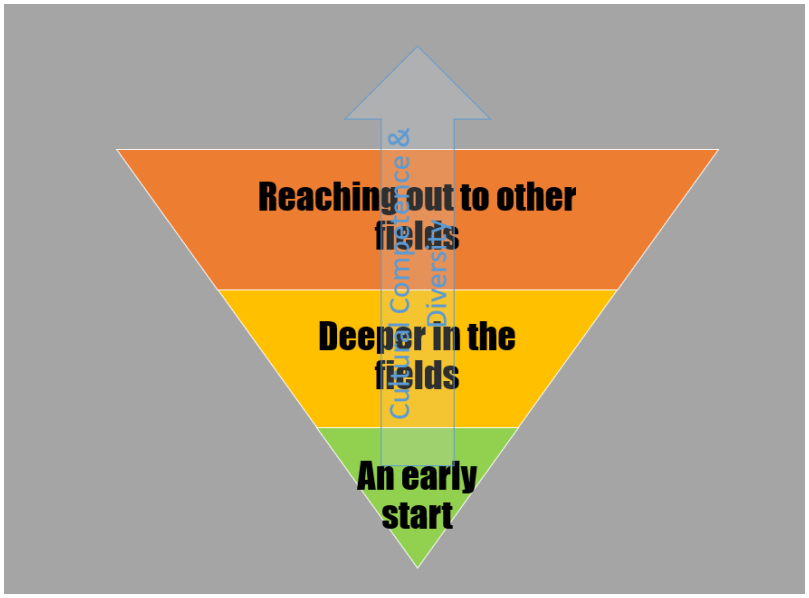
Figure 10 Comprehensive CC development in three settings



In campus-based formal classroom teaching, the results demonstrate that medical students develop their CC following a longitudinal three-stage development (Figure 11). Throughout a five-year MBBS curriculum in the chosen medical school, the early start of teaching mainly takes place in Year 1, when a range of sessions was observed as beneficial to students' CC development. These sessions include subject-specific teaching (e.g. CC lectures and workshops). Other values-based medical subjects, such as professionalism, interprofessionalism, and medical ethics and laws, also contribute to students' development of CC. Teaching around public health, biostatistics and epidemiology can enhance students' CC by exposing them to population-level cultural knowledge. Simulated patient scenarios with culturally embedded topics, where learning takes place in a simulated environment with real-time constraints, are noticed as the most effective teaching format for students to develop CC during the early stage of their medical education. When students move to Year 2 onwards, teaching is integrated among sessions in different clinical contexts. Results show that students can develop their CC in clinical sessions with embedded cultural teaching (e.g. mental health, longitudinal

development on General Practice). Project-based learning (e.g. student self-selected components, clinical humanities projects) are also shown as relevant to students' CC development, if students choose to lead or involve in projects that have culturally relevant themes (e.g. enhancing clinical communication with certain cultural groups). In addition to the standard curriculum, students may enhance their CC by reaching out to other fields with more diverse and dispersed learning. Examples include students' intercalated degrees or global placement programmes.

Figure 11 Longitudinal CC development throughout the structured medical curriculum



In addition to formal classroom learning, the conclusion drawn from the results is that vast learning opportunities exist outside the formal curriculum. When students move to more senior years, medical training in clinical placement becomes an essential component of the medical curriculum complementary to formal teaching in the classroom. Results of the ethnographic fieldwork show that students develop CC both consciously and unconsciously via immersion, observation, interaction, and reflection in clinical placements. Through engaging in different clinical encounters either individually or with other medical students, students are afforded opportunities to learn, imitate, reflect upon, give personal meaning to and seek to integrate their different ways of knowing. Students' learning experiences that can contribute to their CC in a clinical setting are manifested through students' immersion in a culturally inclusive healthcare environment where multicultural artefacts can be seen. Immersion in an inclusive working environment, where diversity is prominent in both the workforces and patient population, may raise students' cultural awareness. As immersion can take place without knowing, students might not be aware of their learning until been prompted to reflect upon their experiences at a later stage. In addition to immersion, active observation is pertinent for students to enhance their cultural attitudes and sensitivity along with cross-cultural

skills. Observational learning in the clinical context includes the observation of how healthcare staff approach cultural issues in different healthcare settings and the interaction among clinicians, and between patients and staff. Besides, through interaction with different personnel in the healthcare setting, medical students are likely to enhance their understanding of culture's impact on health, re-think multilingualism, learn cultural practices, and improve clinical communication. Students' interaction with patients also adds to the CC of a healthcare organisation, creating learning opportunities for others.

Moreover, the results also show that students develop their CC through reflection both at the group and individual level. The facilitated group-level reflection may further develop students' teamwork skills and communication, where individual culture and group dynamics are at play. The individual-level reflective writing (e.g. reflective journals, assignments and portfolios) required by any formal teaching sessions offers students opportunities to individually reflect upon their clinical experience. Reflective writing offers students the freedom to choose a wide range of issues including culture and allows space for in-depth reflection, during which process unconscious learning may surface after being prompted. Self-reflection may also enhance students' motivation to learn when they internalise the significance of CC. This dimension of reflection reveals that students' learning on campus and in clinical placements are not detached entities. Whilst campus-based teaching is essential in preparing students' learning in clinical placement, students' learning in clinical placements may enrich and help them develop a deeper understanding of the topics discussed in the classroom. More importantly, the reflective teaching activities may trigger students' self-driven reflective learning on CC, serving as the catalyst that moves face learning into deep learning.

Beyond the curricular setting, students develop their CC by participating in extracurricular activities. Results show that students may enhance their CC by experiencing diversity within the campus by joining student societies or attending cultural events. This also includes the implicit effects of immersion in a culturally diverse student body. Moreover, students may advance their understanding of culture and diversity through maintaining personal relationships with peers, friends, or family members. Their interest in learning more about a cultural topic might be intensified if they have established intimate or long-term relationships with people from that cultural background. Gaining professional experiences through volunteering and part-time working can potentially enhance students' CC, as these activities can expose students to the real working environment and allow them to interact with culturally diverse people. In addition, receiving cultural information from media channels (e.g. news, documentaries, movies, the Internet) can expand students' cultural knowledge. Networking with people on social media platforms may expand their cultural exposure.

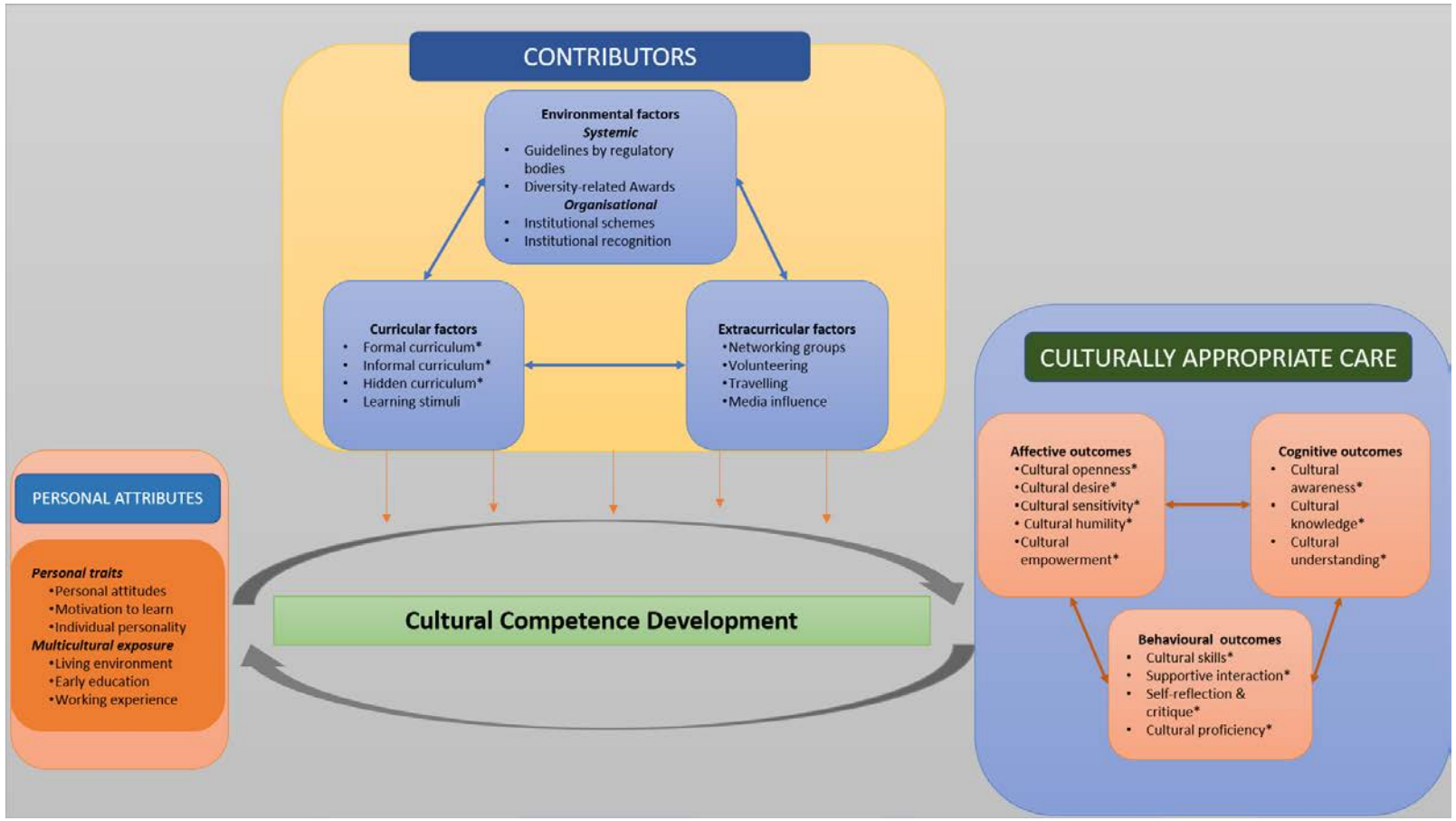
Activities such as travelling or participating in culture-related projects may contribute to students' CC as these activities can potentially widen students' cultural focus through knowledge acquisition.

Nonetheless, the results of this research also identify various factors that may influence students' extracurricular experiences, such as students' personalities, upbringing, personal interests, and varying levels of initiatives in engaging with cultural issues. Therefore, in addition to recognising the learning opportunities, I argue that a critical examination of extracurricular activities also requires acknowledging their limited effects. Although certain extracurricular activities can contribute to students' general CC development, the limitation resides in the fact that students cannot easily translate these experiences to developing CC in the clinical context. Another concern is that students may receive potentially negative influences through culturally exclusive networking or form a superficial level of cultural understanding due to limited exposure.

8.3 Enriching CC theories: A CC development model

Based on the results of this research, I propose the CC Development Model for Undergraduate Medical Education to conceptualise the process of students' CC development (see Figure 12). Distinct personal attributes that affect and influence students' attainment of CC outcomes are described in the model together with the contributing factors. The personal attributes largely decide students' attitudes toward CC and their level of CC prior to formal medical education. The contributors identify the three sets of factors (i.e. environmental, curricular and extracurricular) that have influences on students' CC development in the medical education environment. Through students' constant and dynamic interaction with these factors, CC outcomes in three domains (i.e. affective, cognitive and behavioural) can be gradually acquired. In this model, students' personal attributes and the CC outcomes are interdependent with each other, reflecting a two-way developmental process. The theoretical concepts in this model are based on the results of this research, however, certain concepts that have been proposed in established literature are kept in the model (e.g. formal, informal and hidden curriculum). The findings of this research conform to these concepts and have enriched these concepts by adding details on how they are relevant to students' development of CC. The concepts that have been proposed in the existing literature are marked with an asterisk when presenting the model (Figure 12).

Figure 12 CC development model for undergraduate medical education



Note: The concepts ending with an asterisk are identified by drawing on the results of this research and existing literature.

8.3.1 Personal attributes

Personal attributes in this model refer to a list of finite attributes that were identified based on the views of participants or my observation as an ethnographer. They include students' personal traits and their prior multicultural exposure. Students bring their personal attributes before entering the medical education context, and these attributes may lead to students' varied attitudes toward CC, motivations in engaging with cultural issues, and preferences for learning.

Students' personal traits are reflected in their personal attitudes, motivation to learn, and personalities. Personal attitudes towards cultural differences refer to whether an individual tends to embrace cultural differences or judge another culture based on preconceptions that are found in the values and standards of one's own culture (i.e. cultural ethnocentrism). These deeply rooted attitudes can be attributed to students' upbringing and early education but are still subject to change through adult education (Merriam, 1987). As for motivation to learn, it refers to students' varying degrees of willingness to explore cultural issues. Different levels of motivations affect students' engagement with cross-cultural encounters, consequently having an impact on their CC development. This research shows that if students share certain identities of a cultural group or have established intimate or long-term connections with members from a cultural group, they tend to develop cultural proximity to that group, and therefore, are more likely to actively acquire specific cultural knowledge due to an increased level of personal initiatives. Personality, a term used by some participants, refers to the personality-related elements that may influence medical students' learning, such as whether a student is curious, outgoing, and open to cultural differences. My ethnographic observation shows that students who are outgoing tend to have more opportunities to interact with patients and clinicians. Similarly, students who are curious and open to cultural differences are noticed as more willing to network with culturally different people and engage with diversity issues in an extracurricular setting.

Personal attributes also include students' prior exposure in a culturally diverse environment, reflected from their upbringing, educational background or gained working experience. The results of this research show that students with some level of multicultural exposure during their upbringing and early education tend to be more open to cultural differences. This also applies to students who have gained some level of working experience in a culturally diverse setting (e.g. volunteering, part-time or full-time working). However, more prior exposure does not equate to a higher level of cultural competence, because an established level of cultural knowledge and skills may also lead to cultural blindness, or cultural minimalisation, if students take a reductionist approach to view CC (see Section 5.5.6).

8.3.2 Contributing factors

The contributing factors are identified by drawing on the results of this research and existing literature, particularly theories on social cognitive learning (Bandura, 1977, Bandura, 1986), informal and hidden curriculum (Hafferty and Franks, 1994, Hafferty, 1998, Wear and Skillicorn, 2009).

The CC development model identifies three sets of contributing factors that can influence medical students' CC development: environmental, curricular and extracurricular. First, environmental factors, existing both at the systemic and organisational level, provide the sociocultural environment for medical schools to implement CC and diversity education. Systematic factors include the national-level stipulation on teaching CC and diversity by healthcare regulatory bodies (e.g. the General Medical Council) and systemic recognition of universities that take initiatives in applying for diversity-related awards (e.g. Athena Swan and LGBT Youth Scotland). These factors act as drivers for medical schools to deliver CC and diversity education as part of their curriculum. They are also referred to as regulations and guidelines for students to recognise the need to develop CC in order to become competent healthcare professionals. Organisational-level environmental factors include the relevant institutional schemes that can contribute to the building of a culturally inclusive environment, such as widening participation and tackling discrimination. They also include the institutional development around CC as a medical subject, reflected in the medical schools' infrastructure development and faculty training.

Second, curricular factors refer to the contextual or circumstantial milieu within the educational context that may influence students' CC development. The findings of this research show that students can develop their CC in the formal curriculum, as well as the informal and hidden curriculum. Students develop their CC in the formal curriculum setting through attending associated subjects (e.g. subject-specific teaching, value-based subjects, and relevant clinical subjects), participating in culturally relevant research projects, and taking up medical intercalated degrees. Students also develop their CC in an informal curriculum setting through rotating in clinical placements (e.g. immersion, observation, interaction, and reflection), and receiving influence via institutional cultural schemes (e.g. widening participation, gender equality) or language use (e.g. human values). In the hidden curriculum, peer interaction around cross-cultural encounters, joining diverse student societies, or participating in cultural events, contribute to students' development of CC. The geographical and demographical environment of medical schools may also impact students' CC development, allowing students to develop CC through working with people of certain demographic features. Within this category of factors, this research identifies a set of situational elements, or learning stimuli, that may encourage medical students to explore and reflect cultural

issues. These include pedagogical stimuli in teaching CC in the formal curriculum (e.g. incorporating cultural cases, inviting guest speakers with lived experience). In the clinical setting, learning stimuli include students witnessing both culturally competent and incompetent behaviours. This is because whereas witnessing culturally appropriate behaviours can enable the role modelling effect, witnessing cultural incompetence may also activate individual deep reflection.

The third set of factors includes students' extracurricular choices. This research identifies a range of extracurricular activities that may influence students' development of CC, such as their personal networking, volunteering, utilising media resources, and personal hobbies (e.g. travelling). Nevertheless, whilst these extracurricular activities may in most cases contribute to students' CC, they may also inhibit students' CC development if students encounter culturally incompetent influence or form cultural stereotypes due to limited exposure.

The three sets of factors do not function as independent determinants; instead, they affect each other in a circular fashion. The environmental background conveys to medical students the need to develop CC as future doctors and require medical schools to gain recognition and create educational contexts to facilitate students' learning. Curricular factors facilitate or alter students' individual learning and may lead to educational interventions through institutional development. Individual students can also create or alter their learning environments through extracurricular engagement, and the changes they produce will consequently affect them personally. The three sets of contributing factors function continuously and dynamically, and ultimately allow students to acquire cultural competence in the three domains discussed in the next section.

8.3.3 Developmental outcomes

The outcome attributes listed on the right side of the CC development model are based on the results of my literature review around the theoretical discussion of *cultural competence*. I categorise these attributes into three interactive domains, which accumulatively set up the requirements that are essential to the provision of culturally appropriate care (Liu et al., 2020). The model shows that medical students need to acquire affective, cognitive and behavioural development to prepare for a culturally and linguistically diverse patient population in the healthcare setting.

The affective domain requires openness, cultural desire, cultural sensitivity, cultural humility, and cultural empowerment. Openness refers to the willingness to explore new ideas and treat cultural differences positively and non-judgmentally (Foronda et al., 2016). Cultural desire is a self-motivated "want-to", instead of the "have to" attitude that leads to actively seeking opportunities to develop one's CC (Foronda et al., 2016, p.212). Cultural sensitivity means the intuitive recognition of cultural

similarities and differences between individuals and cultural groups (Burchum, 2002, Betancourt, 2003, Owiti et al., 2014). Cultural humility requires individuals to "throw away one's ego", and inspires modesty, equality, and no act of superiority (Foronda et al., 2016, p.212). Cultural empowerment means to empower students within their studying environment and encourage their willingness to enact their individual agency to actively respond to cultural differences (Almutairi and Rondney, 2013, Almutairi et al., 2015).

The cognitive domain requires the continued acquisition of knowledge about other cultures, and their implications on healthcare and health behaviours (Campinha-Bacote and Campinha-Bacote, 1999, Burchum, 2002, Betancourt, 2003, Dogra, 2003, Mahoney et al., 2006, Owiti et al., 2014, Almutairi et al., 2015). Ongoing professional development in cultural awareness, knowledge, and understanding is an intrinsic part of this domain. Medical students need to be aware of culture's impact on health, and consciously assess their own tendency of ethnocentricity, biases, and prejudices towards other cultures (Campinha-Bacote and Campinha-Bacote, 1999, Burchum, 2002, Betancourt, 2003, Dogra, 2003, Mahoney et al., 2006, Almutairi et al., 2015). The development of cultural knowledge includes the acquisition of cultural knowledge and the exploration of the relationship between cultural knowledge and stereotypes. This means individuals need to distinguish cultural knowledge from stereotypes. While knowledge can inform healthcare professionals on how to interpret a situation at hand, and respond to it appropriately, stereotypes might hinder active engagement with cross-cultural encounters and consequently block creative and collaborative solutions. The results of this research enrich the discussion around cultural knowledge and cultural stereotypes by adding that critical reflection and critique are imperative for students to distinguish cultural knowledge from cultural stereotypes. As for cultural understanding, it requires the understanding of the intrinsic relationship between culture and health. Also, this research adds that understanding the relationship between CC and multilinguistic competence is an essential element, which requires medical students to rectify the prevalent misconception that CC can be simply equated with multilinguistic competence (see Section 6.2.3.2).

The behavioural domain defines the essential competences for medical students to provide appropriate care to all patients, including cultural skills, supportive interaction, self-reflection and critique, as well as cultural proficiency. Cultural skills include respectful questioning, contextual inquiry, appropriate use of non-verbal communication, and use of interpreters when necessary. These skills put patients in the centre to provide beneficial, safe, and satisfying care (Leininger, 1991, Campinha-Bacote and Campinha-Bacote, 1999, Burchum, 2002, Betancourt, 2003, Dogra, 2003, Mahoney et al., 2006, Owiti et al., 2014, Almutairi et al., 2015). An added cultural skill from this research is adopting available technologies (e.g. the adoption of mobile translation applications) in

an appropriate and efficient manner in the real-time clinical setting (see Section 6.2.2.2). Supportive interaction is part of effective communication but specifically refers to positive information exchange among all parties in the healthcare environment (Foronda et al., 2016). Supportive interaction allows two-way communication processes where meaning is co-constructed and negotiated between equal interlocutors, leading to improved trust and shared decision-making. As for self-reflection and critique, it requires medical students to apply a critical mind and constantly reflect on their own thoughts, feelings, and actions in relation to the dynamics of differences, along with the effective use of resources available (Foronda et al., 2016). Ultimately, cultural proficiency demonstrates a commitment and ability to change (Cross, 1989, Burchum, 2002). Future healthcare professionals with cultural proficiency are expected to demonstrate affective advocacy for the vulnerable (e.g. through volunteering) and a high commitment to ongoing evaluation of practice, policies, and initiate changes to improve care (e.g. quality improvement projects). They are also expected to engage with research projects and, if possible, disseminating advanced information through education, publication, and other means.

The three-domain CC outcomes are interdependent. The cognitive development of awareness, knowledge, and understanding, allows for developing "affective competences" in openness, humility, sensitivity, and willingness to self-empower. In return, the affective competences will warrant individual medical students' continuous acquisition of cultural knowledge which will improve awareness and understanding. Development in these two domains will feed into the complex behavioural development that leads to improved clinical skills and effective communication. At the same time, self-reflective individuals continue to evaluate their own practice and enhance affect and cognition.

Moreover, comprehensive CC development in the three domains also has an impact on students' personal attributes, as culturally competent students may produce positive changes in their attitudes or engagements at the personal level. Therefore, the model views students' CC development as a dynamic and interactive learning process. The personal attributes largely decide students' varied attitudes towards CC and motivations in engaging with cultural issues before entering the medical education context. The three sets of contributing factors suggest that individual CC development can only be meaningful if environmental, curricular and extracurricular support is in place. The categorisation of affective, cognitive, and behavioural domains specifies the outcomes that future doctors need to achieve, providing a high-level structure for educational development.

8.4 Educational recommendations: the EDUCATIONIST guide

Collectively the results identify the learning opportunities in both educational and extracurricular settings that are available for students to utilise to develop CC. Some aspects of students' learning are apparent to and internalised by them; other aspects may remain hidden even as they are absorbed. This phenomenon requires medical educators to firstly identify, and then integrate and balance, resources that can support students' development of CC with a holistic view. In the below section, I present the EDUCATIONIST guide, which contains a set of 12 tips, to assist medical educators in developing CC and diversity education with respect to institutional development, teaching content, and pedagogy (see Table 24).

Table 24 The EDUCATIONIST guide

The EDUCATIONIST guide	
E	Establish a culturally inclusive institutional environment
D	Define what constitutes CC and diversity education
U	Utilise all teaching formats innovatively
C	Collaborate with experts with lived experience
A	Allow opportunities for deep reflection
T	Talk about the importance of CC in institutional discourse
I	Integrate and signpost CC content in the formal curriculum
O	Outline learning opportunities in the informal and hidden curriculum
N	Nurture learning in extracurricular activities
I	Improve infrastructure and faculty development
S	Support peer-led learning
T	Team with local communities to enhance cultural immersion

8.4.1 Establish a culturally inclusive institutional environment

Medical schools need to pool resources and provide support to integrate cultural diversity in their institutional plans and address equality and diversity in areas such as admission, employment, and student support. Various institutional schemes (e.g. widening participation, promoting gender equality, tackling discrimination, and applying for Athena Swan) contribute to building a culturally inclusive environment, which will increase students' likelihood to engage cultural issues in a more active manner. These schemes provide institutional support for students to challenge cultural issues when necessary. They also convey to medical students the significance of promoting cultural diversity in an informal manner.

8.4.2 Define what constitutes CC and diversity education

This research identifies a lack of understanding of what constitutes CC and diversity education by medical schools. This is partly due to the fact that the governing and regulatory bodies in medical education have not provided systematic guidance on conceptualising and framing CC and diversity education. This research identifies two reciprocal elements for medical schools to deliver successful CC and diversity education: institutional development and educational interventions. An educational model with seven sub-domains (Figure 6) was proposed for medical schools to review their design and implementation of CC and diversity education holistically.

8.4.3 Utilise all teaching formats innovatively

A wide range of teaching formats can benefit students' CC development. Didactic lectures are a good way to introduce and explain the concept of CC. Workshops are helpful for students to reflect on their cultural bias and enhance awareness. Simulated patient scenarios are the most popular among students as this format allows students to translate internalised cultural knowledge and attitudes into clinical interactions with patients. Engaging with self-selected projects allows students to develop a more in-depth understanding of cultural issues that interest them, but the learning varies significantly depending on the nature of projects students undertake. There are other formal learning opportunities where students might develop CC, including intercalated BScs and global health placements.

A frequently neglected format is that students also develop their CC through assessment. In this research, as the chosen medical school uses reflective writing to assess students' learning of value-based medicine, students reported that the reflective writing process enabled their deep thinking and encouraged them to reflect on a range of issues including CC. In addition, as students expressed that they were not certain whether CC is being assessed during their OSCE stations, this uncertainty made them pay additional attention to potential cultural issues that might exist during the assessment, which may enhance their cultural awareness.

8.4.4 Collaborate with experts with lived experience

Inviting experts or guest speakers with lived experience on certain cultural topics can bring learning to life. Lived experience roles go beyond an experience of illness and encompass an understanding of marginalisation, oppression, and discrimination. Underpinning lived experience perspectives can emphasise and advocate on behalf of those people currently unable to do so. Hearing from those with lived experience can facilitate students' nuanced understanding of cultural topics/issues and

the implications on health and healthcare by exposing them to real-life examples. In this research, students gave positive feedback when they hear opinions from experts beyond the field of medicine and healthcare, particularly from those with lived experience. This is because they brought real-life examples for students to discuss and reflect on. Students could also enhance their clinical communication while interacting with them.

8.4.5 Allow opportunities for deep reflection

As reflection is central to deep learning, educators may consider creating pedagogic platforms to stimulate students' reflection as part of their professional development. This research identifies the situational stimuli (e.g. role modelling, the witness of cultural incompetence) that may encourage students to self-reflect. Providing students with platforms to discuss and exchange their cross-cultural encounters in clinical placements and using facilitating topics of students' primary concern (e.g. LGBTQ issues) for discussion, may help them reflect. This ultimately prompts students to internalise culturally appropriate practices and initiate cognitive and behavioural changes.

8.4.6 Talk about the importance of CC in institutional discourse

Medical schools can instil the importance of CC to students through the strategic use of language in institutional communications. It is shown from this research that naming subjects strategically can strengthen the intrinsic links among the value-based medical subjects and convey the significance of CC to students. In the case of the chosen medical school, almost all participants referred to the "human values" teaching block when reflecting on their learning experience of CC. This means the institutional language use can exert hidden influence upon students' learning. Grouping interrelated sessions also allows students to link CC with other value-based clinical competences such as professionalism, interprofessionalism, and medical ethics.

8.4.7 Integrate and signpost CC content in the formal curriculum

Medical schools need to integrate CC across the formal teaching and make overt signposting of the learning opportunities. As for the timing of incorporating CC into the formal curriculum, an early start is preferable, especially one that incorporates patient contact so that students have an opportunity to relate the principles of CC to future practice. A "spiralling model" needs to be integrated and run in a coordinated way through the early years which are mainly classroom-based on clinical training and ongoing professional development after graduation.

In the formal teaching of CC, students acknowledge that they are aware of the subject-specific teaching but are less aware if teaching is integrated or embedded in other clinical sessions. The ethnographic observation echoes with previous literature (Dogra et al., 2016) by showing that CC teaching has a cross-disciplinary root so not all relevant teachings are clearly labelled. The value of having multi-disciplinary input is that it is more likely to be comprehensive and balanced. However, embedding CC teaching in a cross-disciplinary approach may lead to students' limited understanding of not receiving systematic cultural training during their medical education. The lack of signposting may also form a false impression among students that CC and diversity education is only a "tick-box" exercise that only needs to be delivered to meet national regulations. This indicates the need for educators of related disciplines and subjects to work collaboratively and make overt signposting to help students understand how these opportunities can support their cultural learning.

8.4.8 Outline learning opportunities in the informal and hidden curriculum

Various CC learning opportunities exist beyond the formal classroom teaching for students to utilise. This includes students receiving cultural exposure via different means in clinical placements. It also includes students receiving influence via being exposed in the institutional environment of a medical school, or within a diverse student population. Signposting these learning opportunities and overtly including CC development as one of the learning outcomes in clinical placements will enhance students' awareness in utilising these learning opportunities. In addition, the interconnected relationship between the formal classroom teaching of CC and students' learning in clinical placements indicates that educators of related disciplines and subjects need to work collaboratively to help students understand how these opportunities can support their development of CC.

8.4.9 Nurture learning in extracurricular activities

Students receive subliminal and hidden cultural messages by participating in student activities or networking with students of diverse backgrounds. A comprehensive understanding of students' learning experience requires medical educators to acknowledge the influence beyond the educational setting. This research identifies a range of extracurricular activities that students can potentially utilise to enhance their cultural understanding (e.g. volunteering, travelling, and utilising media resources). Discussing the potential limitations of these extracurricular activities (e.g. limited exposure, and networking within a confined group) is also necessary when signposting these learning opportunities to students.

8.4.10 Improve infrastructure and faculty development

Enhancing infrastructure development and faculty training around CC is key to deliver effective CC and diversity education. The varied content and pedagogy of CC and diversity education across medical schools are partly attributed to whether medical schools have appointed academic leads to integrate teaching resources and challenge thorny issues, or if existing academics leads are well supported and have an influence on the wider curriculum (Dogra et al., 2016). After setting up the faculty structure, the next step is to train the trainers that are involved in delivering CC and diversity education. Purposeful conversations with medical educators revealed that some educators possess a low level of self-perceived confidence in teaching CC and diversity. They also reported a lack of systematic faculty training within their institutions. Moreover, the challenge of faculty training is coupled with the difficulty that medical educators include not only campus-based academics but also clinicians/tutors working for different healthcare trusts and organisations. This phenomenon indicates that the need to enhance faculty training should not only target potential academics or clinical teachers who are involved in CC and diversity education; instead, general training on cultural diversity should be made mandatory to all educators. This is because some students expressed that negative influence might be imparted from a small number of culturally insensitive or even discriminatory tutors/clinicians.

8.4.11 Support peer-led learning

Students can make use of the diversity within their peers to explore cultural differences. Peer interaction provides opportunities for students to exchange and discuss their cross-cultural encounters in a safe environment. In the curricular setting, peer-led learning is best achieved if there are informal learning environments led/facilitated by experienced staff members or senior students, such as within tutor groups and focus groups. Particularly, students expressed that having semi-formal sessions (e.g. focus groups, or tutor groups) to encourage peer-led learning within a safe environment can benefit their learning. A good example is that participants deemed the focus groups consisting of diverse participants conducted for this research a valuable platform to exchange opinions and share culturally relevant experiences. This format also addresses the educational concerns around peer-led learning, which include the potential lack of expertise, mutual learning, or respect among students.

8.4.12 Team with local communities to enhance cultural immersion

Medical schools need to acknowledge that cultural immersion also takes place within local communities. This research shows that the effects of immersion are noticeable not only in culturally

diverse big cities or an international setting but also in any local settings. The added evidence on the effects of cultural immersion in local settings by utilising the "local cultural diversity" can potentially provide remedies to address some of the challenges faced by medical schools in relatively remote areas, as taking advantage of the diversity within the existing communities can also contribute to students' development of CC.

To summarise, the EDUCATIONIST guide has practical implications for medical schools to enhance their CC and diversity education. It may serve as a summary of an institution's CC and diversity education aims and provide a framework for curriculum and pedagogic design. It can also be used as a tool to inform faculty development on CC, to design evaluation of institutional or structural activities, and for students to use as a working document to reflect on their personal learning and development within their own experience.

9 Discussion and Conclusion

9.1 A review of the study

The growing culturally and linguistically diverse patient population requires medical students to develop cultural competence (CC) in order to prepare them for the delivery of culturally competent care in their future practice. A large number of studies have discussed the theoretical attributes around CC and the implementation of CC training in healthcare organisations. However, few studies have discussed and explored how CC is taught across medical education. As a result, we have a limited understanding of what, where and how medical students learn and experience CC teaching and development.

This research addresses the gaps of knowledge by a) presenting an overview of cultural competence and diversity education in UK medical schools and b) providing an ethnographic investigation of students' views and experiences in the development of CC in a chosen London medical school. Adopting an ethnographic approach, I conducted a document review to generate an overview of how UK medical schools teach CC and diversity in Chapter 4. The results bring conceptual clarity by specifying that CC and diversity education requires both institutional development (e.g. the presence of academic leads, faculty training, culturally inclusive institutional schemes) and educational interventions (e.g. teaching content, delivery, assessment). Guided by the document review, I further employed participant observation, interviews, and focus groups to explore how medical students can develop their CC in campus-based formal classroom learning, clinical placements, and extracurricular activities in Chapters 5-7. The analysis of data reveals that students develop their CC both consciously and unconsciously in the three settings. Their learning in each setting is interactive and interrelated with each other, which accumulatively contributes to students' CC development. The new knowledge generated from the ethnographic investigation enabled me to identify the various learning opportunities that educators and students may utilise. It also helped me to generate a theoretical model to conceptualise medical students' CC development, and to propose 12 educational tips to enhance CC and diversity education. This chapter discusses the findings in light of the scholarly literature and highlights the contributions that this study has made to existing theories and practices.

9.2 From formal to informal and hidden curriculum

Wear and Skillicorn's (2009) categorisation of the three levels of the curriculum has guided me to explore students' learning in a range of settings that may contribute to their CC development. As discussed in the literature review chapter (see Section 2.2.2), in the thesis I follow Wear and

Skillicorn's proposition and use the term "formal curriculum" to narrowly mean the "actual course of study, the planned content, teaching, evaluation methods, syllabi and other materials used in any educational setting" (2009, p.452). "Informal curriculum" denotes the opportunistic, pop-up and unplanned learning within the educational setting, including students' learning in the clinical placements. Same as the formal curriculum, the informal curriculum reflects educators' belief in what students need to acquire in terms of attitudes, awareness, knowledge and skills. "Hidden curriculum" includes the ideological and subliminal messages of both the formal and informal curricula, which can be "transmitted" through both human behaviours or the structures and practices of institutions (Wear and Skillicorn, 2009, p.452). The underlying assumptions of the three-level curriculum categorisation are that students learn beyond the formal classroom teaching because not all of what is taught during medical training is captured in course materials. Instead, a great deal of what is taught, and most of what students learnt, takes place not only within formal course offerings but also within medicine's "informal" or "hidden curriculum". Previous studies (Hafferty and Franks, 1994, Hafferty, 1998, Quilligan, 2015) have discussed the significance of exploring informal or hidden curriculum for values-based medical subjects such as ethics, clinical communication, and interprofessionalism. However, a paucity of studies has examined what, if anything, or how medical students can develop their CC in an informal and hidden curriculum setting. This study contributes to the discussion by revealing that although CC can be taught as a medical subject in classroom-based formal teaching, the less structured informal and hidden curriculum experiences appear to have significant influences on the development of students' CC.

Although it is not difficult to acknowledge that the formal teaching of CC does not take place within a cultural vacuum, this seemingly obvious fact sometimes remains critically under-acknowledged in discussions about the development of CC during medical training. Students develop their CC in different ways situated in distinctive curricular environments. While formal teaching introduces to students the significance of CC as future doctors, informal and hidden curricula allow students to acquire knowledge and skills, internalise moral values, and learn to identify matters of rightness and wrongness within the overall culture of medicine. Students' participation in the informal and hidden curriculum setting can also enable them to link their classroom training with practice. This unveils the interconnected relationship between formal teaching and informal/hidden teaching of value-based medical subjects including CC, which is consistent with previous research arguing that most of the critical determinants of forming a healthcare professional identity operate "not within the formal curriculum" but in a "more subtle" or "less officially recognised" informal or hidden curriculum" (Hafferty and Franks, 1994, p.861, Hafferty, 1998, Winter and Cotton, 2012). All these elements of structure and process in educational institutions have heuristic content; therefore, exposure to elements in an informal and hidden setting teaches students the fundamental principles about

medicine and the medical profession, including CC. That being said, naming the learning opportunities is no easy task for educators as students' learning is opportunistic, unstructured and individually diverse in the informal and hidden curriculum. The novelty of this research is that it provides details to understand how students can develop their CC in an informal and hidden curriculum through 1) undertaking clinical placements, 2) socialising within the institutional culture, 3) receiving peer influence, and 4) immersing in both global and local contexts.

First, students utilise a variety of ways (e.g. immersion, observation, interaction, reflection) to develop CC in the clinical setting, even though CC is not signposted as a learning outcome. Students' learning in clinical placements is a complex and messy journey. This is evidenced by their varied engagement, such as the length of their placements, the support they have received, and the number of patients they have interacted with. Lofmark and Wikblad (2001) state that students' learning experience in clinical placements varies based on a range of facilitating and obstructing factors. Facilitating factors include taking up reasonable levels of responsibility and independence, having opportunities to practise, receiving useful feedback, and possessing a comprehensive understanding of clinical encounters and their practising healthcare organisations. Obstructing factors include insufficient or discontinued support from clinicians as supervisors, lack of opportunities to practise, and students' perception of self-insufficiency and low self-reliance. This research confirms that these elements have an influence on students' potential cross-cultural encounters in clinical placements. It further points out how students' development of CC can be influenced by their luck, personalities, and individual initiatives. In a clinical setting, students' "luck" is determined by elements such as patients' willingness to interact, clinicians' supervision styles, and the organisational environment of the healthcare institution they are based. Students' personalities can also influence their cross-cultural encounters as outgoing and confident individuals were observed to connect with patients more easily. The semi-self-reliant nature of clinical placements also means that students' different levels of willingness and initiatives in engaging themselves with cultural issues also affect their learning. Therefore, although the opportunities to explore cultural differences are huge, how students take initiatives to utilise these opportunities varies.

Second, this research shows that students develop CC in an informal setting by receiving overt and covert cultural influences while immersed in the general institutional and cultural environment of the medical school. This is consistent with Hafferty and Franks' (1994, 1998) argument that the hidden curriculum has an impact on students' learning through the daily environment and the language used within organisations. In this research, building a culturally inclusive environment with institutional commitments (e.g. widening participation, applying for Athena Swan, promoting gender

equality) creates the environment for students to digest or internalise culturally appropriate values. In addition, the value-laden "institutional slangs or nomenclature" (Hafferty, 1998, p.403) also have an influence on students' CC development. Particularly, when a new curriculum or a new teaching component is announced, the very work of developing, implementing, and evaluating that curriculum conveys to faculty and students alike a variety of messages about what is, and what should be, valued within the community. An example in this research is that students frequently referred to the term "human values", a teaching block on values-based medicine in Year 1, to relate to their experiences on developing CC. This demonstrates how institutional nomenclature can influence students' learning beyond the formal classroom setting.

Third, this research identifies that students may develop their CC through interaction with peers both in curricular and extracurricular settings. On the one hand, the results show that interacting with peers in a curricular setting can benefit students' CC development, highlighting the role of peer interaction and peer companionship. This type of interaction is indispensable in students' clinical placements because the company of peers offers students emotional support (Lincoln and McAllister, 1993, Topping, 2005) to build confidence in a stressful clinical setting and opportunities to discuss their cross-cultural encounters when relevant. Particularly, storytelling, or case-sharing, of cultural challenges allows students to exchange opinions and reflect within a safe and friendly environment. On the other hand, peer interaction also takes place in the extracurricular setting when students join student societies or participate in cultural events. Previous literature (Loader et al., 2015) describes student societies as a significant dimension of student experience of campus life. Student societies represent the wide cultural interests of the student body. Their organised events provide a focal point for students to communicate and network with others with similar affinities. Loader and colleagues (2015) argue that the socialisation within the student body can be regarded as an experiential learning process where students, through interaction, continually and mutually adjusting their values, habits, and behaviours. However, as networking in a university setting enables "like-minded" people to form bonds and support collective actions through multiplex networks (Crossley and Ibrahim, 2012, p.609), one concern is that students may receive potential culturally exclusive influence through networking. Similar concern also applies when medical students network within their personal relationships, including culturally biased friends and family members.

Lastly, the results of this research add to the existing literature by unveiling how medical students can develop CC through immersion in clinical placements. Through the prolonged immersion in a diverse healthcare setting as student doctors, medical students are provided with opportunities to engage with and explore diversity issues. Immersion can widen students' focuses by exposing them to cross-cultural encounters, which may deepen their cultural understanding. This finding is

consistent with previous literature on describing immersion as an approach to develop intercultural competence. Previous studies (Kavanagh, 1998, Crampton et al., 2003, Neander and Markle, 2005, Canfield et al., 2009, Larson et al., 2010) show that immersion in culture and language is an effective means to learning about oneself and about people of another culture, along with their rituals, traditions, and daily practices. However, most of the existing studies are conducted in the field of language and cultural studies with a few recorded examples of cultural immersion for nursing students during international exchange programmes (Kavanagh, 1998, Watt et al., 2002, Torsvik and Hedlund, 2008, Sandin et al., 2004, Ruddock and Turner, 2007, Koskinen, 2003, Kokko, 2008, Keogh and Russel-Roberts, 2009). A systematic review (Kokko, 2011) on nurse students' development of CC during their international exchange and studies abroad has concluded that nursing students may develop their CC on international exchange through 1) gaining an increased cultural knowledge base, 2) enhancing their self-reliance and self-confidence, and 3) understanding the impact of exchange experiences through practising cultural skills. Based on a prolonged ethnographic observation of medical students' clinical placements in a London medical school, this research adds to the existing literature by showing that immersion can offer limitless teachable moments to medical students and consequently benefit their affective, cognitive, and behavioural competences to deliver culturally appropriate care.

More importantly, the results of this research show that the effects of cultural immersion are omnipresent, even in local communities or seemingly culturally homogenous areas. This finding adds to the existing literature on cultural immersion by revealing that the effects of immersion are not only limited to exchange programmes in international settings, or culturally diverse megacities. Instead, rotating in any local contexts, students would receive culturally diverse exposure, where diversity is manifested in multifaceted sociocultural dimensions. This finding also echoes with the contemporary stand of viewing culture as a multifaceted concept that goes beyond race and ethnicity. In other words, each environment contains some levels of diversity, manifested in the individual sociocultural differences including age, gender, sexuality, disability, and socioeconomic status. This finding is consistent with the argument held by Canfield and colleagues, who state that "most communities have cultural diversity, at least to some extent" (2009, p.320); therefore, meaningful immersion can make use of the diversity at the local community level. The added evidence can potentially provide remedies to addressing some of the challenges faced by medical schools in relatively geographically remote areas, as taking advantage of the cultural diversity within any existing communities can contribute to students' development of CC.

Students' learning in the informal and hidden curriculum distinguishes from that in the formal curriculum where they are taught in a controlled environment and according to particular formats.

This research shows vast learning opportunities exist in the informal and hidden curriculum; however, this potential is identified by the observer but seldom realised by students. The lack of awareness indicates more educational support is needed to help students learn, because "explicitly naming the hidden curriculum is key" for students to initiate an active understanding of their learning (Neve and Collett, 2018, p.495). It also points to the need for educators to incorporate CC as key learning outcomes in the learning environments where CC development can be relevant.

9.3 From adult learning to social cognitive learning in CC

This research contributes to the theoretical underpinning of what cultural competences and how medical students can develop these competences in educational and extracurricular settings. The results of this research largely conform to adult learning theories (Knowles, 1980, Knowles, 1984), which propose distinctive learning approaches that adult learners may use to help them achieve a learning target. The underlying assumptions of adult learning are that adult learners perform distinctive learning features from child learners, manifested from their *self-concept*, *experience*, *readiness to learn*, *orientation to learn*, *motivation to learn*, and *need to learn* (see Table 2 in Section 2.2.1.1). This research adds details in understanding how medical students demonstrate these learning characteristics when developing CC. The results also add details to the *andragogy* theory, which has been criticised for having limited empirical evidence (Merriam et al., 2007, Kaufman et al., 2000). In *self-concept*, students demonstrate varying levels of engagement with CC learning opportunities, such as self-selected culturally relevant research projects, cultural events, or student extracurricular events. Students' prior *experience* (e.g. upbringing, prior cultural exposure) is proven to have an influence on their attitudes toward diversity, desires in developing CC, and self-perception of CC. When students witness culturally competent role models, they are more *ready to learn* as they see how culturally competent practices can help them to deal with real-life situations. As for *orientation to learn*, students demonstrate a *problem-centred focus.* Therefore, when witnessing cultural challenges or recognising a learning need (e.g. embarking on their global placements), students' orientation toward learning shifts from one of subject-centeredness to one of problem-centeredness. They also *prioritise learning of immediacy of application* when they know *why they need to learn something.* When students truly internalise the significance of CC through accumulated learning, they become more *motivated to* seek learning opportunities.

Medical students' CC development revealed in this study also conforms to other educational theories in medical education, such as experiential learning, reflective learning, simulated learning, self-directed learning, and transformative learning (Knowles, 1975, Kolb, 1984, Mezirow, 1991, Cranton, 1994, Moon, 2004, Lateef, 2010, Schön, 2010). *Experiential learning* was observed when students

develop their CC through the observation of role models, and through the interaction with clinicians, patients, and peers in clinical placements. *Project-based learning* was noticed when students self-select diversity-related projects as part of their curriculum learning or self-involve in culturally relevant projects via extracurricular activities. *Situated learning* can be seen when students immerse themselves in a culturally diverse patient population with certain demographic features (e.g. global placements). *Reflective learning* was observed when students attend group-level reflective sessions or work on their individual reflective assignments. Students also develop their CC through *self-directed learning* by participating in culturally inclusive activities (e.g. cultural events, cultural societies) or self-searching culturally relevant information (e.g. media resources, networking with people of lived experience). Moreover, *transformative learning* may surface when students uncover distorted assumptions or errors in learning (e.g. failing to acknowledge the importance of CC until encountering real cultural challenges in the clinical setting). Through reflecting on their experience, the process of their learning and the associated premises (e.g. social context, history, and consequences), students may create and transform their paradigm so radically and internalise CC as an essential clinical competence.

While the above-discussed educational theories provide some level of theoretical guidance, I argue that social cognitive learning (Bandura, 1986) is the most helpful in guiding me to conceptualise medical students' CC development. The social cognitive learning theory sees that adults learn as a result of a continuous, dynamic, and reciprocal interaction among three sets of determinants: personal, situational/environmental, and behavioural factors. Personal factors include individual learners' attitudes, perceptions, values, goals, knowledge, and previous experience. Situational factors encompass all the influence that may reward or hinder actions and the achievement of goals. Behaviours are not detached by-products of persons and situations but also interacting determinants in the learning process. The personal factors in the social cognitive learning theory are consistent with the personal attributes of the CC development model (see Section 8.3), denoting the role of students' personal attributes (e.g. personality, multicultural exposure) in influencing their CC development. The environmental/situational factors are consistent with the contributors in the model as students learn through receiving influence in the three contexts (e.g. environmental, curricular and extracurricular) during their medical education. The three sets of contributing factors interrelate with each other and collectively have an impact on students' development of CC.

In addition, this research also identifies the situational elements (e.g. the identification of role modelling and the witnessing of cultural inappropriateness/incompetence) that may trigger students' deep thinking and self-reflection, consequently benefiting their CC development. Through observing culturally appropriate behaviours, medical students may develop their cultural attitudes

such as cultivating respectful behaviours towards diverse patients. This is consistent with the notion of role modelling (Murray and Main, 2005), when the senior members of the community enact through their behaviours, both tacitly and explicitly, how problems of the discipline are approached, how colleagues are regarded, and how knowledge is built and used. Role modelling encourages students to explore the attitudes, knowledge, and skills embedded in the daily clinical practice and facilitate students' learning by linking the practice with relevant academic theories or concepts learned in the formal curriculum. On the contrary, witnessing cultural inappropriateness enables students to visualise the potential healthcare consequences if cultural issues are not dealt with appropriately, creating chances for reflective deep learning. This phenomenon also indicates that students' learning experiences can be both positive and negative, echoing with previous studies that have discussed the unhelpful experiences of clinical training (Neve and Collett, 2018). More importantly, it highlights the need to support students to think critically about these experiences and empower them to make active choices.

However, although social cognitive learning is sufficient to partly explain students' CC development, I argue it is limited in conceptualising the comprehensive outcomes of CC. This is because CC is not merely a behavioural-based competence but encompasses individual development in more abstract areas, such as schemes of perception, appreciation and feelings. In other words, in addition to the behavioural dimension of CC development (e.g. cultural skills, self-reflection and critique), developments in the affective (e.g. openness, humility) and cognitive dimension (e.g. awareness, knowledge) are also essential to comprehensive CC development. Therefore, in the CC Development Model for Undergraduate Medical Education (see Figure 12), I outline the three-domain comprehensive and interactive CC development. The three-domain development not only includes an individual's behaviours but also comprises one's attitudes, mannerisms, tastes and moral intuitions. It refers to the way that individuals perceive their surrounding social world and enact their reactions. On this basis, the proposed model is useful as it not only addresses how individuals perceive, react and attach values to certain cultural events or phenomena but also emphasises how these attitudes, perceptions, knowledge and behaviours are formed and negotiated. In the process of CC development, students are constantly influenced by their learning in distinctive educational and sociocultural contexts to demonstrate cultural attitudes, awareness, knowledge and skills shaped by their individual experiences and opportunities in the past, present and future educational paths.

9.4 Limitations

Despite the contributions of this study, several limitations need to be discussed. In addition to the methodological limitations that are discussed in Chapter 3, this study has not provided detailed guidelines or educational practices of how medical educators can enhance their educational development besides offering 12 general educational tips. The CC development model it proposes has not been formally evaluated. The focus of this thesis has been on where and how students currently experience CC both formally and informally and offer a wider understanding of that. It is reasonable to argue that an increased understanding in this regard will be of value to medical educators when devising CC education in a meaningful way. The results of this research pave the way for future research to provide details on curriculum structure and pedagogy and explore how students can enhance their CC through educational interventions.

The second limitation is that whilst this research acknowledges that students are not a homogenous group, it has not systematically examined the relationship between students' CC development and their individual sociocultural backgrounds. Results show that students' diverse sociocultural backgrounds have an influence on their CC and their attitudes toward developing CC. However, how and to what extent their individual backgrounds may affect their development of CC is beyond the scope of this research and needs further investigation.

Another limitation of this research is that it only focuses on exploring the CC development of individual medical students. I acknowledge that CC development needs to be viewed from individual, team and institutional levels, but discussing and arguing for a multilevel approach for CC in depth on all levels would be beyond the capacity for one study. I chose to focus on CC development of medical students as this is an area that medical educators in the field have some power and immediate influence. With such research-based evidence, medical educators and learners are in a better position to challenge institutions and systems.

Lastly, while the document review concludes that many challenges to enhance CC and diversity education have been expressed by medical schools (e.g. timetabling, weak infrastructure development, limited funding, and culturally homogenous geographical environments), these remain situation-specific among individual medical schools. More educational research is required to provide an in-depth understanding of these challenges and what efforts can be implemented to address these challenges in consideration of the different types of medical schools.

9.5 Conclusion

Medical students' development of CC is a complicated and interactive process taking place in different learning environments. CC and diversity education in medicine continues to face challenges. The realities and challenges need to be actively considered, discussed and addressed. This research, hopefully, fills the gap in understanding students' development of CC by unveiling their learning experience in both educational and extracurricular settings. The potential learning opportunities are identified, and pedagogical suggestions are offered. The proposed CC development model helps educators gain a holistic perspective of how medical students develop their CC and the essential attributes that are required to achieve CC. The EDUCATIONIST guide may be beneficial to medical educators to overcome some uncertainty in CC and diversity education. Application of these may advance curriculum development around CC to be more systematic than it has been to date and enable evaluation of its impact on outcomes of graduates and the delivery of culturally appropriate care. Additionally, the exploratory nature of this ethnographic study may shed light on understanding medical students' learning experiences around CC in a global context. As global mobility is becoming a theme worldwide, this research is not only of pragmatic implication within the UK context. Universal themes can be contextualised culturally, which makes the study an important addition to the field.

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Appendices

Appendix 1. List of retrieved publications

1. Abu-Arab, A., & Parry, A. (2015). Supervising culturally and linguistically diverse (CALD) nursing students: A challenge for clinical educators. *Nurse Education in Practice, 15*(4), e1-e9.

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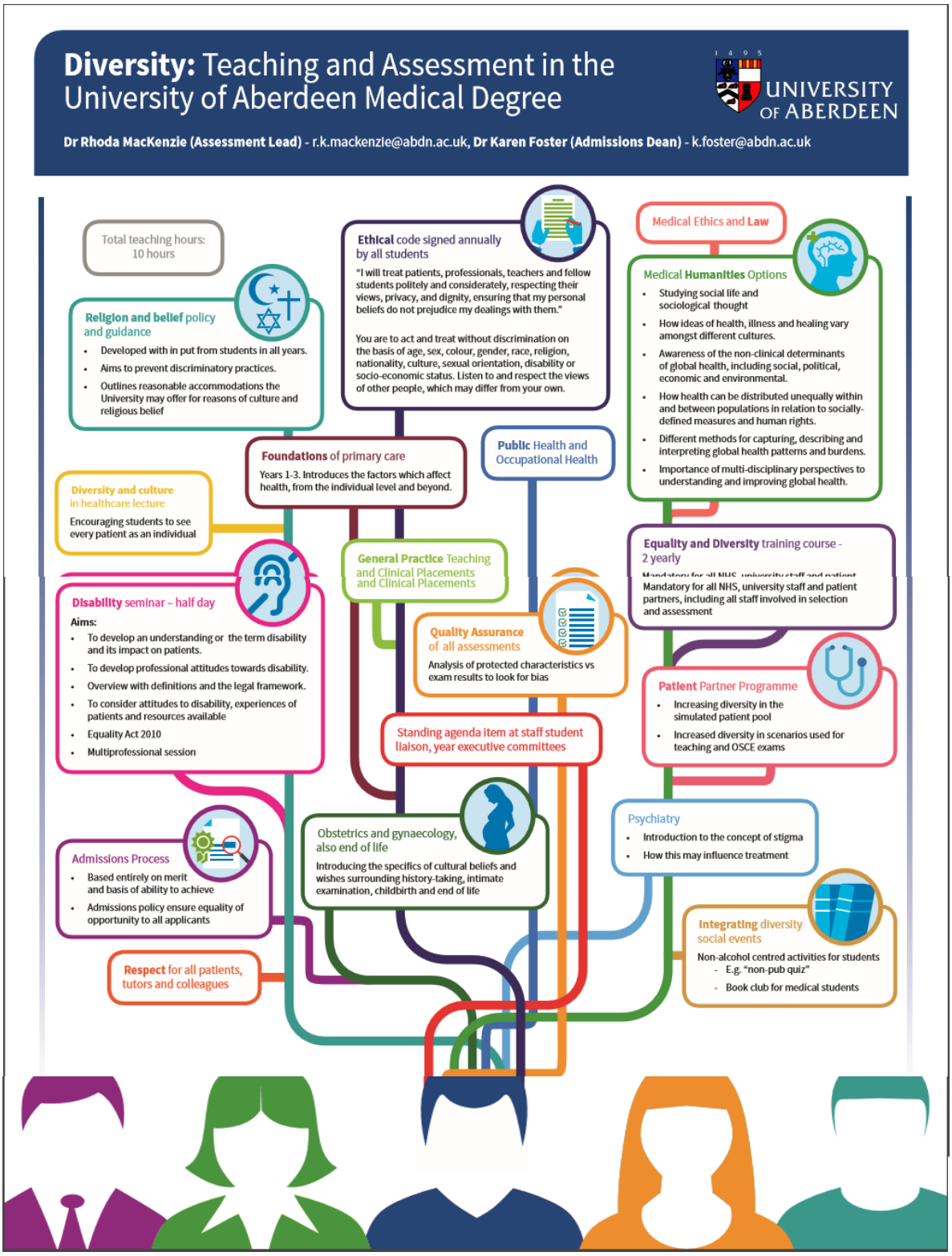
Appendix 2: Sample DIMAH posters



Diversity Education in Queen's University Medical School Belfast

Dr Mairead Corrigan

Diversity Topics in the Core Curriculum

Strengths of Current Diversity Teaching

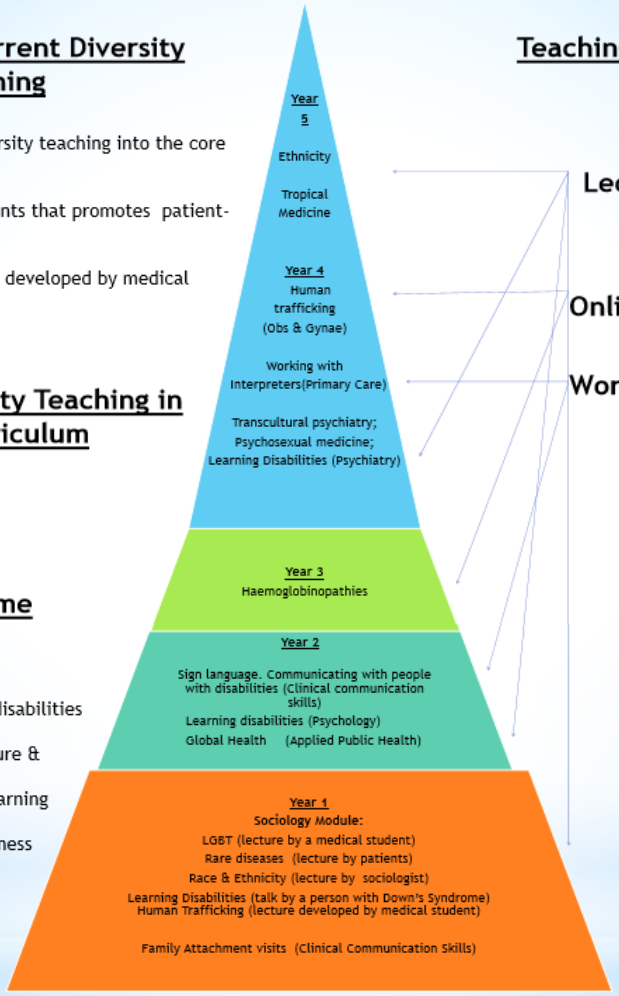
- Vertical integration of diversity teaching into the core curriculum.
- Lectures delivered by patients that promotes patient-centred care.
- Peer-led teaching on topics developed by medical students.

Assessing Diversity Teaching in Core Curriculum

- Family Attachment Report
- Short answer questions

SSC Programme

- Alternative Therapies
- Multicultural Medicine
- Working with children with disabilities
- Sign Language
- Latin American Health, Culture & Language
- Working with people with learning difficulties
- Movies, Myths and Mental Illness
- Human Trafficking
- Global Health



Teaching Methods

- Lecture
- Online Lecture
- Workshop

Challenges

- Teaching methods that are interactive, discursive & reflective.
- Developing OSCEs to assess diversity.
- Developing clinically meaningful assessments within an assessment culture that is driven by standardisation & psychometrics.
- Recruiting diverse standardised patients.
- Integrating diversity teaching using a spiral approach.

Opportunities

- Integrate the theme of equality & diversity into the portfolio
- Changes to the academic year in first & second year at QUB may provide an opportunity to develop an equality & diversity workshop.
- Plans to develop an OSCE for fourth years 2017/18.

BACKGROUND – THE CAMBRIDGE CURRICULUM

Students study medicine at Cambridge for 6 years. It is broadly separated into pre-clinical (years 1 to 3) and clinical (years 4 to 6). Diversity is addressed throughout all 6 years of the curriculum in different elements of the course. This document draws together all of these opportunities.

DEFINITION OF DIVERSITY

The concept of diversity encompasses acceptance and respect and includes recognition and acceptance of our individual differences. These can be along the dimensions of race, ethnicity, gender, sexual orientation, socio-economic status, age, physical abilities, religious beliefs, political beliefs, or other ideologies.
Throughout the curriculum, we aim to explore these themes in a safe but intellectually challenging environment.

DIVERSITY WITHIN THE CAMBRIDGE CURRICULUM

YEARS 1-3: MVST TRIPOS

SOCIAL CONTEXT OF HEALTH AND ILLNESS COURSE

In year 1 all students undertake 'Social Context of Health and Illness'. Addressing diversity in health, in addition to exploring social inequalities in health are the intended learning outcomes for the first 2 lectures of the course. The final 2 lectures address stigmatism and cultural stereotyping.
In addition to lectures, students receive small group teaching within their Colleges where case studies are discussed. The case studies are designed to raise issues around diversity. One example is that of a woman with a diabetic foot ulcer. The case study addresses the dynamics within her family (she has a female partner) which shape her engagement and interaction with health services.

PREPARING FOR PATIENTS COURSE

Preparing for Patients (PfP) is a programme that provides pre-clinical medical students at the University of Cambridge with early patient contact. The first three years of medical studies in Cambridge concentrate on the science that underlies medicine. Alongside this study, running throughout the three pre-clinical years, students undertake a programme designed to provide them with opportunities to relate their class work to real patients' experiences of health problems. The programme also allows students to progressively develop the communication skills needed to interact successfully with patients.
There are 4 modules of PfP:

- **PfP A** involves meeting patients in general practice (year 1)
- **PfP B** involves meeting patients in a hospital setting (year 2)
- **PfP C** involves visiting community-based health-related agencies (complementary therapy and a charitable/voluntary organisation) (year 2/3)
- **PfP D** enables you to follow a pregnant woman and her family at home over some time (year 3)

These four elements provide a complementary set of different healthcare experiences. and emphasises issues relevant to diversity:

- the importance of communication between doctor and patient
- patients' perception of illness and the personal and social factors relating to this
- the relationship between the patient's perception of illness and their underlying disease
- inter-relationships between the various organisations and agencies that provide support for people with health-related problems.

Each of the PfP modules have objectives which are linked to patient's abilities to access healthcare and encourage students to explore real clinical examples of the theory which is covered within the Social Context of Health and Illness Course in year 1.

YEARS 4-6 MB IN CLINICAL MEDICINE (MBBS)

The clinical medicine course includes the following integrated themes which are taught throughout the final 3 years of the course, in addition to more traditional ward, general practice and clinic based training.

1. Clinical Communication
2. Professionalism
3. Ethics and Law
4. Public Health

These integrated themes all form part of the core curriculum for students.

MANDATORY TRAINING

All students complete an on-line equality and diversity training module (e-LFH), prior to commencing the clinical component of the course.

CLINICAL COMMUNICATION

The clinical communication course is based around classroom based small group sessions in which students learn and practise the skills they will need to communicate with patients, their families and with other professionals. The early sessions focus on core skills such as history taking, moving through to more complex skills such as death and dying, and shared decision making by the final year. The teaching uses simulated patients and many of the roles are developed to include socioeconomic or cultural factors which then increase the richness of students learning. Where we have attempted to more overtly incorporate diversity (around race and religion) into roles, this has resulted in feedback from students that the roles are so stereotyped as to be counterproductive. As such, we have moved away from overt signposting of diversity as a learning objective, but more try to build them into roles. Examples include sessions around the elderly, a bisexual patient and mental health.

PROFESSIONALISM

Professionalism is undertaken in groups of about 12 students, facilitated by a trained clinician. Each session has a theme and students reflect on their experiences during the session, and also submit a written summary of their reflections. Issues such as team working and professional behaviour are discussed in earlier sessions and there is a session entitled 'dealing with discrimination' which is designed to help students cope with their own responses if they witness discrimination for any reason.

ETHICS AND LAW

Within the Ethics and Law course respect for individual differences is discussed in most sessions. The concept of 'Values-Based Medicine' (Fulford) is used to teach students to identify, and give appropriate weight to, the value systems of their patients. In year 6, all students will undertake a workshop on 'Justice: Rights, Responsibilities and Resource Allocation', which addresses the legal duty of non-discrimination imposed by the Equality Act 2010. During this workshop, students address a 'mock prioritisation committee' exercise during the, which involves ranking service proposals in order for funding from a CCG. A part of the exercise addresses fair treatment of disadvantaged groups and not unwittingly further entrenching social disadvantage through funding and rationing decisions. There are also workshops in which students are taught about their duties under the Equality Act: 'a public sector equality duty requiring public bodies to have due regard to the need to eliminate discrimination and to advance equality of opportunity and foster good relations between people who share certain protected characteristics and those who do not. The protected characteristics are age, disability, gender reassignment, pregnancy and maternity, race, religion or belief, sex and sexual orientation'

PUBLIC HEALTH

The Public Health course in the clinical years has a strong focus on health inequalities and the social drivers of these, including inequalities between groups based on income, gender, ethnic origin and culture. In particular there is a session in year 5 entitled "Vulnerable Groups" which seeks to ensure students are aware of the disadvantages faced by different populations; in this session the full spectrum of protected characteristics (as defined by the Equality Act 2010) is explored including LGBT* issues and challenges faced by disabled people. In the core public health teaching in year 5, we introduce the idea that doctors and healthcare workers can themselves perpetuate and reinforce discrimination and inequality through unconscious biases, and encourage the students to assess critically their own attitudes using online tools. The year 6 joint teaching with Ethics and Law (described above) includes a prioritisation exercise that highlights the importance of a raised consciousness around issues of discrimination in making funding decisions on a population level.

PALLIATIVE CARE

The Palliative care component of the clinical course includes a half-day seminar "Care after Death" in which the needs of people from different religious communities are covered with regard to care of people in the immediate period before and after death. This session is taken by the senior chaplain at Addenbrooke's Hospital Rev Dr Derek Fraser. We have a series of recorded interviews with religious leaders on the MedEd (Jewish, Hindu, Muslim, Roman Catholic, Secular, Jehovah's Witness) which students are encouraged to view before the seminar. I attach the handout which is not gone through in detail during the session: students are encouraged to read it afterwards.other opportunities

STUDENT SELECTED COMPONENTS

Students undertake student selected components during years 4 to 6 of the curriculum, which may provide additional exposure to diversity, for example by gaining additional experience within the deaf community, or with the homeless.

GENERAL PRACTICE

During their time in general practice, all students meet with a disabled patient on at least 2 separate occasions, within their own home in order to gain deeper understanding of living with disability, with a particular focus on issues around accessing healthcare. We also expect all students to undertake at least one consultation during their senior rotation in general practice, using either a face to face interpreter, or language line.

PATIENT VOICE

During the regular review and integration weeks there is a "Patient's voice" programme. Representatives from patients groups are invited to give a lecture to and take questions from students. There is often discussion around access to funding for medicines (for example novel cancer treatments), in addition to the reality of living with chronic illness such as diabetes or cystic fibrosis.

CONCLUSIONS

Diversity is addressed throughout the curriculum for students studying Medicine at Cambridge. This document has summarised where diversity is known to be addressed within the curriculum, however, there are likely to be many other opportunities for students to reflect on diversity during clinical practice. Whilst we very much hope that the role models our students encounter are good ones, the professionalism course small groups where students are able to discuss behaviours (both positive and negative) that they have witnessed in practice, supervised by an experienced facilitator.

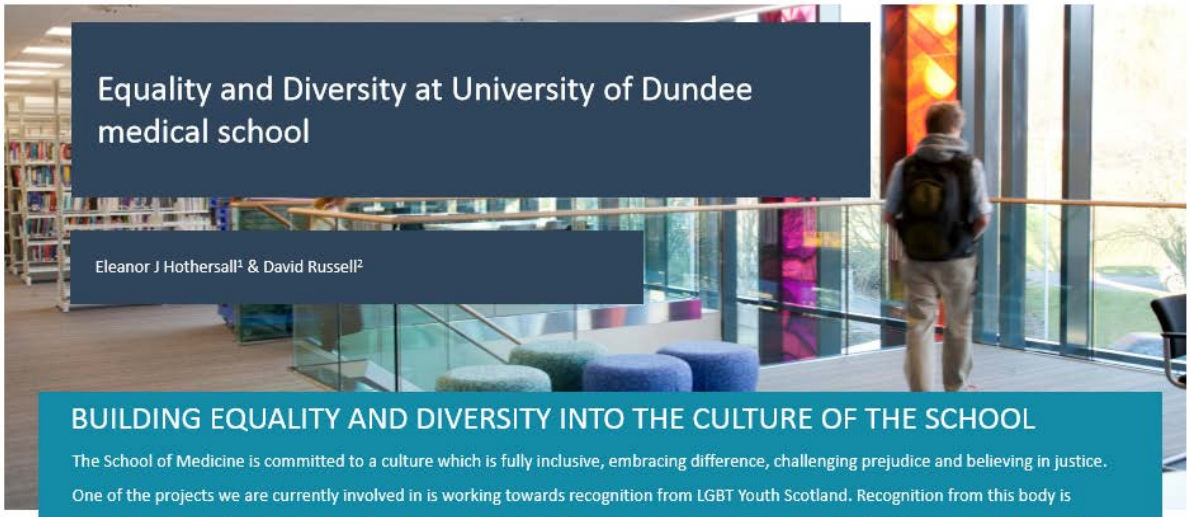
University of Dundee

Undergraduate Medical School

1. Systems in Practice Convenor, Ninewells Hospital and Medical School, Dundee, 2. Manager, Undergraduate Education

Athena SWAN Bronze Award

LGBT Youth Scotland



Equality and Diversity at University of Dundee medical school

Eleanor J Hothersall[1] & David Russell[2]

BUILDING EQUALITY AND DIVERSITY INTO THE CULTURE OF THE SCHOOL

The School of Medicine is committed to a culture which is fully inclusive, embracing difference, challenging prejudice and believing in justice. One of the projects we are currently involved in is working towards recognition from LGBT Youth Scotland. Recognition from this body is awarded to organisations that have policies, practices and training that create an inclusive environment for the LGBT community. Our student population is a diverse group of people and this project is one project amongst many designed to embed diversity, not only in our curriculum, but in our school culture

INTRODUCTION

In line with the outcomes set by the GMC[A] we aim to give students the opportunity to gain knowledge and understanding of the needs of patients from diverse social, cultural and ethnic backgrounds.
Dundee medical school has a spiral curriculum that builds knowledge and develops reflective practice. Ethics and communication skills are repeating topics where much of our teaching of equality and diversity takes place.
We aim to create doctors who are strongly aware of E&D and can incorporate this into their practice of medicine. This is an area of the medical curriculum we constantly aim to develop.

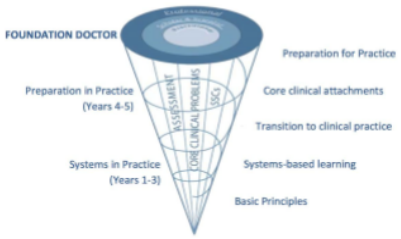


FIGURE 1. The "spiral curriculum" at Dundee Medical School

AREAS OF GOOD PRACTICE

Dundee has a very well delivered programme of education in communication and ethics that are used to deliver E&D teaching.
An example of this is the interprofessional learning sessions around complex communication needs (CCN) in conjunction with the school of computing. This has led to recruitment of simulated patients with CCN.
Ethics teaching is used to cover areas including IVF treatment for same sex couples; treatment of those with religious or moral beliefs; ethics of a transgender individual who wishes maxillofacial surgery during male to female transition and the funding of this under the NHS.
Learning opportunities around learning disabilities feature strongly in the Dundee curriculum in both structured teaching as well as

PARTNERSHIP WITH STUDENTS

In 2014 we introduced a religious code of practice document[B]. This document is centred around professionalism and the encouragement of individuals to meet their potential, whilst acknowledging the need for religious observance in clinical settings. This document was based on a the St George's document and was introduced with consultation with students. This document has since been adopted by the schools of Nursing and Dentistry as well as NHS Tayside.

AREAS FOR FUTURE DEVELOPMENT

Two areas are particularly highlighted for further development within the curriculum. Physical disabilities are dealt with from an administrative point of view, but the teaching and learning on the impacts both for the individual and the institution are not well covered at present. Other recent curriculum additions such as the physical activity resources[1] may be a useful way to link these topics together.

Ethnicity is also challenging to cover well in Tayside, where the ethnic composition of the patient population is considerably more homogeneous than the students attending the medical school (see Figures 1 and 2). Solutions here include increasing the diversity of simulated patients (for example a recent recruitment effort in a Muslim women's project), and enhancing teaching in settings such as the elective.

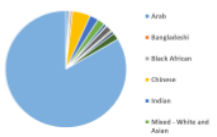


FIGURE 2. Ethnicity in Dundee medical students

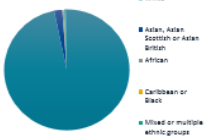


FIGURE 3. Ethnicity in local population (NHS Tayside)
Data: Scotland Census 2011 (scotlandcensus.gov.uk)

LGBT YOUTH SCOTLAND CHARTER

The medical school have been working with LGBT Youth Scotland to meet the requirements of the LGBT Foundation Charter Mark. This award is intended to raise awareness and increase visibility of LGBT people, ensuring that all LGBT people are valued, included and supported – whether they are staff, students or the patient population.
The LGBT Charter process requires participants to look at their policy and practice, including their legislative obligations in the context of LGBT equality. However, at the school we were keen to ensure that this work extended beyond the administrative function to include teaching and culture.

As a consequence of the LGBT Charter work, all senior teaching and support staff will have targeted training on relevant issues, and be encouraged to share that training widely.
By completing and displaying the LGBT Charter of Rights, the school will send a positive message to LGBT people in the medical school and across Tayside that they are included, valued, supported and our workplace is a safe and supportive place for LGBT people.

The panel of LGBT Champions who form the steering committee for the LGBT Charter work come from all areas of the undergraduate curriculum, with representation from students, postgraduate colleagues, as well as administrative teams. Successful events such as LGBT History month and International Trans Day of Remembrance have helped to set the tone in the medical school ethos and demonstrated our commitment publicly.

The Norwich Medical School Teaching and Learning Diversity

Dr Laura Bowater **6th of May 2016**

University of East Anglia

Introduction

At the Norwich Medical School (NMS) we teach medicine using a Problem Based Learning (PBL) curriculum. Our course relates learning to real life, using scenarios and clinical problems from patients, with an emphasis on developing practical experience integrated with theoretical knowledge from week 1 of the MBBS.

Example of PBL Learning Outcomes

Module 1: Public Health

- Define the concept of Health Inequalities, using examples from the UK and globally within and between population subgroups (e.g by ethnicity, gender, sexuality, disability and residence status).
- Demonstrate awareness of the non clinical determinants of health, including the role of political, economic, cultural, environmental policies and gender disparities.

Module 1: Sociology

- Understand sociological concepts of gender, race and ethnicity and the impacts of diversity on health.
- Describe contemporary social and culture variations in family forms.

Example of Mapping Exercise

Examining where Diversity is embedded within the MBBS curriculum using **Consultation Skills Teaching** as an example.

Tomorrow's Doctors	Consultation skills
a Communicate clearly, sensitively and effectively with patients, their relatives and carers, and colleagues from the medical and other professions by listening, sharing and responding	• From Year 1 week 1 consultation skills early teaching prior to primary care placement • Scenarios year 4 and 5 triadic consultation (children and parents), and consultation with carer (dementia) • Year 3 and 5 communication with colleagues as part of role play scenarios
b Communicate clearly, sensitively and effectively with groups and individuals regardless of their age, social, cultural or ethnic background or their disabilities including when English is not their first language.	• Scenarios with elderly in year 4 and 5 • Year 4 Sexual history session – same sex relationship • Year 5 Homelessness scenario
c Communicate by spoken, written and electronic methods (including medical records) and be aware of other methods of communication used by patients. Appreciate the significance of non verbal communication in the medical consultation.	• Written communication M14 (assistantship) • Telephone consultations • Use of visual aid (from year 2)and decision aids (year 4) • Non verbal communication from year 1 session1
d Communicate appropriately in difficult circumstances such as breaking bad news, and when discussing sensitive issues such as alcohol consumption, smoking or obesity	• Year 1 dealing with emotions • Year 4 and 5 breaking bad news (opportunities in 4 sessions in total) • Lifestyle year 3 (smoking), year 4 alcohol (adolescents and risk)
E Communicate with difficult of violent patients	• Angry patients and conflict Year 5
F communicate appropriately with people with mental illness	• Year 4 Psychiatry (4 sessions)
G Communicate appropriately with vulnerable patients	• Year 4 contraception, Y4 elderly care, y4 and 5 end of life • Year 4 Sexual history • Year 4 early onset dementia and suicide risk assessment
H communicate effectively in various roles for example patient advocate, teacher, management or improvement leader	• Patient advocate Handover (year 3 and 5) • Other roles in other parts of course, although PBL encourages communication within teams.

Teaching and Learning Diversity

- Norfolk and the East of England does not expose students to a widely, diverse patient community.
- Within the MBBS curriculum at the NMS, students are introduced to the concept of diversity and its impact on health within the first taught module they encounter.
- Students learning builds on this foundation within the 5 year spiral curriculum.
- Diversity and equality has been mapped within different aspects of the curriculum.

Additional points

- Student demographics represent wide socio-economic backgrounds.
- The Norwich Medical School offers A104, a Medicine with a Foundation year programme to promote widening participation to medicine.
- Norwich Medical School has a Silver Athena Swan award.

Athena SWAN Silver Award

Appendix 3: Advertising posters for interviews and focus groups

Are worried about unconscious bias?

Have you had daunting experience dealing with cultural differences?

Let us hear your voice and make a difference in your medical curriculum

All medical students from King's College London are warmly invited to take part in an interview to share your experiences of cultural competence development. This project aims to explore medical students' experience in dealing with cultural differences and inform pedagogical development of cultural competence education. You will get a £5 voucher for your participation. If you choose to participate you will be invited to an interview on Guy's campus, which will take about 30 minutes to 45 minutes. For those who are interested, please sign up for the interview by emailing me via jia.2.liu@kcl.ac.uk . It is a great opportunity for you to have your saying in your own medical curriculum.

Interested? Please email
Jia.2.liu@kcl.ac.uk

GKT School of Medical Education
Division of Medical Education
Chantler SaIL Centre

KING'S College LONDON

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Interested? Please email
Jia.2.liu@kcl.ac.uk

GKT School of Medical Education
Division of Medical Education
Chantler SaIL Centre

KING'S College LONDON

Appendix 4: Information sheet for shadowing in the non-clinical setting

Guy's and St Thomas' NHS
NHS Foundation Trust

KING'S College LONDON

INFORMATION SHEET FOR PARTICIPANTS

REC Reference Number: LRS-17/18-5013

IRAS ID: 234940

YOU WILL BE GIVEN A COPY OF THIS INFORMATION SHEET

Developing cultural competence among medical students in the UK: Preparing to care for a culturally and linguistically diverse UK patient population

Researcher:

Ms Jia Liu

Who is invited?

I would like to invite MBBS medical undergraduates at King's College London to participate in this project, which forms part of my PhD research. Before you decide whether you want to take part, please take time to read the following information carefully and discuss it with others if you wish.

What is the purpose of the study?

The aims of this study are to identify relevant factors which contribute to the development of cultural competence among medical students, and to inform pedagogical development of cultural competence training in medical education.

Why have I been invited to take part?

This is an ethnographic case study and will involve the observation of medical students undertaking their study and work (see 'What will happen to me if I take part' for detailed information).

Do I have to take part?

Participation is voluntary. You should only participate if you want to. Choosing not to take part will not disadvantage you in anyway. You should ask me if there is anything that is not clear or if you would like more information. My contact details can be found at the end of this document.

What will happen to me if I take part?

If you decide to take part you will be given this information sheet to keep and will be asked to sign a consent form. The researcher will then discuss the observation procedure with you. With your permission, I will come to your class (this includes lectures, seminars, workshops taking place in classrooms) or other relevant sociocultural activities (e.g. activities organised by the Student Union) to observe how medical students learn and practice cultural competence. During the observation process, I will sit or stand somewhere out of the way so that I do not interfere with your study/work and will watch and take notes.

Before observing big-size lecture, I will obtain verbal permission from the lecturer. Before observing small-size seminars or workshops, I will obtain verbal permission from the tutor/facilitator and make all students are aware that observation is taking place. I will also make sure all parties involved in teaching are aware that the purpose of the observation is not to assess or audit teaching/student performance. Before observing relevant sociocultural activities, I will obtain verbal permission from anyone else who are involved and make sure they are happy for me to observe. If you have any questions or concerns before or during the observation period you can ask me to clarify.

Can I withdraw?

If you decide not to take part before the observation, you can withdraw by informing the researcher. If you feel distressed at any point during the observation and want me to stop observing, you can ask me to do so at any time. You can choose to speak to the researcher or the academic supervisor if you wish. If you decide to withdraw from the study after the observation has been conducted, you can contact the researcher within two weeks and all data that is relevant to you will be withdrawn from analysis. You cannot withdraw after the observation has been conducted for longer than two weeks.

What are the possible benefits and risks of taking part?

The feedback you have provided will have influence on the cultural competence education at King's College London. There are no foreseeable risks in participating in the study.

Will my taking part be kept confidential?

All participants will be anonymised in the reporting of the research. In cases where names need to be mentioned, pseudonyms will be used. All your information and data is regarded as strictly confidential and will be encrypted and held securely on a password protected computer at KCL according to KCL data storage regulations and the UK Data Protection Act 1998. Data will be kept for three years after the completion of the study to allow disseminations. All data will be destroyed after this period.

How is the project being funded?

The project is self-funded. The study has been approved by the King's College London Research Ethics Committee. Permission has been granted by the GKT School of Medical Education.

What will happen to the results of the study?

I will produce a final report summarising the main findings, which forms part of my PhD thesis. I also plan to disseminate the research findings through publication and conferences.

Who should I contact for further information?

If you have any questions or require more information about this study, please contact me or my supervisor using the following contact details:

Jia Liu, GKT School of Medical Education, King's College London, Guy's Campus

London SE1 9RT Email: jia.2.liu@kcl.ac.uk Tel: 075 9988 2536

Dr Shuangyu Li, GKT School of Medical Education, King's College London, Guy's Campus

London SE1 9RT Email: shuangyu.li@kcl.ac.uk Tel: 020 7848 6387

What if I have further questions, or if something goes wrong?

If this study has harmed you in any way or if you wish to make a complaint about the conduct of the study you can contact King's College London using the details below for further advice and information:

Research Ethics Office, Biomedical Sciences, Dentistry, Medicine and Natural & Mathematical Sciences Research Ethics Subcommittee Chair, Email: rec@kcl.ac.uk

Thank you for reading this information sheet and for considering taking part in this research.

Appendix 5: Information sheet for shadowing in the clinical setting

Guy's and St Thomas' NHS
NHS Foundation Trust

KING'S College LONDON

PARTICIPANT INFORMATION SHEET (OBSERVATION)

YOU WILL BE GIVEN A COPY OF THIS INFORMATION SHEET

Developing cultural competence among medical students in the clinical environment: Preparing to care for a culturally and linguistically diverse UK patient population

REC Reference Number: LRS-17/18-5013

IRAS ID: 234940

Researcher:

Ms Jia Liu

Who is invited?

I would like to invite MBBS medical undergraduates at King's College London to participate in this project, which forms part of my PhD research. This is an ethnographic case study and will involve the observation of medical students undertaking their clinical placement. Before

you decide whether you want to take part, please take time to read the following information carefully and discuss it with others if you wish.

What is the purpose of the study?

The aims of the observation are to explore individual students' personal journey of cultural competence development, to identify relevant factors which contribute to the development of cultural competence, and to inform pedagogical development of cultural competence training in medical education.

Do I have to take part?

Participation is voluntary. You should only participate if you want to. Choosing not to take part will not disadvantage you in anyway. You should ask me if there is anything that is not clear or if you would like more information. My contact details can be found at the end of this document.

What will happen to me if I take part?

With your permission, I will observe you during your clinical placement (in a NHS Foundation Trust) to gain insight of your life as a medical student and how your clinical experience may contribute to your cultural competence development. Specifically, I will observe how you interact with other people and how you deal with cultural-relevant issues. I will follow you for one working day (possibly from 9am to 5pm but it depends on your availability), and will produce fieldnotes during this process. I might ask you some questions to clarify things when necessary, but nothing will be recorded. When any other parties are involved during the observation process (e.g. NHS staff, NHS patients, or other medical students), I will obtain verbal permission from all the relevant parties. No observation will take place until all the involved are happy with this. If you have any questions or concerns before or during the observation you can ask me to clarify. If you want me to stop observing during the process, you can ask me to do so at any time.

Can I withdraw?

If you decide not to take part before the observation, you can withdraw by informing the researcher. If you feel distressed at any point during the observation and want to withdraw, you can withdraw by informing the researcher and your data will only be used with your permission. You can choose to speak to the researcher or the academic supervisor if you wish. If you have participated in the research for some time and want to withdraw during the process, you can withdraw at any time by informing the researcher, but relevant data will still

be used for analysis unless you ask us to withdraw the data. If you decide to withdraw your data from the study after all the observation process has been completed, you can contact the researcher within two weeks and all relevant data will be withdrawn from analysis.

What are the possible benefits and risks of taking part?

You will have an opportunity to express your opinions regarding cultural competence development. The feedback you have provided will have influence on the cultural competence education at King's College London. There are no foreseeable risks in participating in the study.

Will my taking part be kept confidential?

All participants will be anonymised in the reporting of the research. In cases where names need to be mentioned, pseudonyms will be used. If direct quotes are used, permission will be sought from the participants, but these quotes will not have identifiable information in them. All your information and data are regarded as strictly confidential and will be encrypted and held securely on a password protected computer at KCL according to KCL data storage regulations and the UK Data Protection Act 1998. A password protected personal computer/laptop will be used for data analysis and storage at home. Personal information will be encrypted and stored within a separate file. Research data will be kept for five years after the completion of the study to allow disseminations. Non-research data will be destroyed after 12 months.

How is the project being funded?

The project is self-funded. The study has been approved by the King's College London Research Ethics Committee. Gatekeeper approval has been granted by the GKT School of Medical Education at King's College London. This study is co-sponsored by King's College London and Guy's and St Thomas Foundation Trust.

What will happen to the results of the study?

I will provide you with a summary of a final report describing the main findings if it interests you. This report will form part of my PhD thesis. I also plan to disseminate the research findings through publications and conferences.

What to do if there is a problem?

If the research has upset you in any way, the researcher will ask if you want to pause or stop the observation and may also offer referral services to the Head of Student Affairs and Pastoral support. If urgent action is required, then occupational health and emergency medical (psychiatric) attention will be sought.

If this study has harmed you in any way, or if you wish to make a complaint about the conduct of the study you can contact King's College London using the details below for further advice and information:

Research Ethics Office, Biomedical Sciences, Dentistry, Medicine and Natural & Mathematical Sciences Research Ethics Subcommittee Chair, Email: rec@kcl.ac.uk

Who should I contact for further information?

If you have any questions or require more information about this study, please contact me or my supervisor using the following contact details:

Jia Liu, GKT School of Medical Education, King's College London, Guy's Campus

London SE1 9RT Email: jia.2.liu@kcl.ac.uk Tel: 075 9988 2536

Dr Shuangyu Li, GKT School of Medical Education, King's College London, Guy's Campus

London SE1 9RT Email: shuangyu.li@kcl.ac.uk Tel: 020 7848 6387

Thank you for reading this information sheet and for considering taking part in this research.

Appendix 6: Information sheet for interviews

Guy's and St Thomas' NHS
NHS Foundation Trust

KING'S College LONDON

PARTICIPANT INFORMATION SHEET (INTERVIEW)

YOU WILL BE GIVEN A COPY OF THIS INFORMATION SHEET

Developing cultural competence among medical students in the UK: Preparing to care for a culturally and linguistically diverse UK patient population

REC Reference Number: LRS-17/18-5013

IRAS ID: 234940

Researcher:

Ms Jia Liu

Who is invited?

I would like to invite MBBS medical undergraduates at King's College London to participate in this project, which forms part of my PhD research. This is an ethnographic case study and will involve interviews with medical students at King's College London. Before you decide whether you want to take part, please take time to read the following information carefully and discuss it with others if you wish.

What is the purpose of the study?

The aims of the interviews are to understanding medical students' personal opinions in terms of cultural competence development, identify relevant factors which contribute to the development of cultural competence among medical students, and to inform pedagogical development of cultural competence training in medical education.

Do I have to take part?

Participation is voluntary. You should only participate if you want to. Choosing not to take part will not disadvantage you in anyway. You should ask me if there is anything that is not clear or if you would like more information. My contact details can be found at the end of this document.

What will happen to me if I take part?

You will attend a semi-structured interview. The interview will last approximately 30-40 minutes and will take place in a room on Guy's campus/online at your convenience. Before the interview starts, the researcher will explain the study to you and go through a consent form with you to make sure you are happy to take part. The interview will be audio-recorded. The recording will only be reviewed by the researcher.

Can I withdraw?

If you decide not to take part before the interview, you can withdraw from the interview by informing the researcher. If you feel distressed at any point during the interview, you can inform the researcher during the process, but relevant data will still be used for analysis unless you ask us to withdraw the data. You can choose to speak to the researcher or the academic supervisor if you wish. If you decide to withdraw from the study after the interview has been conducted, you can contact the researcher within two weeks and your quotes will be withdrawn from data analysis. However, you cannot withdraw after two weeks as this would be impossible once information has been used in the analysis.

What are the possible benefits and risks of taking part?

You will have an opportunity to express your opinions regarding cultural competence development. The feedback you have provided will have influence on the cultural competence education at King's College London. There are no foreseeable risks in participating in the study.

Will my taking part be kept confidential?

All participants will be anonymised in the reporting of the research. In cases where names need to be mentioned, pseudonyms will be used. If direct quotes are used, permission will be sought from the participants, but these quotes will not have identifiable information in them. All your information and data are regarded as strictly confidential and will be encrypted and held securely on a password protected computer at KCL according to KCL data storage regulations and the UK Data Protection Act 1998. A password protected personal computer/laptop will be used for data analysis and storage at home. Personal information will be encrypted and stored within a separate file. Research data will be kept for five years after the completion of the study to allow disseminations. Non-research data will be destroyed after 12 months.

How is the project being funded?

The project is self-funded. The study has been approved by the King's College London Research Ethics Committee. Gatekeeper approval has been granted by the GKT School of Medical Education at King's College London. This study is co-sponsored by King's College London and Guy's and St Thomas Foundation Trust.

What will happen to the results of the study?

I will provide you with a summary of a final report describing the main findings if it interests you. This report will form part of my PhD thesis. I also plan to disseminate the research findings through publications and conferences.

What if I have further questions, or if something goes wrong?

If the research has upset you in any way, the researcher will ask if you want to pause or stop the interview and may also offer referral services to the Head of Student Affairs and Pastoral support. If urgent action is required, then occupational health and emergency medical (psychiatric) attention will be sought.

If this study has harmed you in any way or if you wish to make a complaint about the conduct of the study you can contact King's College London using the details below for further advice and information:

Research Ethics Office, Biomedical Sciences, Dentistry, Medicine and Natural & Mathematical Sciences Research Ethics Subcommittee Chair, Email: rec@kcl.ac.uk

Who should I contact for further information?

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Jia Liu, GKT School of Medical Education, King's College London, Guy's Campus

London SE1 9RT Email: jia.2.liu@kcl.ac.uk Tel: 075 9988 2536

Dr Shuangyu Li, GKT School of Medical Education, King's College London, Guy's Campus

London SE1 9RT Email: shuangyu.li@kcl.ac.uk Tel: 020 7848 6387

Thank you for reading this information sheet and for considering taking part in this research.

Appendix 7: Information sheet for focus groups

Guy's and St Thomas' NHS
NHS Foundation Trust
KING'S College LONDON

PARTICIPANT INFORMATION SHEET (FOCUS GROUP)

YOU WILL BE GIVEN A COPY OF THIS INFORMATION SHEET

Developing cultural competence among medical students in the UK: Preparing to care for a culturally and linguistically diverse UK patient population

REC Reference Number: LRS-17/18-5013

IRAS ID: 234940

Researcher:

Ms Jia Liu

Who is invited?

I would like to invite MBBS medical undergraduates at King's College London to participate in this project, which forms part of my PhD research. This is an ethnographic case study and will involve focus groups with medical students at King's College London. Before you decide whether you want to take part, please take time to read the following information carefully and discuss it with others if you wish.

What is the purpose of the study?

The aims of the focus group are to explore medical undergraduates' understanding of cultural competence development, to identify relevant factors which contribute to the development of cultural competence, and to inform pedagogical development of cultural competence training in medical education.

Do I have to take part?

Participation is voluntary. You should only participate if you want to. Choosing not to take part will not disadvantage you in anyway. You should ask me if there is anything that is not clear or if you would like more information. My contact details can be found at the end of this document.

What will happen to me if I take part?

You will attend a focus group with 5-7 other medical students to discuss your understanding of culture and the development of cultural competence. The focus group will last no more than 2 hours and will take place in a classroom on Guy's campus. The focus group will be a group discussion facilitated by the researcher and an assistant. The focus group will be video-recorded for analysis. The recording will only be viewed by the researcher and the academic supervisor.

Can I withdraw?

If you decide not to take part before the focus group starts, you can withdraw from the focus group by informing the researcher. If you feel distressed at any point during the discussion, you can inform the facilitator during the discussion, but relevant data will still be used for analysis unless you ask us to withdraw the data. You can choose to speak to the researcher or the academic supervisor if you wish. If you decide to withdraw after the focus group has been conducted, you can contact the researcher and your quotes will be withdrawn from data analysis. However, you cannot withdraw after two weeks as this would not be practical once information has been used in the analysis.

What are the possible benefits and risks of taking part?

You will have an opportunity to express your opinions regarding cultural competence development. The feedback you have provided will have influence on the cultural

competence education at King's College London. There are no foreseeable risks in participating in the study.

Will my taking part be kept confidential?

All participants will be anonymised in the reporting of the research. In cases where names need to be mentioned, pseudonyms will be used. If direct quotes are used, permission will be sought from the participants, but these quotes will not have identifiable information in them. All your information and data are regarded as strictly confidential and will be encrypted and held securely on a password protected computer at KCL according to KCL data storage regulations and the UK Data Protection Act 1998. A password protected personal computer/laptop will be used for data analysis and storage at home. Personal information will be encrypted and stored within a separate file. Research data will be kept for five years after the completion of the study to allow disseminations. Non-research data will be destroyed after 12 months.

How is the project being funded?

The project is self-funded. The study has been approved by the King's College London Research Ethics Committee. Gatekeeper approval has been granted by the GKT School of Medical Education at King's College London. This study is co-sponsored by King's College London and Guy's and St Thomas Foundation Trust.

What will happen to the results of the study?

I will provide you with a summary of a final report describing the main findings if it interests you. This report will form part of my PhD thesis. I also plan to disseminate the research findings through publications and conferences.

What if I have further questions, or if something goes wrong?

If the research has upset you in any way, the researcher will ask if you want to pause or stop the focus group discussion and may also offer referral services to the Head of Student Affairs and Pastoral support. If urgent action is required, then occupational health and emergency medical (psychiatric) attention will be sought.

If this study has harmed you in any way or if you wish to make a complaint about the conduct of the study you can contact King's College London using the details below for further advice and information:

Research Ethics Office, Biomedical Sciences, Dentistry, Medicine and Natural & Mathematical Sciences Research Ethics Subcommittee Chair, Email: rec@kcl.ac.uk

Who should I contact for further information?

If you have any questions or require more information about this study, please contact me or my supervisor using the following contact details:

Jia Liu, GKT School of Medical Education, King's College London, Guy's Campus

London SE1 9RT Email: jia.2.liu@kcl.ac.uk Tel: 075 9988 2536

Dr Shuangyu Li, GKT School of Medical Education, King's College London, Guy's Campus

London SE1 9RT Email: shuangyu.li@kcl.ac.uk Tel: 020 7848 6387

Thank you for reading this information sheet and for considering taking part in this research.

Appendix 8: Consent form

Guy's and St Thomas' NHS
NHS Foundation Trust

KING'S College LONDON

CONSENT FORM

Title of Project: Developing cultural competence among medical students in the UK: Preparing to care for a culturally and linguistically diverse UK patient population

REC Reference Number: LRS-17/18-5013

IRAS ID: 234940

Name of Researcher: Jia Liu

Please initial box

1. I confirm that I have read the information sheet dated...22-Feb-18... for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐
2. I understand that my participation is voluntary and that I am free to withdraw up to two weeks after the observation/focus group/interview, without giving any reason, or legal rights being affected. ☐
3. I understand that the information collected about me will be used to support other research in the future, and may be shared anonymously with other researchers. ☐
4. I agree to take part in the above study. ☐
5. I consent to my interview being audio recorded. (if it applies) ☐
6. I consent to my focus group being audio/video recorded. (if it applies) ☐
7. I understand that some direct quotes from the interview/focus groups may be published but these will not have identifiable information. (if it applies) ☐

Name of Participant	Date	Signature
Name of Person taking consent	Date	Signature

Appendix 9: Participant demographic questionnaire

Participant Demographic Form

Please tick or fill out the form appropriately.

Gender: *male* ☐ *female* ☐ *other preferred identity* ☐

Age: *18-24 years* ☐ *25-34 years* ☐ *35-44 years* ☐

above 45 years ☐ *I'd rather not say* ☐

Year of Study: *Year 1* ☐ *Year 2* ☐ *Year 3* ☐

Year 4 ☐ *Year 5* ☐

Programme: *MBBS* ☐ *GPEP* ☐ *EMDP* ☐

Sexual orientation: *heterosexual* ☐ *homosexual* ☐ *bisexual* ☐

oth☐ *I'd rather not*☐

How many years have you stayed in the UK?

less than one year ☐ *1-3 years* ☐ *3-5 years* ☐

5-10 years ☐ *since I was born* ☐ *I'd rather not say* ☐

Nationality:

Native language:

Other languages you can speak:

Ethnicity:

Religion:

Do you have a previous diploma?

If yes, please given details.

Which social class do you consider your family belong to?

Thank you for completing this form!

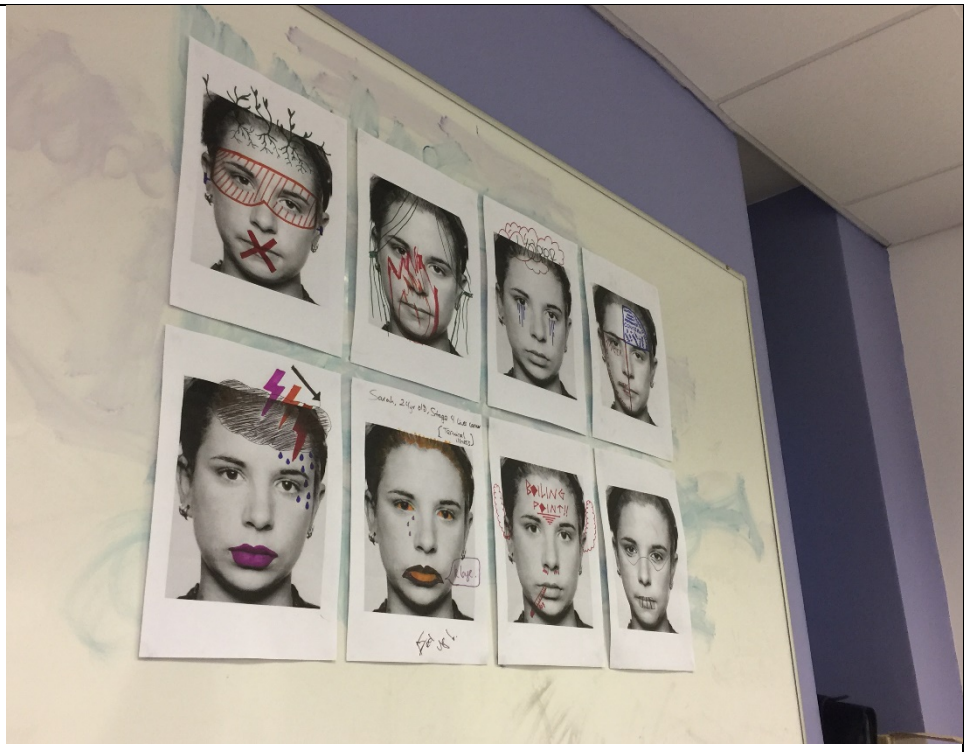
If you have any questions or require more information about this study, please contact:

Jia Liu, GKT School of Medical Education, King's College London, Email: jia.2.liu@kcl.ac.uk

Appendix 10: Observation template 1 (with sample fieldnotes)

Course Title	Clinical Humanities Project
Topic	Clinical Learning through the arts
Module	Longitudinal Placement-General Practice
Space	Introductory session-Henriette Raphael Function Room Teaching session- Henriette Raphael classroom 2.11
Time	22 December 2017 1pm-5pm
Participants	Year-2 students Artist E Professional facilitator S Student facilitator K 12 year-2 students PhD researcher (me)
Object	Photos and pictures, pens, white board PowerPoint locked due to Christmas holiday
Learning Outcome	-To train students to think outside the box for health and healthcare-to enable competent, patient-centred, safe, respectful, resourceful and resilient doctors who are capable of critical thinking, managing uncertainty, responding to pain and suffering, acting with cultural competence, promoting health and advocating for (and leading) change.

	- to provide opportunities to help with the students think about the coming clinical humanities projects within a wider group
Teaching Format	Introductory + facilitated session with lots of discussions
Activity	1. E asked students to google her profile and ask her questions 2. E cleared the confusion on what is clinical humanity (all humanistic approaches can used to inform clinical learning) 3. Restricted by no slides, Emma asked students to read patients' faces (these are printed out). 4. E then showed students patients' faces during her exhibition, together with a simple drawing by themselves to express their feelings 5. Students are divided into groups (each given a paper with a face). They are supposed to discuss and read the face and draw something to represent the face. (coloured pens are provided) Then, each group shared their feelings, and these are commented by the facilitators 6. Students were left in groups to discuss their forthcoming clinical humanities projects facilitated by the three (following the procedure of identifying a target group, create a challenge map, and figure out approach) 7. Students wrote down them project plan on a postcard and shared their idea within the winder group.

	
Analysis: **CC-Content**	This session has extensively addressed the importance and effectivity of using art to enhance clinical learning. Through observation and conversations with students, it is felt that the skill to read patient's faces (facilitated by artistic methods) is significantly addressed. This skill is in line with the cultural skill to learn and interact. The concept of cultural awareness is also subtly mentioned, when Emma mentioned during her professional career that Polish patients voiced their dissatisfaction and mistrust of the British healthcare services. Culture knowledge is not mentioned in this session.
Analysis: **Pedagogy**	The teaching method of combining an introductory session with a session with different themes is very effective. Before heading to each small-group session, students were given a clear message what their learning outcomes should be. This style of teaching seems quite prevalent for all the GP longitudinal campus events.

	As I attended the clinical learning through arts session for the individual-theme workshop, it was quite different experience that students were facilitated to read patients' faces. This method was generally very creative, but due to the restriction of no slides, the effect was not utmost satisfactory as the black-and-white printed faces were not as vivid as electronic photos. The presence of two facilitators was very useful as they could offer insights and opinions from both a professional and a student's perspective, especially when some facilitators are externals who are not very familiar with the higher educational environment. Students were a bit restless in this session. It is understandable as it is the last working day before Christmas and the campus is quite empty. some students came with suitcases ready to head off to the airport after the session. Moreover, my personal feeling as a student is that the main facilitator's teaching style can be a bit presumptuous. For example, though with no slides for introduction, the way to google her and raise questions as a start can be a bit strange compared to most teaching sessions. Nevertheless, as the facilitator is an external artist who is very different from a traditional academic, this diversity can also possibly bring students different perspectives to think about things and communicate with different groups of people.
Direct quotes from student (if	The group I was involved commented that the skill to read faces is valued.

have a chance)	Other students summarised their projects at the end of the session, including the following: 1. using arts to enhance communication with recreational drug users 2. using arts to communicate with homeless people 3. represent medical students through music score 4. using arts to talk about aging 5. using arts to communicate with patients with disability 6. using portraits to communicate with patients with bad diagnosis
My Reflection	Seemingly irrelevant art exhibitions and art methods can be used to enhance clinical learning. students are encouraged to think outside of the traditional box by treating medicine and healthcare as a positivist biomedical model. The clinical humanities project has a range topic of by using humanities methods to learn medicine, for example photography, poetry, and stitching etc. The core of these sessions is to using humanities as/of/for healthcare. During the introductory session, O from the cultural institute brought her with a stitching artwork she has brought her with in various occasions. students are encouraged to sew their name on the cloth. The cloth currently shows a diverse collection of first names from different cultures.  Though the clinical humanities projects are not necessarily about cultures, the term culture has been mentioned constantly throughout the teaching.

Appendix 11: Observation template 2 (with sample fieldnotes)

<table>
<tr><td colspan="2">AICF framework Participant: Miss Manda and Lizzy Date: 01/05/2018

ACTIVITIES Week Theme: PREGNANCY</td></tr>
<tr><td>General impressions/Observations

I followed Miss Manda and Miss Lizzy (they are clinical partners, one British Chinese and one British Caucasian) for one day at St Thomas hospital. They were allocated in the Early Pregnancy Unit and Emergency Gynaecology Unit this morning. Miss Manda was very early at 8:30 in the ward (she was told to come at 8:30), but the nurse told her to come at 9:00am in the future. Later, I followed Miss Manda to lots of places in the Early Pregnancy Unit to find her a patient to talk to. I unfortunately did not manage to observe any history taking with Miss Manda. This is because one patient she was asked to talk with was suddenly discharged and the other patient was angry and refused to talk with any medical students. Fortunately, she was offered a chance to observe the ultrasound scan for a pregnant lady (I was asked to not observe due to privacy and sensitivity issues). I did spend lots of time waiting and talking with Miss Manda and learnt lots of life experiences on her placements.</td><td>Sketch/photo-summary of activities

Scan observation 1: Miss Manda was asked to observe an ultrasonic scan for a pregnancy lady. She told me it was very interesting experience.

Activity 2: Miss Manda was refused a history-checking conversation by a patient.

ENVIRONMENT

Generally, a very busy environment, especially when there is an emergency section in this unit. Usually women had unexpected early-pregnancy symptoms (e.g. miscarriage, sudden bleeding) come here to seek healthcare.

Medical students are often left by themselves to ask and explore. Staff are generally very helpful but too busy. Medical students often feel do not know what to do.</td></tr>
</table>

Miss Manda did not go to the afternoon session as she said she was not very keen on that.

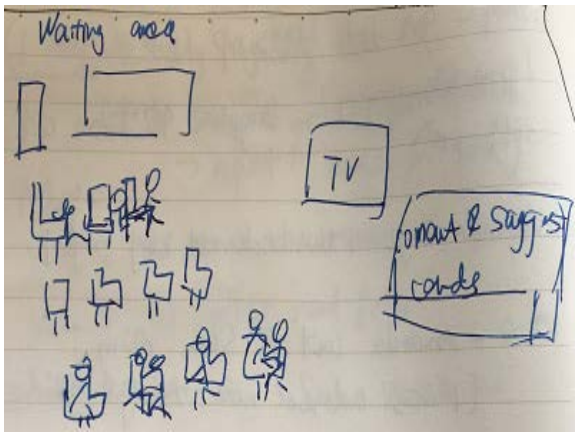
Elements, features and special notes

It was a very 'unhelpful' morning, according to Miss Manda. She later told me that lots of her peers thought this block was not particularly useful.

I can tell Miss Manda is a very keen student as she is punctual and took the lead of her placement whereas her clinical partner was late for almost forty minutes. She was constantly looking for opportunities to have a history-taking practice with patients.

I can also tell she is a bit nervous on placement. Miss Manda said because she is only Year-2, she doesn't think she is 'actually doing anything' on placements. Year 4 students should be able to help much more.

This is a very stressful environment. I saw a few women under serious pain and crying. In the waiting area, some women are weeping sadly, some with their partners offering support besides. In the waiting area, there is a TV playing health-relevant programmes. I saw one woman was staring at the TV screen with tears coming out of her eyes.



INTERACTION	
General impressions/Observations (Who is interacting with whom) Lots of interactions took place between different parties. Medical students vs. patients Medical students vs. nurses Medical students vs. clinicians Medical students vs. staff Medical students within their pair	**Description of interaction** -medical students interact with patients to learn about communication skills. -medical students interact with clinicians to learn about clinical skills, such as how to do an ultrasonic scan. -medical students interact with nurses and staff to clarify things and ask for guidance -medical students interact with pair to discuss their case, prepare for their case report, and exchange opinions on a case
Elements, features and special notes support from peers: Miss Manda says she wouldn't start talking with patients until her partner is there. This is because 1) she doesn't want her peer to feel lag behind and 2) she would be more supported if two persons are doing things together to support each other Support from staff: As Miss Manda was scheduled with a patient to talk with to practice history-taking, the nurse-in-charge gave her heads up saying that 'that is a very angry lady. I'm not sure if she agrees to talk with you'. In fact, it happens that the patient said she was too tired to talk with medical students. I feel this is important information as the head-up prepares inexperienced medical students mentally, so they would not be too sad or self-blaming if knowing this. Miss Mandy told me things like this happen, but not very often. Generally, patients are very nice and supportive.	

Unpredictable elements: I agree with Miss Manda that she has not done too much this morning. She was scheduled with another patient to talk with. But the first time she went in, the patient was not there. The second time she went in, the patient went out for a walk. The third time she went in, the patient was discharged already.

Different institutional contexts: Miss Manda told me that clinical placements experiences in different hospitals and institutions can be very different. For example, some hospitals can be more organised in terms of medical students' allocation and supervision, some not. This is the same for GP clinics. She told me that some GP placements can be very rigid, such as taking about students' feedback for the whole afternoon, whereas other GP clinics can be more flexible (some GPs even don't show up). There are lots of differences in terms of students' experiences depending on different institutional contexts.

CULTURAL ELEMENTS

General impressions/Observations	**Cultural stories heard from others**
Miss Manda told me that she thinks that being culturally competent is extremely important in working in a such diverse place like London. She also mentioned that culture is of different elements, so it is not only what where people come from, but also their educational level, personality, and socioeconomic status. Miss Manda shared me with some of her clinical placement experiences last week.	Story 1- one patient came to the post-natal ward and does not speak English. They had a Spanish interpreter for the patient via Language Line. Due to bad communication issues, the staff in the hospital did not know that they were expecting an interpreter (ineffective team communication). What is worse, the interpreter was late. As the patient is about to deliver a baby, the staff asked around who can speak Spanish. Miss Lizzy tried to help as she speaks Italian and a little bit Spanish but unfortunately medical English in a foreign

Elements, features and special notes Workforce diversity is a theme for staff. A mixture of staff from different ethnicities work together. The patient population is very diverse as well. As I sit in the waiting area, I can hear lots of patients from diverse ethnicities and speak different languages.	language is not just easy as daily conversation. At last, they had to use google translator to help the lady deliver. The delivery went OK. The translation applications helped tremendously. But the team were so nervous as being unable to communicate in the same language in a critical medical moment can be very daunting. Story 2: Miss Manda told me that she met a doctor who can speak three languages last week. As one patient was unable to speak English, the doctor used Polish to communicate with the patient. This went very well. Miss Manda commented that being multilingual is really a great advantage to be a doctor.

FEELINGS	
General impressions/Observations Diversity is a theme for both the hospital workforce and patient population. Communication challenges (e.g. language differences, national cultural differences) were not noticed during this observation but was shared by Miss Manda.	**Feelings as an ethnographer** 1. different learning experiences Depending on where students are allocated and when they are having their placements, they can have very different learning experiences on their placements. Different hospitals and GP clinics can have very different styles in working with medical

Miss Manda also encountered angry patient but fortunately she is resilient enough to deal with that.	students. For example, Miss Manda told me that one year-2 medical student was even asked to help with delivery in one of King's working hospitals during her placement, though she just started and barely know anything. The different learning experiences can also be influenced by other factors such as whether there are consultants and clinicians around to help, and the different cases and personalities of patients.
Cultural competence Knowledge: can be learnt from talking with patients and clinicians. *After-sessions workshop to reflect and exchange cases can enhance the learning experiences.* However, it seems that students are not too keen on this. Skills: communication skills are very relevant Miss Manda told me that being culturally competent requires skills to deal with emergencies in critical moments. Good example: *When no one is there for language help, the ability to quickly and effectively utilise phone translation software can be of key importance.*	2. different parties Lots of parties are involved during students' placements, such as clinicians, midwives, nurses, lecturers, and peers. This reflects different learning formats including experiential learning, peer learning, and structured classroom learning. To teach cultural competence, Miss Manda said a lecture is a good idea in giving an introduction, but discussion in small groups will help more when it moves to more depth. 3. unconscious learning through exposure My feeling, also agreed by Miss Manda, is that students are developing cultural competence unconsciously through exposure during clinical placements. But they might not be aware of that. Exposure is a key factor in developing one's cultural competence, but the extent of exposure depends on too many elements.

Appendix 12: Interview question guide

Topic Guide for Student Interview

1. How important do you think it is to be culturally competent as a medical student and future doctor?
2. What do you think being culturally competent in the medical setting requires?
3. How do you think official documents and guidelines at Medical school have made you aware of the importance to develop cultural competence?
4. How much do you think King's recognise the importance of cultural competence education for medical students?
5. How culturally competent do you think your tutors are at King's medical school (tutors here include academics and clinicians who are involved in teaching in MBBS program) are? Any good and bad examples?
6. Where do you think cultural competence has been taught in your curriculum? Any examples?
7. What kind of teaching formats do you think are most effective to allow you to develop your cultural competence?
8. How has your cultural competence been assessed in the curriculum?
9. How have you been developing your cultural competence in your clinical placements? Any examples?
10. How do you think you can develop your cultural competence through extracurricular activities? Any examples?
11. What factors do you think can contribute to your cultural competence development?
12. What challenges do you think you have in terms of cultural competence development?
13. What opportunities do you think you have that can support your cultural competence development?
14. What suggestions do you have to enhance clinical cultural competence education?
15. How do you think having widening participation is helping you develop your cultural competence?
16. How do you think promoting diversity and equality (e.g. gender, race) across the medical school is helping you with cultural competence development?

17. What do you think King's medical school can do to further support students' cultural competence development?

Appendix 13: Question guide for focus groups

Topic Guide for Focus Group 1

17 December 2017

1. Can everyone briefly introduce yourselves (name, year of study, where from)?
2. In your view, what is culture?
3. How can we best understand one's culture?
4. What is clinical cultural competence?
5. Why is it important to be culturally competent as a medical student?
6. What factors can influence one's cultural competence development? (within educational setting or hidden curriculum?)
7. During your medical training (e.g. clinical placement), have you witnessed cases in which situations are not dealt with cultural competence? Can you give some examples?
8. How have you been developing your cultural competence? Can you give some examples when and where it has happened?
9. How do you think we can train cultural competence most effectively?

Topic Guide for Focus Group 2

(based on campus observation)

2 May 2018

Can everyone briefly introduce yourselves (name, year of study, region)?

1. How important do you think it is to be culturally competent as a medical student and future doctor?
2. What do you think being culturally competent requires in the medical setting?
3. Where do you think cultural competence has been taught in your curriculum? Any examples?

   -cultural competence lectures and workshops

   -human values-based sessions (interprofessional education, clinical communication, patient scenarios, medical ethics and law)

   -philosophy sessions

   -clinic skills sessions (GP-longitudinal placement, Population and disease)

   (Which session do you remember most specifically? What's the impact of this session? Why this session does not stay with you? Do you have any further examples to add?)
4. What content has been taught about clinical cultural competence?

   attitudes-respect, empathy, non-judgemental

   -awareness of cultural differences, awareness of unconscious bias

   -cultural knowledge about specific groups

   -clinical communication
5. What kind of teaching formats do you think are most effective to allow you to develop your cultural competence?

   -lecture, workshop, self-directed learning

   -channels/resources: YouTube videos, artistic methods (e.g. painting, music, poetry), movies

   (Any teaching format you remember specifically? Can you rank the effectiveness of different teaching formats? Do you have any examples to add?)
6. How do you think you can develop your cultural competence through extracurricular activities? Any examples?

-networking with friends from different cultural backgrounds

-cultural societies/clubs or attending different cultural events

-previous working/internship experiences (e.g. gap year working experiences)

-volunteering experiences

-interacting with family members

7. What other factors do you think can contribute to one's cultural competence development? (please discuss things we have not mentioned above)

   -Growing-up environment

   -personality

   -linguistic capabilities

   -appearances

   -confidence levels

8. What do you think are the similarities/differences in terms of cultural competence development between domestic medical students and international medical students?

   -linguistic challenges

   -cultural challenges (different concepts of health)

   -international medical students can easily communicate with patients from similar backgrounds

   -any similarities/differences between ethnic-majority and ethnic-minority in communicating with patients?

9. What challenges do students have in terms of cultural competence development?

   In terms of cc domains:

   -Awareness, attitudes, knowledge, and skills

   -In terms of personal developmental process:

   -deal with differences in social economic status

   -deal with differences caused by linguistic challenges

   -deal with differences in cultural backgrounds and healthcare backgrounds

10. What do you think King's medical school can do to further support students' cultural competence development?

Note: Italicised points are preliminary results generated from observation that are used for facilitation.

Topic Guide for Focus Group 3

(based on clinical observation)

8 June 2018

Can everyone briefly introduce yourselves (name, year of study, region)?

1. In what ways do you think you can develop your cultural competence through exposure in clinical placements?
   -purposeful observation (patient diversity during history taking and clinical observation)
   -unconscious immersion (environmental diversity e.g. ward talks, cultural events)
2. In clinical placements, with whom do you think you can develop your cultural competence by interacting with them?

   -interaction with clinicians (role models)
   -interaction with nurses (learning about working environment, heads-up about patients, some communicational tips)
   -interaction with patients (history-taking, gaining exposure to diversity)
   -interaction with documents (signposts, medical notes-discussing cases and share thoughts)
   -interaction with peers (peer support and peer learning)
   -interaction with other clinical staff (guidance, clarification and heads-up)
3. Whose support in clinical placements do you think are essential in developing your cultural competence?
   -Staff
   -Patients
   -Peers
4. In what ways do you think the afternoon workshops in clinical placements can help you develop your cultural competence?

   -case sharing
   -cultural knowledge e.g. children in multilingual environments speak later
   -cultural skills e.g. when addressing sensitive questions, frame these as must-ask questions for everyone
5. What environmental elements in clinical placements do you think can influence (both positively and negatively) your cultural competence development?

   -diversity (patient diversity, workforce diversity, hospital events diversity)
   -learning environment (busy, stressful, institutional-different; student-led)
   -unpredictability (angry patients, no patients available for practice, no consultants, too many medical students)
6. What individual-level elements do you think can influence (both positively and negatively) your cultural competence development in clinical placements?

-e.g. personality, gender, linguistic capability, confidence, personal cultural interest, level of initiatives

7. What challenges have you encountered in dealing with culturally diverse patients in clinical placements?
   -linguistic challenges
   -education-level challenges
   -age group challenges (elderly, kids)
   -health beliefs challenges
8. How do you think students' different learning experiences in clinical placements will affect their cultural competence development?

   -different learning experiences

9. How do you pay attention to developing cultural competence in clinical placement?

   -active or passive
   -conscious or unconscious

10. What do you think are the similarities/differences in terms of cultural competence development between domestic medical students and international medical students?
    previous living environments of a country

11. What do you think King's medical school can do to further support students' cultural competence development?

Note: Italicised points are preliminary results generated from observation that are used for facilitation.

Appendix 14: Student transcription confidentiality agreement

CONFIDENTIALITY AGREEMENT

Transcription Services

Developing cultural competence among medical students in the UK: Preparing to care for a culturally and linguistically diverse UK patient population *REC Reference Number: [LRS-17/18-5013]*

I, _____, transcriptionist, agree to maintain full confidentiality in regard to any and all audiotapes and documentation received from [Jia Liu] related to [her] doctoral study on [Developing cultural competence among medical students in the UK: Preparing to care for a culturally and linguistically diverse UK patient population]. Furthermore, I agree:

1. To hold in strictest confidence the identification of any individual that may be inadvertently revealed during the transcription of audio-taped interviews, or in any associated documents;

2. To not make copies of any audiotapes or computerized files of the transcribed interview texts, unless specifically requested to do so by [Jia Liu];

3. To store all study-related audiotapes and materials in a safe, secure location as long as they are in my possession;

4. To return all audiotapes and study-related documents to [Jia Liu] in a complete and timely manner.

5. To delete all electronic files containing study-related documents from my computer hard drive and any backup devices.

I am aware that I can be held legally liable for any breach of this confidentiality agreement, and for any harm incurred by individuals if I disclose identifiable information contained in the audiotapes and/or files to which I will have access.

Transcriber's name _____

Transcriber's signature _____

Date _____

Appendix 15: The University Ethical Approval letter

Research Ethics
Office

Franklin Wilkins Building
5.9 Waterloo Bridge Wing
Waterloo Road
London SE1 9NH
Telephone 020 7848 4020/4070/4077
rec@kcl.ac.uk

KING'S College LONDON

Jia Liu

23 November 2017

Dear Jia

LRS-17/18-5013

I am pleased to inform you that full approval for your project has been granted by the BDM Research Ethics Panel

- Ethical approval is granted for a period of **three years** from 23 November 2017
- You should report any untoward events or unforeseen ethical problems to the panel Chair, via the Research Ethics Office, within a week of occurrence. Information about the panel may be
- accessed at:

http://www.kcl.ac.uk/innovation/research/support/ethics/committees/sshl/reps/index.aspx

If you wish to change your project or request an extension of approval, please complete and submit a Modification Request to crec-lowrisk@kcl.ac.uk. Please quote your ethics reference number, found at the top of this letter, in all correspondence with the Research Ethics Office. Details of how to complete a modification request can be found at: http://www.kcl.ac.uk/innovation/research/support/ethics/applications/modifications.aspx

All research should be conducted in accordance with the King's College London *Guidelines on Good Practice in Academic Research* available at: http://www.kcl.ac.uk/college/policyzone/assets/files/research/good%20practice%20Sept%2009%20FINAL.pdf

Please note that we may, for auditing purposes, contact you to ascertain the status of your research.

We wish you every success with your research.

Best wishes,

Ms Laura Stackpoole

Senior Research Ethics Officer

For and on behalf of:

BDM Research Ethics Panel

Appendix 16: NHS R&D Approval letter

Guy's and St Thomas' NHS
NHS Foundation Trust

Jia Liu
29 Tayfield

Ickenham

Uxbridge

UB10 8XA

Our ref: LOA854

Date: 20 April 2018

Dear Jia,

Letter of access for: Developing cultural competence among medical students in the UK-1 IRAS Reference: 234940

This letter confirms your right of access to conduct research through Guy's and St Thomas's NHS Foundation Trust for the purpose and on the terms and conditions set out below. This right of access commences on the **20/04/18** and ends on the **31/12/18** unless terminated earlier in accordance with the clauses below.

You have a right of access to conduct such research as confirmed in writing in the letter of permission for research from this NHS organisation. Please note that you cannot start the research until the Principal Investigator for the research project has received a letter from us giving permission to conduct the project.

The information supplied about your role in research at Guy's and St Thomas's NHS Foundation Trust has been reviewed and you do not require an honorary research contract with this NHS organisation. We are satisfied that such pre-engagement checks as we consider necessary have been carried out. The research has not been identified as being subject to Criminal Records Bureau Disclosure and therefore you should not undertake any work which involves unsupervised contact with children or vulnerable adults.

You are considered to be a legal visitor to Guy's and St Thomas's NHS Foundation Trust premises. You are not entitled to any form of payment or access to other benefits provided by this NHS organisation to employees and this letter does not give rise to any other relationship between you and this NHS organisation, in particular that of an employee.

While undertaking research through Guy's and St Thomas's NHS Foundation Trust you will remain accountable to your employer, King's College London Where any third party claim is made, whether or not legal proceedings are issued, arising out of or in connection with your right of access, you are required to co-operate fully with any investigation by this NHS organisation in connection with any such claim and to give all such assistance as may reasonably be required regarding the conduct of any legal proceedings.

You must act in accordance with Guy's and St Thomas's NHS Foundation Trust policies and procedures, which are available to you upon request, and the Research Governance Framework.

You are required to co-operate with Guy's and St Thomas's NHS Foundation Trust in discharging its duties under the Health and Safety at Work etc Act 1974 and other health and safety legislation and to take reasonable care for the health and safety of yourself and others while on Guy's and St Thomas's NHS Foundation Trust premises. You must observe the same standards of care and propriety in dealing with patients, staff, visitors, equipment and premises as is expected of any other contract holder and you must act appropriately, responsibly and professionally at all times.

You are required to ensure that all information regarding patients or staff remains secure and *strictly confidential* at all times. You must ensure that you understand and comply with the requirements

of the NHS Confidentiality Code of Practice (http://www.dh.gov.uk/assetRoot/04/06/92/54/04069254.pdf) and the Data Protection Act 1998. Furthermore you should be aware that under the Act, unauthorised disclosure of information is an offence and such disclosures may lead to prosecution. You should ensure that, where you are issued with an identity or security card, a bleep number, email or library account, keys or protective clothing, these are returned upon termination of this arrangement. Please also ensure that while on the premises you wear your ID badge at all times, or are able to prove your identity if challenged. Please note that this NHS organisation accepts no responsibility for damage to or loss of personal property.

We may terminate your right to attend at any time either by giving seven days' written notice to you or immediately without any notice if you are in breach of any of the terms or conditions described in this letter or if you commit any act that we reasonably consider to amount to serious misconduct or to be disruptive and/or prejudicial to the interests and/or business of this NHS organisation or if you are convicted of any criminal offence. Your substantive employer is responsible for your conduct during this research project and may in the circumstances described above instigate disciplinary action against you.

Guy's and St Thomas's NHS Foundation Trust will not indemnify you against any liability incurred as a result of any breach of confidentiality or breach of the Data Protection Act 1998. Any breach of the Data Protection Act 1998 may result in legal action against you and/or your substantive employer.

If your current role or involvement in research changes, or any of the information provided in your Research Passport changes, you must inform your employer through their normal procedures. You must also inform your nominated manager in this NHS organisation.

Yours sincerely,

J. Bagshaw

Jo Bagshaw Research Facilitator (non-commercial team)

Cc: HR department of Substantive Employer timothy.j.rogers@kcl.ac.uk